Title:	Completing total progress notes in the nursing home and hostel
Department	Acute Care & Residential
Approved by	Clinical & Aged Care Governance Committee

Description

Total Care Progress notes are legally accountable documents. Total care progress notes are used as an adjunct to the Care Plan and record exceptional events and outcomes, document assessments interventions and evaluations using the ISBAR formula conducted by Nursing, Medical and Allied Health personnel and visiting health professionals.

Procedure Applies To

Registered Nurses Division I & 2 and Personal Care Attendants, Medical Officers, Allied Health and visiting specialist service providers

Purpose and Scope:

Exceptional events, incidents and adverse outcomes not anticipated in the care plan are documented, Responses to treatment are recorded and evaluated. Notes are written by other health professionals recording assessments, treatments and evaluations of care initiated or given during the course of the day

Procedure Standards

- Total Care Progress notes are legally accountable documents and a staff member who gives care must be the person to record that care
- Total Care Progress notes are designed to record the ongoing care of a resident and document the resident's response to their Care Plan. This includes changes in their condition resulting from adverse events such as a fall.
- It is preferable that the ISBAR formula is applied so that the assessment, planning intervention and response to the intervention are clearly demonstrated and documented:
  I: Introduction of self
  S: Situation: Current Clinical details
  B: Background:
  A: Assessment
  R: Request
- All unexpected events and incidents are to be documented in the progress notes as well as using extra documentation where required e.g. incident reports and falls reports.
- The administration of PRN medication is to be documented including: -
  the reason for administering the medication
  the medication given
  the response to the medication
- All entries in the progress notes **must have**: Patients U/R number, Patients name, Date of Birth, Age and Gender, Date and time of entry, Profession, Signature of staff member making entry and surname printed including designation

Key Aligned Documents

Key Legislation, Acts & Standards

QICSA Standard Reference: Standard 1.8

References

Commonwealth Documentation and Accountability Manual amendment 2003

Author / Contributors

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