BHS Progress Note Format: P-I-R-P

1. Problem
2. Intervention
3. Response
4. Plan

Sources of Information: (a) 2012 SFDPH-BHS Documentation Manual, page 16; (b) 2005 SDFPH-BHS Documentation Manual, page 18
Problem: This is the problem (from the treatment plan) that you focused on in the session.

When you document the "Problem," use a clear and complete notation or description regarding the client’s current complaint(s), condition(s), assessment of client and/or reason(s) presented during the session. Use behavioral terms, and include an assessment of the client. This is not a statement of diagnosis but rather a statement of why this session is necessary.

- Why this session is necessary?
- Is progress being made?
- Any remaining impairments?
- Is the diagnosis still valid?
Intervention: This is the intervention (from the treatment plan) you provided in the session.

When you document the "Intervention," use descriptive sentence(s) about your interventions (i.e., what you did). Identify the skills used to cope-adapt-respond-problem solve. Reinforce new behaviors, strengths. Identify specific skills that are taught-modeled-practiced.

The Interventions elements of the progress note shall describe the following:

- Clinician's interventions
- Clinician's assessment (including risk assessment when needed)
- Document advice-recommendations given to client-family
Response: This is the response of the client to your intervention.

When you document the "Response," use descriptive sentences about the client’s response to the staff’s intervention; describe the response to the intervention in behavioral terms and include the client’s progress or lack of progress. Intermittently document the client’s progress or lack of progress towards the Plan of Care goals. The Response may also include a description of other significant changes in client status. Any new assessment findings?

If there is a lack of improvement:

- Explain the reasons for lack of improvement
- Obtain consultation, if needed, to verify the diagnosis or TPOC
- Explain the need for additional treatment due to Medical Necessity
- Include outcome measures in documentation, as appropriate.
Plan: These are the next steps of you and the client to achieve treatment plan goals.

When you document the "Plan," include **the clinical decisions** regarding the TPOC, collateral contact, referrals to be made, follow-up items, homework assignments, treatment meetings to be convened, etc. Any **referrals to community resources and other agencies when appropriate, and any follow-up appointments** may also be included.

- Document if **any new goals are needed**
- Document that the **treatment goals remain appropriate or revise as needed**
- Consider **treatment titration and plan for discharge**