

Nursing Progress Note (Long Version)

This form is to be completed by a LPN, RN, BSN, or MSN when providing nursing services primarily in residential or inpatient substance use treatment programs, such as TSS, Detox, etc. Nurses with a RNCS or an APRN with prescribing privileges should complete the Psychopharmacology Progress Note.

There are two different versions of the Nursing Progress Note – a short and long version. The short version is to provide adequate documentation for short length services such as injections, etc. while the long version has additional data fields that support the focus of the Psychopharmacology Progress Note including an interim history and mini mental status section.

Data Field	Identifying Information Instructions
Person's Name	Record the first name, last name, and middle initial of the person. Order of name is at agency discretion.
Record Number	Record your agency's established identification number for the person.
Person's DOB	Record the person's date of birth.
Organization Name	Record the organization for whom you are delivering the service.
List of Names of Persons Present	Check appropriate box: <i>Person Present</i> ; <i>Person No Show</i> ; <i>Person Cancelled</i> . If <i>Provider Cancelled</i> is checked, document explanation as relevant. If <i>Others Present</i> is checked, identify name(s) and relationship(s) to person.
Interim History	Record a review of the person's condition, medications, dosages, any allergic reactions, and health changes since last encounter, person's assessment of progress related to symptoms, side effects, overall functioning, effectiveness of medications and medication compliance. If no changes are reported or observed, indicate whether person is at baseline, no progress made, meds still working, etc.
Person's Condition: Mood/affect Thought Process/Orientation Behavior Functioning Medical Condition Substance Use	This is a mini-mental status exam. Check appropriate box to indicate person's condition or to indicate <i>No Change</i>. Also, describe any changes. Note: Notable is defined as behavior or symptoms different from the person's baseline status. These changes may be signs the person is experiencing increased problems or distress or may indicate an improvement in functioning/symptoms/behavior. Example: Thought process/orientation is marked <i>Notable</i> and the comments are: "John is distracted and responding to voices he is hearing today." However, if John's baseline is that he always hears some voices and responds, a <i>Notable</i> comment would not be needed unless the intensity or impact of the voices on John is significantly different than his baseline.
New Issue(s) Presented Today	There are four options available for staff using this section of the progress note: 1. If person does not report/present any new issues, mark "None Reported" and proceed to planned intervention/goals. 2. If person reports a new issue that was resolved during the session check the "New Issue resolved, no CA Update required" box. Briefly document the new issue, identify the interventions used in the Therapeutic Interventions Section and

Skilled Nursing Progress Note

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Adopting the Tune of Term: An Psychological Symphony within **Skilled Nursing Progress Note**

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