



TUTOR TIPS

Department of Employment, Economic Development and Innovation
Funded under the Skilling Queenslanders for Work initiative

Documentation Skills in Aged Care - Progress Notes

Overview

Each client, who is receiving aged care assistance, must have a Care Plan in place to ensure on-going care needs are met. Progress Notes contribute to the review and updating of Care Plans to ensure these care needs are adequate. Documentation of care and any changes is a legal requirement and affects the level of care and government funding.

Aged care providers' ability to meet their Duty of Care to clients is dependent on changes being recorded in the Progress Notes. It is also important to be aware that clients with dementia generally lose their ability to express, clearly, their needs and therefore carers and providers become their advocates.

Important general information about documenting:

- Documenting needs to be completed as soon as possible after an event or incident.
- Progress notes are legal documents and must be filed out in the following manner:
 1. Progress notes MUST be recorded in black ink and printed.
 2. No correction fluid (whitener) can be used.
 3. A line must be drawn through any corrections, the correction initialed and the information rewritten.
 4. A line to the end of the page must be drawn where documenting does not use all the line space.

5. All notes must be dated, including the time of incident.
6. All notes must be signed and include the caregiver's printed name and status (eg. J Thomas J THOMAS PC).

The Writing Process

Documenting should be:

- by exception
- objective
- concise
- appropriate in language; and
- include only necessary information.

Documenting by Exception

It is necessary to record only events and instances that may affect the care plan. This includes client changes in behaviour, emotions and physical ability and any incidents involving the client. In order for care staff to decide what needs to be documented, they need to ask themselves the following questions:

- Will it affect the direction of care or the Care Plan?
- Does it relate to the status of the client's health?
- Did client refuse care?
- Was any care limited?
- Did the client make a complaint?
- Did the client do/try to do something which will impact on the status of their health and overall well-being?

Structuring information:

The SW + How plan is a good one to follow to ensure that all the necessary information is included in notes.

Who - Who is it about?

Where - Where did it happen?

When - When did it happen?

What - What happened?

Why - Why did it happen?

How? - Include this only if there is direct evidence
eg. signed event/incident

PLUS **What** you did about it if appropriate. Information about what care staff did for the resident can be written like a procedure. Below are examples. Note that each sentence starts with a verb (is doing or action word).

Assisted Mrs Hope to eat her dinner by cutting her food up. **Prompted** her to eat her coffee.

Using Appropriate Language

Notes should not be written using slang, unless recording a client's exact words. Language should be simple but appropriate.

Examples of inappropriate language:

| Inappropriate language | More appropriate language |
|--|--|
| She went round the bend when PC turned off the light. | She complained loudly when PC turned off the light. |
| He smeared poo all over his cupboard door. | He smeared faeces all over his cupboard door. |
| He went off his head at me when I tried to remove his teeth. | He shouted angrily at me when I tried to remove his teeth. |
| He pissed in another resident's cupboard. | He urinated in another resident's cupboard. |
| She did her number when I tried to shower her. | She became angry and yelled, 'Don't you touch me!' when I tried to shower her. |

| | |
|---|---|
| She did a runner when the door was open. | She left the room when the door was open. |
| I had to pick up all the crap she had thrown out of her cupboard. | I picked up all the items she had thrown out of her cupboard. |
| He touched me up when I was dressing him. | He put his hands on my breasts when I was dressing him. |

Include only necessary information

Progress Notes are a legal document not an opportunity to be creative and write an interesting story.

Below is an example of a note which is too long. It has been rewritten objectively, more concisely, in the active voice and only necessary information included.

| Long note | Rewritten note |
|--|---|
| Client was taken to the day room by staff at approx 08.30am. When she got to the day room staff assisted her to sit in one of the big comfortable arm chairs near the TV. She sat there for about 20 minutes and then started to have mood swings. She would be as sweet as pie one minute and then the next she'd be like 'Aaaa the flim carrying on and on about something or other and swearing over and over. All of a sudden she stood up out of her chair and walked over to Mr Long who was sitting across the room and punched him in the arm. | Client was continuously swearing and gouting loudly in the day room at approx 08.30am. She walked over to Mr Long and punched him in the left arm. Spoke gently to client and guided her back to her room. Set her in a chair and gave her a cup of tea. She stopped swearing and swearing (50 words) |

Documentation Skills In Aged Care Progress Notes

M Mark



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