RESOURCES

Professional Practice Support Guide

Drafting Guide for Progress Notes

Designed with ❤ by

Psylio

ATTENTION: THIS GUIDE WAS CREATED IN SEPTEMBER 2021. IT IS THE RESPONSIBILITY OF THE PERSON UTILISING IT TO ENSURE THAT THE INFORMATION ENCLOSED CORRESPONDS TO THE CURRENT RECOMMENDATIONS AND GUIDELINES OF THEIR PROFESSIONAL ASSOCIATION, IF APPLICABLE.

NOTE QUALITY CRITERIA

Regardless of the drafting method and model used, certain elements must be included in a note:

- ➔ Date of the intervention, including the year;
- ➔ Nature of the intervention;
- ➔ Names of the people involved;
- ➔ The purpose and brief results of the intervention;
- ➔ The clinical focus of the intervention;
- ➔ The signature of the intervener.

RELEVANT	• Is the recorded information about the person being assisted? • Is the recorded information applicable to their situation and progress? • Does the recorded information reflect the professional decisions and the basis for those decisions? • Does the recorded information provide an account of services rendered or results achieved? • Does the recorded information provide new information? • Is the recorded information helpful for the continuity of the service? • Is the recorded information related to the service request/intervention plan?
PRECISE	• Does reading the note provide a common understanding of what is written? Is it exempt from the possibility of interpretation and approximation? ***Here, we want to ensure that everyone understands the same thing when they read the note!

EXACT	● Is the information added to the file accurate and truthful? ● Is the information exempt from the possibility of interpretation? ● Are the sources of information listed?
ORGANISED	● Does the note reflect the presence of a common thread in its reading? ● Does the recorded information follow the chronology of events? ● Is the information presented in a logical order that facilitates understanding?
CONCISE	● Is the content of the note clearly and succinctly written? ● Have the superfluous words and unnecessary details been removed to prioritise what is essential? *** Ideally, we aim for a maximum of 15-18 words per sentence.
UP TO DATE	● Does the note demonstrate the current situation in its reading? ● Are the notes recorded progressively, as quickly as possible? *** Drafting deadlines are not set up to put stress on the intervenor but rather to protect them since the more time passes, the less the note is perceived as reliable and credible.
COMPLETE	● Does the information in the note reflect and support professional decisions? ● Is the information in the note sufficient to monitor the client's situation and detect a change? ● Does the information in the note allow for a reconstruction of the facts if necessary?

Drafting Guide – Notes by Category

Meeting Objective

Indicate the meeting objective (the target for intervention stemming from the intervention plan) as clearly and precisely as possible. If there is a discrepancy between the planned and current objectives, include it in your note.

Topics Addressed

Main topics addressed by the counsellor during the meeting.

Facts Reported/Information Collected

What is being reported to me by the client or the people present?

- Perception of the client or their network.
- Perception of their symptoms or problems.
- Expectations, complaints, frustrations reported and specified by the client.
- Client's suggestions for improving the situation.
- Major or significant changes reported by the client that subsequently affect the follow-up.

Observations

What are my observations as a counsellor?

- Provide measurable data and facts;
- Description of the person's behaviour, physical appearance, non-verbal communication, signs, places, events, etc.

Intervention

What are my professional actions?

- Services provided
- Significant steps for the client (orientation, referral, network mobilisation)
- Information given
- Intervention techniques
- Testing of hypotheses

Results

Evaluating the impacts/effects of the intervention or previous tasks and assignments on the client or their situation. Visible changes relating to the intervention objectives.

Clinical Impression

What is my clinical understanding of the client's progress and problem situation?

- Feeling, perception, immediate intuition of a thing, a person, an event.
- Provisional explanation resulting from a combination of facts and observations (hypotheses)
- Impression to verify with the person
- Professional view/opinion
- The need to partner with other counsellors is also determined in this category.

Plan/Follow-up

Planning of the follow-up or the steps to be taken by the counsellor

- What will I do?
- When is the next meeting scheduled?

Agreement

Homework, tasks for the client to complete within an agreed timeframe (ex: before the next meeting), agreement between the 2 parties (ex: safety net).

