Progress Note Guidelines

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Introduction

Progress notes should be succinct and readable notes that summarize the progress your patient has made over the last 24 hours (or whatever interval your hospital requires). It is likely that your hospital has adopted an electronic health record software with templates leading to bloated daily notes with reams of excessive data. This makes the progress notes unreadable and relatively useless for efficiently tracking patient progress. All hope is not lost. In this fact sheet we recommend the tried-and-true **SOAP note** (Subjective, Objective, Assessment, Plan) format. Alternatively, you can use the increasingly common **APSO note** (Assessment, Plan, Subjective, Objective) format that places the most important parts of the note at the beginning.

Progress note format

Patient Name:
DOB:
Medical record #:
Date of visit:

Subjective (how the patient is doing on the unit) plus interval history (any relevant clinical information obtained since the last progress note)

- Status of target symptoms (eg., main symptoms leading to hospitalization)
    - Tip: It's helpful to include a representative quote from your interview that illustrates how the patient is presenting to you. Eg.,. "I don't need to take medications, I am a God." "The medication's working, but it makes me sleepy. Can I take it all at bedtime?" "I'm just super-bored here, can I just leave today?"
- Any significant events occurring over the last 24 hours (eg., restraints, medication refusals, conflicts with staff)
- Status of ADLs (eg., sleep, eating, hygiene, visibility in milieu)
- Group attendance
- Information recently obtained from contact with collaterals, such as outpatient providers or family members

Objective (MSE and labs)

- Formal mental status exam
    - Appearance (hygiene, grooming, clothing)
    - Behavior/attitude (agitation, cooperation, isolation etc.)
    - Affect/mood (sad, happy, anger, flat, labile etc…)
    - Thought process (linearity, organization)
    - Thought content (delusions, hallucinations, ruminations etc….)
    - Safety (SI/HI)
    - Cognition (orientation, memory)
- Labs of note
- Vital signs

Assessment

- DSM-5 diagnoses
    - Tip: Include all DSM-5 diagnoses, not just the main one requiring inpatient hospitalization (eg schizophrenia, paranoid type; methamphetamine use disorder; antisocial personality disorder).
- Medical diagnoses

    - Comorbid medical diagnoses (eg diabetes, hypertension, hyperlipidemia) are common among psychiatric patients.
    - Make a note indicating whether these are stable or require attention (e.g., consultation with endocrinology service to adjust medications for diabetes)
- Assessment of whether patient is improving.
    - If symptoms are not improving, comment on why this is (Eg., awaiting response to a new medication trial, medication dose is too low, side effects interfering with response, diagnosis is in doubt etc….)
    - Explain why your patient needs continued hospitalization and provide details (Eg., don't just say the patient is suicidal; instead say the patient has a plan to e.g., overdose on pills if discharged. Don't just say the patient doesn't have a safe aftercare plan in place; instead say the patient's discharge plan is not reasonable because they intend to move, eg., into the parents' home despite their having a restraining order against the patient)
- Do not simply type the admission diagnosis without some comment on whether the problem is improving or not.

Plan

- Medication plan
    - List all active psychiatric meds that the patient is taking, including dosage, and PRNs if patient has required them
        - Specify which meds are to be continued, discontinued, increased in dose, decreased in dose, or started.
        - If you are making med changes, the reasons for the change should be clear based on your assessment above; if it isn't, add a few words in the plan clarifying your thinking
    - List non psychiatric meds the patient is taking for medical reasons (e.g., diabetes)
- Legal status
    - Mention the start and end dates of the psychiatric hold.
    - If there's an order for involuntary medications, include start and end dates.
    - If the patient's legal status is in flux (eg., awaiting a commitment hearing), provide relevant updates.
- Discharge plan
    - Comment on whether there is a plan for disposition/discharge.
- Tip: Make sure the plan relates directly to your assessment, eg., if you said the diagnosis was in doubt, then you should add something to your plan to do more assessment, eg., ask another attending for a second opinion, initiate contact with the outpatient provider for more information, etc….