# Helpful Tips for Documenting Progress Notes

The following list is made up of characteristics that supports quality documentation:

- ☐ Strength based
- ☐ Relevant
- ☐ Reliable
- ☐ Consistent
- ☐ Accurate/Precise
- ☐ Descriptive
- ☐ Timely
- ☐ Clear

Below are a few common guidelines to keep in mind to ensure that notes are meeting regulatory requirements, are high quality, concise, and can reduce documentation burden.

## 1. Don't Rely on Subjective Statements

It's generally better to be specific and include objective details in addition to subjective descriptors.

You might be tempted to write things like, "*client is a good mother*," Instead, consider writing, "*client is bonding with infant and able to read and respond to infant's cues*." In addition, don't hesitate to use illuminating quotes directly from the client.

When your notes are based on facts, they're more valid. It also helps other members of the team to access a clear picture of what is going on with the client and how to best support them.

## 2. Avoid Excessive Detail

There's a fine line between including enough detail to meet regulatory requirements and writing long, drawn-out descriptions that are overindulgent or express far more than is necessary. Consider whether your long paragraph can be expressed equally well in one or two sentences.

This doesn't mean that you should cut corners or skip clinically relevant information. And one caveat is that you should thoroughly document your process in managing professional or ethical dilemmas as well as high-risk situations like suicidality. Be sure to include the steps you took in these circumstances as well as clear and careful reasoning behind how you chose to manage it.

## 3. Know When to Include or Exclude Information

To protect the privacy of people who have not consented to therapy or other behavioral health services with you, avoid naming or identifying third parties when possible. If your notes are read by another clinician, subpoenaed, or even read aloud in court, you want to be sure that you're not disclosing something or putting someone else at risk unnecessarily.

On the flip side, if a client expresses a wish that you leave out certain information in your progress notes, it's important to have an open conversation with them about what you can omit and what needs to be included depending on legal, ethical, and regulatory requirements.

## 4. Don't Forget to Include Client Strengths

No matter how dire the situation seems, everyone has strengths. These can include something that's going well at the moment, community support, or personal resilience. It is valuable to include client strengths to paint the full picture of their experience and to ensure that you recognize and build on their strengths in treatment.

5. **A Note on “Compliance,” and disallowances:**

Compliance within a Medi-Cal context is focused on ensuring that there is no fraud, waste, and abuse within the service provision and claiming system. Disallowances in audits will only occur when there is evidence of fraud, waste, and abuse. Documenting accurately, in a timely manner and in alignment with the guidelines listed are necessary steps to promote compliance.