Residential Weekly Progress Note – Narrative Instructions

REQUIRED FORM:

If the residential program has opted to use weekly progress notes, this form is a required document and must be used in conjunction with the "Residential Weekly Progress Note – Services" form.

WHEN:

Weekly progress notes shall be completed from Sunday – Saturday.

The LPHA or counselor shall type or legibly print their name and sign and date the weekly progress note within the following calendar week.

If you do not use this form, you must use the SUD Treatment Progress Note (Form 601) to document each service provided at the Residential program.

This form is used to summarize the client's participation in weekly activities/ services.

This form must be completed within the following guidelines:

- Residential programs shall document each client's progress on a weekly basis and complete the note within the following seven (7) days.

NOTE: Case management and/or physician consultation services are never captured on weekly notes. An individual progress note (Form 601) must be completed for every case management and/or physician consultation service that is provided/claimed.

COMPLETED BY:

BHS SUDQM recommends that the primary counselor writes the narrative summary of the weekly services.

REQUIRED ELEMENTS:

Progress notes shall be legible.

1. **Client Name:** Enter the client's full name.
2. **Client ID:** Enter the client ID number as determined by agency guidelines.
3. **Week of:** Enter the beginning date through the ending date of the service week.
4. Total service hours
5. Total clinical hours

Narrative must include a summary of the clinical services provided to the client during the week :

1) Provider support & interventions: Enter support and/or treatment intervention services delivered to the client.

- Support/treatment intervention services to compliment the client's treatment goals/objectives as listed on his/her Treatment Plan.
- Specify which of the two recommended Evidence Based Treatment Interventions were used; Motivational Interviewing (MI), or Relapse Prevention (RP), and how the EBT interventions were utilized.
- Interventions to address client level of participation/stage of change.
- Specify attempts to refer or link the client to additional resources, unless this was provided in a case management service (Reminder: case management services are documented on an individual progress note)

2) **Description of client's specific progress on treatment plan problems, goals, action steps, objectives, and/or referrals:** Enter information regarding client's progress.
    - Client's progress on treatment plan problems, goals and action steps
    - client's ongoing plan including any new issues

3) **If service (s) are provided in the community, identify location(s) and how confidentiality was maintained:** Enter where services were provided if in the community and explain how counselor/LPHA ensured confidentiality during provision of service.

Client's plan: Enter information regarding client's indicated goals.

- May use client's own words
- Client issues/goals may reflect existing goals on the Treatment Plan or may be a "new" treatment issue. If it appears that the "new" treatment issue will be of an ongoing nature, it is recommended to update the client's treatment plan.
- Offer the client to rate the priority of his/her stated "issue" or "goal" in his/her current life circumstance.
- Next steps in plan of care.

Signature:

- **Counselor/LPHA Printed Name, Title:** Type or legibly print primary counselor (**who documented the service/note**) name and title.
- **Signature, Credentials:** Complete signature and credentials by hand.
- **Date of Completion:** Complete date of progress note is signed here by hand. This must be completed within the following week from when the service(s) were provided.