

PROCEDURE FOR: Documentation: Progress Notes

- POLICY:**
1. All nursing progress notes will be written using DAR (focus) format.
 2. A progress note is required a minimum of every 24 hours.
(Exceptions: well newborns on carepath with no variances, women on OB carepaths for vaginal and C/S deliveries.)
 3. The following events require a progress note:
 - Admission
 - Discharge
 - Transfer: both sending and receiving units
 - Code Blue
 - Death
 - Post-operative
 - Post procedure (e.g. PICC placement, interventional radiology procedure)
 - A significant even in patient's therapy (e.g. RBC procedure)
 - Presence of a new sign or symptoms or acute change in patient's behavior or condition
 - Resolution of a patient problem (that cannot be determined from the flowsheet)
 - Failure to meet expected outcomes on the carepath or care plan
 - Room search or unit search
 - Family meeting or patient care conference
 4. The progress note may be labeled using a nursing diagnosis, an event or symptom, or a variance.
 5. The patient's status at discharge or transfer must be communicated. This may necessitate writing a Progress Note for each active clinical problem.
 6. In the event of a patient death, a Progress Note must be written using the event, which precipitated the patient death (i.e., code blue for patient that arrests without warning or altered cardiac output for DNR patient who died from end-stage heart disease). It is not necessary to complete a Progress Note for each active problem.
 7. Unit/department specific charting requirements will be reflected in unit/department standards.
 8. Approved exceptions to documentation standards are:
 - a. OB/GYN:
 - For antenatal women admitted for long term hospitalization, Discharge Planning will be addressed at least every 7 days.
 - b. NICU:
 - The following Patient Care Problems will be addressed as indicated (refer to unit specific documentation procedure):

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- Discharge Planning - every seven (7) days

c. Med Surg 5:

- Discharge Planning - every seven (7) days

PROCEDURE:

ACTION

POINTS OF EMPHASIS

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| <p>1. All progress notes are timed, dated and signed.</p> <p>2. Notes are written according to the Focus Charting format:</p> <p>a. <u>D</u> (DATA): Subjective and/or objective information, which supports the problem or describes observations at the time of a significant event in therapy.</p> <p>b. <u>A</u> (ACTION): Past, present or future actions based on the assessment/evaluation of the patient's condition. The action also includes evaluation of the present care plan, any changes required and the plan for future care.</p> <p>c. <u>R</u> (RESPONSE): Description of patient responses/outcomes to care.</p> <p>3. Address one problem/event at a time.</p> | <p>2. Staff is encouraged to use all three components when necessary. However, it is not always appropriate to include all three components in certain patient care situations.</p> <p>a. Refer to the resource manual <u>Focus Note Charting</u> on each nursing unit for more information and examples.</p> <p>3. Several variances may be related to one problem/event.</p> |
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APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/90

REVISION DATES: 12/92, 7/93, 5/94, 1/96, 10/97, 11/99, 11/02, 10/06, 5/07, 7/09