Effective Progress Notes

Progress notes are a journal of care delivery and health information. Progress notes contribute to the review and update of the PWP to ensure care needs are adequate. Documentation of care and any changes is a legal requirement.

When you see, hear or experience changes in a Resident, making clear, concise and complete progress notes benefits everyone. What should you document? Ask yourself:

- Will it affect the direction of care or the PWP?
- Does it relate to the status of the Resident's health?
- Did Resident refuse care?
- Was any care omitted?
- Did the Resident make a complaint?
- Did the Resident do/not do something which will impact on the status of their health and overall well-being?

Be aware that Residents with dementia generally lose their ability to express clearly their needs – it becomes vital that Team Members become their advocates.

F.A.C.T. Notes

Good documentation is F.A.C.T. based. Factual, accurate, complete, timely and recorded in a structured way. F.A.C.T. provides a common framework to document.
The tool allows TMs to share concise and focused information. The F.A.C.T. is focused on data, this decreases the likelihood of misunderstanding.

Because a team of care providers require access to current Resident data, updates or changes in a Resident's condition need to be completed in a timely and competent manner.

Documentation must be **Factual:**

- descriptive objective data and subjective information is obtained by the team member

Documentation must be **Accurate**:

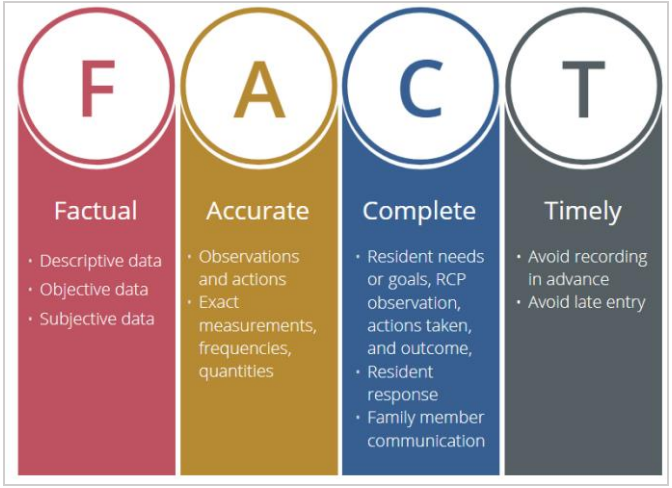
- before making an entry in the Resident's Health File (RHF), ensure it is correct
- document only your observations and actions
- use of exact measurements, frequencies and quantities ensures accuracy

Documentation must be **Complete**:

- document all necessary information and give a clear picture of what took place
- include the needs or goals of the Resident, your observations, the actions based on the needs and the outcomes
- document all changes in condition
- include Resident responses - especially unusual, undesired or ineffective responses
- include communication with the Resident's family

Documentation must be **Timely**:

- avoid recording in advance
- avoid late entry documentation

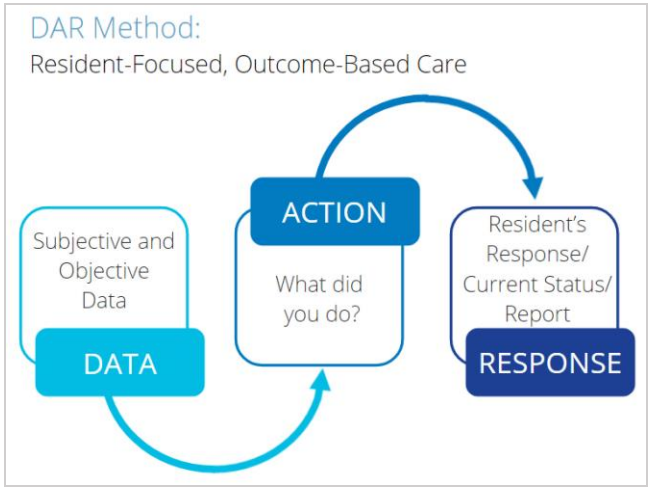


Capturing Data – the D.A.R. Method

D.A.R. is a recognized method of capturing data consistently and efficiently across interprofessional teams. It is used throughout Canada in the health sector.

D.A.R. is Resident-centred. It uses Resident data and tracks the actions (sometimes called interventions) of the care partner and the results (sometimes called outcomes) of the Resident.

Effective Progress Notes



D.A.R.

D stands for data. Both subjective and objective data.

Subjective data includes statements and feedback from the Resident. Use quotes when you are document what they said. Examples:

- ”I feel a strong shooting pain while standing, but it goes away when I’m sitting.”
- Mary repeatedly asked for her mother in a loud voice calling out, “I want my mother, where is she?” during morning noodle exercises in the MC neighbourhood.

Objective data is information of the Resident that can be observed. Objectivity means documenting facts without distortion of personal feelings, prejudice or interpretations. Examples:

- Resident was crying.
- Blood pressure is 120/80.
- Res was shaking and c/o chest pain in the hallway.

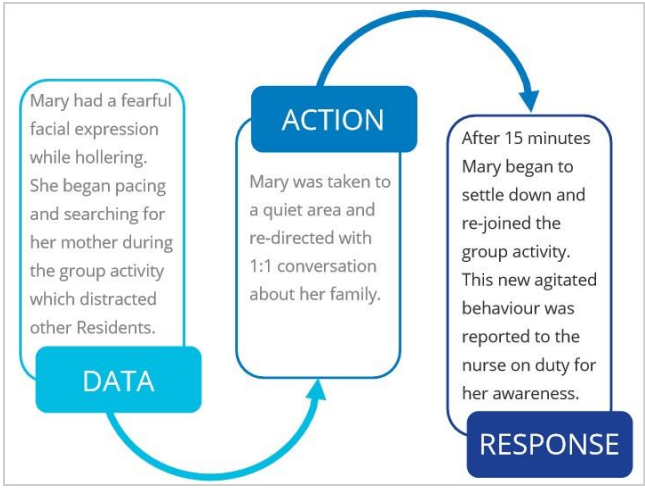
Documentation should include both subjective and objective data. For example, you may document:

- the *objective fact* that a Resident’s temperature is 38 degrees; and,
- the *subjective information* is the Resident reports “I am feeling warm and dizzy.”

A stands for action. What did you do?

R captures the **Resident’s response**, or **current status**, and if applicable, **what was reported to the nurse.**

Example: Resident Agitation During an Activity in the Memory Care Neighbourhood



Documentation Notes

- Be concise. Get to the point in the note, it is not a long narrative. Focus on facts, not feelings, assumptions or interpretations.
- Keep it simple.
- The Resident’s name or word Resident can be omitted.
- Maintain the confidentiality by using initials when referring to another Resident or quoting from another Resident.
- Only use approved abbreviations (refer to Amica’s approved list)
- Sharing information is essential to our ability to support and help our Residents. With this information comes the responsibility to manage and protect it. It is also the law.