SENIOR & LONG TERM CARE DIVISION
COMMUNITY SERVICES BUREAU

HOME AND COMMUNITY BASED WAIVER Policy Manual	Section: ADMINISTRATIVE REQUIREMENTS
	Subject: Progress Notes

References: N/A

DEFINITION

Objective entry of facts justifying actions taken and support determinations made by Case Management Team (CMT). Progress notes must be documented either in a CMT database progress notes section or handwritten and kept in member's chart.

Progress notes are legal records of the CMT's or Department's actions that include Quality Assurance Reviews, Amendments, Fair Hearings, and Fraud investigation/prosecutions.

REQUIREMENT

Progress note requirements include the following:

1. All entries must be entered into CMT database progress notes or if handwritten, must be in ink and legible;
2. Must have an Addendum added to the note if it contains an error and Case Manager's (CM) name;
3. The full date of each entry must be recorded;
4. Each entry must end with the signature or initial of the person making the entry;
5. Entries must be made in sequence;
6. Must be entered into the CMT database within 30 days when any type of contact is made regarding the member; and
7. Must be up-to-date in the CMT database prior to submitting a Serious Occurrence Report (SOR) or any prior authorization requests to the Department.

RULES OF CHARTING

Charting rules are as follows:

1. Case notes should be clear, concise, and brief;

2. Do not sign entries of any kind for another person. It is permissible for one person to chart when both team members visit the member, but both team members should sign or initial the entry; and

3. Do not chart before an event occurs.

CHART CONTENT

Progress notes should include the following content:

1. Record pertinent observations, psychosocial and physical manifestations, incidents, any unusual occurrences or abnormal behavior;

2. Chart the facts by using the five “W’s”: Who, what, when, where, why and include how the issue was resolved. Progress notes should be objective statements. Avoid making generalizations, vague comments and/or opinions;

   EXAMPLE: Objective statement--Less talkative than yesterday. Taking medications as prescribed. Subjective statement--Quiet and cooperative.

3. Record approaches to correcting problems identified in the member care plan;

4. Record all teaching efforts, including instruction given to the member’s family;

5. Record an opening statement when a member is enrolled and a closing statement when a member is discharged from services; and

6. Record the type of contact; e.g., telephone call, office visit, home visit, etc., and specifically identify who made the contact.