BHS Progress Note Format: Checklist Items for 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?

**Checklist for ***Problem:***

- Identify the problem you focused on in the session. Does this problem appear on the current TPOC?
- Assess and describe the current level of the client's problem (e.g., current complaint, current condition, reasons presented during the session)?
- Describe why the session is necessary?
- Describe the progress being made, any remaining impairments and/or if the diagnosis is 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 a risk assessment when applicable
- Document advice-recommendations given to client-family.

**Checklist for Intervention:**

- Describe your interventions and what you did? Does this intervention appear on the current TPOC?
- Describe the interventions you used that help the client cope, adapt and/or problem solve?
- Describe the interventions you used that reinforce and/or develop new client behaviors and strengths?
- Identify specific skills that you taught, modeled and/or practiced with the client?
- Describe your assessment (including risk assessment when needed) and/or advice-recommendations you gave to the 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 a consultation, if needed, to verify the diagnosis or treatment plan
• Explain the need for additional treatment due to Medical Necessity
• Include outcome measures in documentation, as appropriate.

Checklist for Response:

☐ Client's response to interventions?

☐ Client's progress/lack of progress in response to your interventions?

☐ Progress/lack of progress toward TPOC goals/objectives?

☐ Identify other significant changes in the client's status? New assessment findings?

☐ Document a lack of improvement (explain reasons for non-improvement) and/or obtain consult to verify diagnosis-TPOC and/or explain need for additional treatment (due to medical necessity) and/or include outcome measures in documentation?
“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.

Checklist for Plan:

- Describe clinical decisions regarding TPOC?
- Describe any of the following: Collateral contacts? Referrals to be made? Homework assignments? Treatment meetings to convene?
- Describe referrals to community resources and/or other agencies?
- Describe follow-up appointments?
- Document if new goals are needed?
- Document that existing treatment goals remain appropriate (or revise as needed)?
- Consider treatment titration and/or discharge planning?