Structuring information:
The 5W + How plan is a good one to follow to ensure that all the necessary information is included in notes.

Who - Who is it about?

Where - Where did it happen?

When - When did it happen?

What - What happened?

Why - Why did it happen?

How? - Include this only if there is direct evidence
eg. sighted event/incident

PLUS **W**hat you did about it if appropriate.
Information about what care staff did for the resident can be written like a procedure. Below are examples. Note that each sentence starts with a verb (a doing or action word).

Assisted Mrs Hope to eat her dinner by cutting her food up. **Prompted** her to use her cutlery.

Using Appropriate Language
Notes should not be written using slang, unless recording a client's exact words. Language should be simple but appropriate.

Examples of inappropriate language:

Inappropriate language	More appropriate language
She went round the twist when PC turned off the light.	She complained loudly when PC turned off the light.
He smeared poo all over his cupboard door.	He smeared faeces all over his cupboard door.
He went off his head at me when PC tried to remove his teeth.	He shouted angrily at me when I tried to remove his teeth.
He pissed in another resident's cupboard.	He urinated in another resident's cupboard.
She did her narnna when I tried to shower her.	She became angry and yelled, 'Don't you touch me!' when I tried to shower her.
She did a runner when the door was open.	She left the room when the door was open.
I had to pick up all the crap she had thrown out of her cupboard.	I picked up all the items she had thrown out of her cupboard.
He touched me up when I was dressing him.	He put his hands on my breasts when I was dressing him.

Include only necessary information
Progress Notes are a legal document not an opportunity to be creative and write an interesting story.

Below is an example of a note which is too long. It has been rewritten objectively, more concisely, in the active voice and only necessary information included.

Long note	Rewritten note
Client was taken to the day room by staff at approx 09.30am. When she got to the day room staff assisted her to sit in one of the big comfortable arm chairs near the TV. She sat there for about 30 minutes and then started to have mood swings. She would be as sweet as pie one minute and then the next she'd be like Attila the Hun carrying on and on about something or other and swearing over and over. All of a sudden she stood up out of her chair and walked over to Mr Long who was sitting across the room and punched him in the arm.	*Client was continuously swearing and speaking loudly in the day room at approx. 09.30am. She walked over to Mr Long and punched him in his left arm. Spoke gently to client and guided her back to her room. Sat her in a chair and gave her a cup of tea. She stopped swearing and was quiet. (56 words)*

TUTOR TIPS

Department of Employment, Economic Development and Innovation
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Documentation Skills in Aged Care - Progress Notes

Overview
Each client, who is receiving aged care assistance, must have a Care Plan in place to ensure on-going care needs are met. Progress Notes contribute to the review and updating of Care Plans to ensure these care needs are adequate. Documentation of care and any changes is a legal requirement and affects the level of care and government funding.

Aged care providers' ability to meet their Duty of Care to clients is dependent on changes being recorded in the Progress Notes. It is also important to be aware that clients with dementia generally lose their ability to express, clearly, their needs and therefore carers and providers become their advocates.

Important general information about documenting:
- Documenting needs to be completed as soon as possible after an event or incident
- Progress notes are legal documents and must be filled out in the following manner.
    1. Progress notes MUST be recorded in black ink and printed.
    2. No correction fluid (whiteout) can be be used.
    3. A line must be drawn through any corrections, the correction initialled and the information rewritten.
    4. A line to the end of the page must be drawn where documenting does not use all the line space.
    5. All notes must be dated, including the time of incident.
    6. All notes must be signed and include the compiler's printed name and status (eg, J Thomas J THOMAS PC).

The Writing Process
Documenting should be:
- by exception
- objective
- concise
- appropriate in language; and
- include only necessary information.

Documenting by Exception
It is necessary to record only events and instances that may affect the care plan. This includes client changes in behaviour, emotions and physical ability and any incidents involving the client. In order for care staff to decide what needs to be documented, they need to ask themselves the following questions:
- Will it affect the direction of care or the Care Plan?
- Does it relate to the status of the client's health?
- Did client refuse care?
- Was any care omitted?
- Did the client make a complaint?
- Did the client do/not do something which will impact on the status of their health and overall well-being?

Example of a change that should be recorded

If a client has been able to eat independently, but this changes and he or she needs assistance, it should be noted in the Progress Notes so that the Care Plan can be updated and this assistance given.

