General Guidelines:

1. Patient’s first and last name and HPH number on all forms
2. Date all entries. Date and time for all progress notes.
3. Time frame for completion of progress notes:
   • Within 24 hours of contact for home care
   • At end of visit for nursing home/inpatient
4. Use black ink on forms or input into electronic medical record
5. Avoid late entries. When a late entry is necessary, put the current date and time in the date area and begin the note stating “Late entry. On (date) at (time),” etc.
6. On forms, errors should be crossed out with a single line, bracketed, marked “error” and initialed. Do not erase or use “white out.” In the electronic medical records, notify the IT Specialist to make a note of the error.

Clinical Notes

1. Use the Data-Action-Response-Plan (DARP) method for each focus area addressed.

   **DATA:** What did you see – hear – assess?
   Include subjective and/or objective information relative to the focus areas addressed. Includes P/F behaviors, status, your observations, input from other professionals, test results, etc.

   **ACTION:** What did you or will you do in response to the data obtained?
   Note interventions here, including contacts you made to the physician, referrals to other team members, any changes in what is being provided, or changes in frequency of services.

   **RESPONSE:** What was P/F response to actions taken? Were actions successful in addressing the issue(s)?
   After you took action, was the P/F more calm? Less anxious? Comfortable? Remained ambivalent? Understood teaching/gave accurate return demonstration? Receptive to further visits? Etc.

   **PLAN:** What follow up actions will you take? Changes in plan should be added to the IDT Care Plan.

2. Not all notes will include data, action and response. You may chart data and action on one visit and not assess response until a follow up phone call or you next visit.
Bottom line is that simply reporting observations is not enough, nearly all physical, psychosocial and spiritual data compels us to some type of action! See charting tips section.

3. For additions/changes to the care plan as a result of your visit, you can simply state “see care plan.” **Remember: update the plan for changes or additions in what will be done, who will be involved, and/or changes in the frequency of interventions or visits.**

4. Identify in the **Focus** area the problem you are charting, i.e.: bowels, pain or coping. This corresponds with the Care Plan.

5. You do not have to repeat data in the progress note that has been documented elsewhere (initial assessments, checklist, and flow sheets) unless further explanation is needed.

**Charting Tips**

1. **Avoid basket terms:** “usual day/quiet night” syndrome. Other pet phrases: no c/o, watching TV, OOB ad lib., etc.

   The note is meant to show progress or lack of progress toward the goals stated in our care plan. Notes are also built around our focus areas. You don’t need to document the status quo and you don’t need to document every item you talked about during your visit. If you feel these phrases are important, go to tip #2:

2. **Be Specific!** The symptom or observation must be described well enough so that others will know what you mean. Examples:

   - “Patient confused” becomes “Patient believes he is at home and is attempting to climb OOB to get dressed for work.”
   - “Wife not coping with decline in husband’s condition” becomes “Wife continues to plan for their vacation despite John’s bedridden, lethargic status. Is resisting attempts by SW to address her fears about the possibility of John’s death.”
   - “Provided emotional support” becomes “Using touch and reflective listening, helped Mary express her grief.”
   - “Provided spiritual support” becomes “Prayed with Jim for calmness, that he and Joyce not be so hard on each other, that they will remain open to help from family and friends.”
   - “OOB ad lib” becomes “Able to walk 10 feet with one person assist. Sat in chair X 4 hrs.”
   - “No c/o” becomes “Pain controlled with MS Contin 30 mg. Q. 12 hrs.”

3. **Never use the word STABLE!** Our patients have their symptoms controlled or managed due to our interventions.