To get access to the progress notes by category template, log in to your Psylio account or download the editable document at:
https://www.psylio.com/resources/tenue-de-dossier/note-evolution-rubriques

Drafting Guide – SOAP Model

Subjective Information

Subjective information collected directly from the client or the client system. *** Reported information must be relevant to the service request and the intervention plan.

Notably:

- Client or client's network perceptions
- Description of the problem and how it manifests according to the client's perception;
- Social and family context
- Expressed goals, frustrations, complaints, expectations;
- Client's suggestion for improving their situation;
- Assessment of the person's situation with regard to their health (mental, physical) and the intervention plan;
- Reported medical and social history and response to previous treatments;
- Medications;
- Identification of new situations;
- Information provided by third parties;
- Relevant quotations
  *** No interpretation, make sure that information has been verified or indicate who reported it.

Objective Elements

Objective elements observed by the counsellor that can be described clearly (facts). This is a description of a behaviour or activity. Examples:

- How does a person behave towards others?
- How does a person's problems manifest in their behaviour?
- How does a parent fail to get their child to listen to them?
- How does a child's hyperactivity manifest in the session?
- Which of the client's comments/remarks are significant?
- Information provided by other professionals;
- Results and changes relating to the intervention plan

Analysis

Reflection arising from subjective and objective data/professional opinion;

- What the counsellor understands about the situation and will inform the establishment of an intervention plan or precise professional actions to be taken.
- The clinical understanding of a client's assessment over time;
- Any psychosocial assessment or reassessment.
- Any predictions or conclusions.

Allows to:

- Establish the problem;
- Justify the intervention plan
- Identify progress (made or not);
- Identify the client's understanding and motivation;
- Establish repeated discrepancies between what the client says and the counsellor's observations;
- Suggest other options for intervention, other resources relevant to the follow-up;
- Identify new situations

Plan

Intervention plan/Intervention

- What the counsellor plans on doing after analysis (decisions-actions)
    - Intervention plan follow-up (objectives, means, etc.)
    - Modifications to the intervention plan
    - Individualised service plan
    - Requests for consultation or referral to other professionals.
    - Etc.
- Interventions carried out/Intervention techniques
- Intervention report
- Follow-up(s) to add to the file
- Date of next appointment
- Etc.

To get access to the SOAP model template, log in to your Psylio account or download the editable document at:
https://www.psylio.com/resources/tenue-de-dossier/note-evolution-SOAP

Drafting Guide – ECRIS Model

Event

What is the purpose of the activity? Phone call, home visit, interview, case discussion, received or sent correspondence, etc.

Context

Who is involved in the activity? (name, relationship with the client, professional title and name of the resource person, if applicable). What are the objectives of the activity with regard to the intervention plan? Topics addressed.

Reaction

Observation of the client's reactions and evolution with regard to the intervention objectives. Client's opinion.

Intervention

Interventions carried out, professional opinion (hypotheses, impressions, clinical interventions).

Sequence

Steps to be taken by the professional, the client, the third party or the partner following the activity.

To get access to the ECRIS model template, log in to your Psylio account or download the editable document at:
https://www.psylio.com/resources/tenue-de-dossier/note-evolution-ecris

Comparative Grid of the Models

No matter which drafting model is used, certain information remains essential and is found in different sections depending on the model. The table below identifies correspondences, i.e., where certain information is located in the models.

Categories	SOAP	ECRIS
-	-	Event
Objective	-	Context
Topics Addressed	-	Context
Facts Reported	Subjective Info	Reaction
Observations	Objective Info	Reaction
Interventions	Plan	Intervention
Results	Objective Info	Reaction
Clinical Impressions	Analysis	Intervention
Plan/Follow-up	Plan	Follow-up
Agreement	Plan	Follow-up

You will find templates for drafting progress notes according to the different models directly in your Psylio account or in the Resources section of our website:

1. SOAP: https://www.psylio.com/resources/tenue-de-dossier/note-evolution-SOAP
2. Categories: https://www.psylio.com/resources/tenue-de-dossier/note-evolution-rubriques
3. ECRIS: https://www.psylio.com/resources/tenue-de-dossier/note-evolution-ecris