Example of an event that does NOT need to be recorded

Mrs Brown had a very happy day with her family today. They took her for a drive to the beach and this evening she is very tired.

Objective Documenting

Only information that is seen, heard, tasted, witnessed or initiated should be included in Progress Notes, in other words, facts. Information that is subjective should NOT be included. Subjective information is based on assumptions or the feelings of the carer about the event or incident.

Example of an objective note

At approx 2.30pm, Mrs Brown was observed to have a large, red patch on her forehead above her left eyebrow. She was rubbing it and frowning. She had just returned from a walk around the garden.

Example of a note that is both objective and subjective

Mrs Brown must have bumped her head on something in the garden as she had a huge, nasty looking red patch on her forehead when she returned from a walk at about 2.30pm. She was rubbing it and looking very troubled.

In the above note, the carer has included both objective and subjective information. The fact that a red patch on the forehead can be observed, is objective. But that the client 'must have bumped her head on something' is subjective and therefore an assumption. The carer did not observe any incident that may have caused it. The terms 'huge', 'nasty-looking' and 'looking very troubled' are also subjective as they are personal judgements about what was observed.

Writing objectively can be difficult as we view events from our own perspective and assumptions.

Look at the picture below and think about what you might write, if you had to write an objective description about it.

You might have thought about writing something like this:

An elderly man in a wheelchair has been taken for a walk by his male carer in the grounds of the nursing home. The carer is standing behind the elderly man and is giving him a massage and is leaning forward slightly over the elderly man in an affectionate manner. The elderly man is enjoying the massage and both are smiling.

A more objective description would be:

In the foreground, there is a figure wearing a hat seated. A second figure is standing behind the seated figure and has his/her hands placed on the shoulders of the seated figure. He/she is leaning slightly over the seated figure. Both have smiling expressions.

This second note may seem like an extreme adjustment to the first one; however, many assumptions have been made in the first note. Some of these are that:

- the person seated is elderly or that he is even a man. It could be a woman, or a younger man wearing make-up – or they could be wax models
- the seated person is in a wheelchair
- the pair are on a walk
- they are in nursing home grounds
- the person standing is a carer and is giving a massage
- they are both happy
- the posture is an affectionate display

Although the first note contains reasonable assumptions – they are merely assumptions and therefore not evidence in the legal sense.

Documenting Concisely

This means giving not too much, or too little, information. If too much information is given, it may obscure the main point of the note. If too little information is given, the client may not receive the correct care. This could cause suffering to the client or may lead to legal consequences.

Concise documenting depends on

- the information included
- the words used
- the structure of both the sentences and information.

If care staff document only by exception and record objectively, this is a good basis for keeping notes concise since they will be necessary and factual. Often fewer words can be used to get the same message across. Below are some examples of using one word instead of a phrase:

Common Phrases	Alternative Words
kept an eye on/ watched over	monitored, observed, supervised
put client's legs/arm up	raised, elevated
make the swelling go down	reduce, decrease, alleviate
kept on/over and over again	continually, constantly
all the time/a lot	frequently, often, continually, constantly
take off	remove
every now and again	continuously, often, frequently
looks the same as	resembles
spoke too quietly to be heard	inaudible
singing one minute then swearing the next	alternatively singing and swearing
going on about	complaining
put client's clothes on	dressed
pulls faces	grimaces

Examples:

Mr Smith keeps going on and on about the noise from the ceiling fan.
*Mr Smith **continually** complains about the ceiling fan noise.*

I put Mrs Jones legs up, to make the swelling go down.
*I **raised** Mrs Jones legs to **reduce** the swelling.*

After I gave Mr Chan his medication, I kept an eye on him for an hour.
*After I gave Mr Chan his medication, I **monitored** him for an hour.*

Each time I put Mr Go's shoes on his feet, he pulls faces.
*Each time I put Mr Go's shoes on his feet, he **grimaces**.*

Structuring Progress Notes

Sentence structure

Using the active voice rather than the passive voice will get the message across more directly as the active voice places the focus on the doer of the action.

Example:

Active voice	Passive voice
Mrs Lee refused dinner.	Dinner was refused by Mrs Lee
The RN changed Mr Ford's bandage.	Mr Ford's bandage was changed by the RN.
Staff assisted Ms Free to dress.	Ms Free was assisted to dress by staff.
Staff heard Mrs Ray call out	Mrs Ray was heard to call out by staff.