PROGRESS NOTES

Progress Notes

Progress notes are a journal of care delivery and information. They are important, brief narrative entries to record negative or positive occurrences relating to the clients. Progress notes are also used to document important issues or concerns that are related to the client's services or treatment. Depending on the case, progress notes may provide significant documentation related to some or all of the following concerns:

1. Documenting treatment: Progress notes allow a case manager/therapist to describe his or her work with a client. Without progress notes, it would be difficult, if not possible, for a case manager/therapist to create a service record that accurately reflects his or her sound clinical judgment, the standards of the profession, and the nature of the services being rendered. Furthermore, the progress notes provide the case manager/therapist with an opportunity to document his or her exercise of judgment in dealing with complex and challenging treatment scenarios.

2. Documenting treatment necessity: Progress notes provide evidence of the client's need for the services or treatment at a particular point in time.

3. Documenting Treatment Planning: Therapists occasionally utilize progress notes to refresh their recollection of clinical information from prior therapy sessions. This is particularly helpful when an extended period of time has elapsed since the last contact or changes in therapists. Progress notes also provide a source of clinical information that informs a therapist about the efficacy of clinical interventions that may have been utilized earlier in the client's treatment.

4. Billing /payment Documentation: In the event of a dispute over the amount or type of services rendered, progress notes substantiate the fact that services were rendered on a given date and that the billing was consistent with the nature of services rendered.

Examples of information that may want to include in progress notes:

- **Date, time, duration of service**
- **Attempts of contact with clients, FCMs, foster parents, other professionals, etc.**
- **Requests to FCMs, foster parents, other professionals, etc.**
- **Summary of Child and Family Team Meetings, case conferences, staffing**
- **Treatment modality used**
- **Progress, and/or lack of progress**
- **Service/Treatment plan**
- **Modification(s) of the service/treatment plan**
- **Clinical impressions regarding diagnosis, and or symptoms**
- **Relevant psychosocial information**
- **Safety issues**
- **Clinical emergencies/actions taken**
- **Treatment compliance/lack of compliance**
- **Clinical consultations/supervision**
- **Collaboration with other professionals**

- **Communication with client, significant others, other professional, school, foster parents, etc.**
- **Case manager/therapist's recommendations**
- **Termination/issues that are relevant to the termination process**
- **Issues related to cases**