Clinical Case Notes/Progress Notes Guidance - Inpatients

Purpose/Aim: Good record keeping is a vital part of effective communications in nursing and integral to promoting patient safety and continuity of care. This guidance supports clinical handover guideline (CG20) to ensure documentation supports the handover to share appropriate clinical information, reducing duplication and support patient safety.

The guidance below aims to act as a prompt for the 'must haves' for inpatient nursing progress notes.

Do	Do not
Use timed entries as soon as possible after the event Make objective comments Wherever possible involve the person – they should be able to understand what is written Document any non-compliance Document oral communication (phone calls, in person conversations etc) and actions taken Document informed consent State objections regarding care or case management	Use abbreviations or jargon Make offensive, humorous or personal comments Use ambiguous terms Make assumptions or speculate Delete or alert the contents of clinical notes in a way that is untraceable.

Adapted from Rousalova et al, 2016; RCN 2018

Areas to include in progress notes for Inpatients

Observation Level: What observation level is the patient on? Why? Did it change or was it reviewed? Why and by whom?

Legal Status: What is the patient's legal status? Has it changed? This is important as the electronic system can take time to update this information. MHA / DOLs

Condition & Symptoms – How is the patient? Better, the same, or worse? Diagnosis? The signs and symptoms monitored to inform the assessment and show how treatment progress. Are the symptoms still present, better, same or worse?

Mental State, Behaviours & Presentation during the shift – Insight into mental state **-** Any disturbed thinking? Any anxiety? What does the mood seem to be? What was the patient's appearance? Did they complete their personal care or need support? Behaviours during the shift, interaction with peers and staff, compliance with rules/routines, diet and fluid intake, and medication compliance.

Risk & Risk Assessment: What were the risks on admission? What are the risks now and to who - Self or others? Did the patient manage these? Did the patient need staff support to manage the risks? If so, what support was given and how did it manage the risks? Did the risks change? Were there any incidents and if so what happened? Was this reported and a Datix completed?

Activities – What has the patient done during the shift? What therapeutic activity/take leave/have visitors? Is so what did they do? Where did they go and how long for? Who visited? How did you interact with the patient? Did the patient have 1:1 nursing time?

Physical Health: Have vital signs been carried out and documented in the electronic patient record? Are there any concerns and if so what actions have been taken? Were there any health appointments attended or made?

Medication including Side effects: Compliance with medications? Are there are reports or signs of possible side effects? Even if not labelled as side effects include drowsiness, unsteady gait, dry mouth, etc to enable inform the overall picture.

Care Plans/Treatment plan: Did the patient engage with the care plans? How was the care plan followed? Was the care plan updated or does it need to be reviewed? Were they concordant with treatment/side effects?

Specific documentation: some patients have specific documentation like diet and fluid charts, seclusion, medical-legal papers such as MHA or MCA, incident reports etc.

Communications, Reports, Emails etc: Did you take/make any phone calls, receive/send and letters, emails or reports regarding the patient? These must be uploaded onto the system. What was the communication and who was it from/to? What actions have you taken? How will this be communicated with the patient and multi-professional team?

Tips

Be Clear and Concise and give specific details avoiding statements like 'low profile', 'seemed settled', 'interacted well', etc.

Example 'low' profile' could mean anything for each individual patient. Some patients are quieter when well and prefer not to seek noisy active environments; for other patients it would be unusual for them to be withdrawn. Notes need to specific to the individual with supporting details to help the overall assessment. 'Low profile' is not specific so be detailed and see some examples below that tell the reader about the patient with specific details.

- 'withdrawn and did not respond to verbal interaction or make eye contact when directly addressed.'

- 'refused to come out of bedroom today. Staff tried hourly to encourage him out of room with choice of activities, food, short walk for fresh air and different drinks by still refused. Water and coffee accepted when taken to the room and encouraged, but only consumed in their room.'

- 'remained in lounge for most of the day and did not interact with patients and only responded to direct verbal address by staff, although was not keen to hold a conversation saying he felt too tired and low today'.