Nursing Progress Note (Short Version)

This form is to be completed by a LPN, RN, BSN, or MSN when providing **nursing services primarily in residential or inpatient substance use treatment programs, such as TSS, Detox, etc**. Nurses with a RNCS or an APRN with prescribing privileges should complete the Psychopharmacology Progress Note.

There are two different versions of the Nursing Progress Note – a short and long version. The short version is to provide adequate documentation for short length services such as injections, etc. while the long version has additional data fields that support the focus of the Psychopharmacology Progress Note including an interim history and mini mental status section.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name:	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: *Person Present; Person No Show; Person Cancelled.* If *Provider Cancelled* is checked, document explanation as relevant. If *Others Present* is checked, identify name(s) and relationship(s) to person.
Data Field	**Interim Update**
Interim History see long note manual	Record a review of the person's condition, medications, dosages, any allergic reactions, and health changes since last encounter, person's assessment of progress related to symptoms, side effects, overall functioning, effectiveness of medications and medication compliance. If no changes are reported or observed, indicate whether person is at baseline, no progress made, meds still working, etc.
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and indicate the resolution in the Response Section of the progress note. 3. If person presents an issue that has been previously assessed and for which Goals/Objectives and services have been ordered, then the information may be briefly documented as an indicator of the progress or lack of progress achieved. 4. If person presents any new issue(s) that represent a therapeutic need that is not already being addressed in the IAP, check box indicating a "CA Update Required" and record notation that new issue has been recorded on a Comprehensive Assessment Update of the same Date and write detailed narrative on the appropriate CA Update as instructed in this manual. Also, the newly assessed therapeutic information may require a new goal, objective, therapeutic intervention or service that will require further use of the IAP Review/Revision form. **Example: Person reported harassment by neighbor, leading to increase in worry and anxiety symptoms. Referred person to Legal Services and left message for individual therapist to coordinate care around legal issues and work with person on anxiety management skills.** **Example: Person reported that last week she was involved in a car accident and**

	since that time she is having nightmares and memories or physical abuse when she was in elementary school. See CA Update written today.
Measurements	Record vital signs, height, weight, BMI and/or AIMS, check as pertinent.

Data Field	Goals, Interventions and Response to Intervention
Goal(s)/Objective(s) Addressed from IAP	Identify the specific goal(s) and objectives in the Individualized Action Plan being addressed in this note. (Progress notes must be linked to specific goal/objectives in the IAP).
Person's Response to Intervention and Progress Toward Goals and Objectives	This section should address **BOTH**: • The **person's response** to the intervention, including evidence of how the person participated in the session and how the person was able to benefit from the intervention e.g. through active participation, better understanding of issues, understanding or demonstration of new skills. • **Progress towards goals and objectives**. This should include an assessment of how the session has moved the person closer, further away or had no discernable impact on meeting the identified goal and objectives. If no progress is made over time, this section should also include a discussion of how the staff person intends to change his/her strategy. **Example: Person was able to correctly identify medications and dosages. Has an understanding of potential side effects and agrees to report same to staff.**
Plan / Additional Information	The clinician should document future steps or actions planned with the person such as homework, plans for the next session, etc. *Plan to overcome lack of progress* - If no progress is made over time, this section should also include how the counselor intends to change his/her strategy to produce positive change in the person. Document additional pertinent information that is not appropriate to document elsewhere. **Example: Person was not able to correctly identify medications and dosages, so index cards were utilized to give more explicit instructions for each of the medications.**
Issues to be Referred to Physician/APRN:	Note issues, concerns, and/or information to be brought to the attention of the physician and time frame to do that. **Example**: **Positive lab results, medication problems, etc.**
Data Field	**Medicare "Incident To" Instructions**
Medicare "Incident to" Services Only (if applicable)	Check the box when service is to be billed using the "incident to" billing rules.
Name and Credentials of Supervising Professional on Site (if applicable)	Enter the name of the supervising professional who provided the on-site supervision of the "incident to" service. **Note:** The presence of an appropriately licensed supervising professional is one of the key requirements for an "*incident to"* service. In some cases, the service is billed under the number of the supervising professional. In others, the attending professional's number should be used. Providers should consult with their Medicare Carrier's Local Medical Review Policies.
Data Field	**Signature, Medicare Services and Billing Strip Instructions**
Provider (Print name):	**Legibly** print the provider's name..
Provider Signature/ Credentials:	**Legibly record provider's** signature credentials and date.
Supervisor Name:	If required, **legibly** print name of supervisor.

Supervisor Signature/Credentials:	If required, **legibly record supervisor's** signature credentials and date.
Person's Signature:	If appropriate, or clinically indicated, record the person's signature.