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# SHSS6065

## SOAP Notes

*Trawsnewid Addysg; Trawsnewid Bywydau*  
*Transforming Education; Transforming Lives*



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# Aims

- Review some terminology around notation
- Discuss SST requirements for notation
- Investigate examples of notation



# SOAP Notes

- **SOAP notes** are a highly structured format for documenting the progress of a patient during treatment and is only one of many possible formats that could be used by a health professional. They are entered in the patients medical record by healthcare professionals to communicate information to other providers of care, to provide evidence of patient contact and to inform the Clinical Reasoning process.



# SOAP Notes

- **Subjective** - What the patient says about the problem / intervention.
- **Objective** - The therapists objective observations and treatment interventions (e.g. [ROM](#), [Outcome Measures](#))
- **Assessment** - The therapists analysis of the various components of the assessment.
- **Plan** - How the treatment will be developed to the reach the goals or objectives



# SOAP Notes

- SOAP notes were developed by Dr. Lawrence Weed in the 1960's at the University of Vermont as part of the Problem-orientated medical record (POMR). Each SOAP note would be associated with one of the problems identified by the primary physician, and so formed only one part of the documentation process. However, various disciplines began using only the "SOAP" aspect of the format, the "POMR" was not as widely adopted and the two are no longer related.



# SOAP Notes

- Quinn and Gordon (2003) suggest that the major advantage of the SOAP documentation format is its widespread adoption, leading to general familiarity with the concept within the field of healthcare.
- However, the format has also been accused of encouraging documentation that is too concise, overuse of abbreviations and acronyms, and that it is sometimes difficult for non-professionals to decipher. Delitto and Snyder-Mackler (1995) have also suggested that a sequential, rather than an integrative approach to clinical reasoning is encouraged, as there is a tendency by the health professional to merely collect information and not assess it. They feel that the emphasis on the problem-orientated approach to documentation is misplaced and that it is not conducive to clinical decision-making.
- One major difficulty with SOAP notes for therapists is the lack of guidance on how to address functional outcomes or goals. Having said that, the format is not so rigid that it cannot be adapted to take this into account.



# Writing SOAP Notes

- While documentation is a fundamental component of patient care, it is often a neglected one, with therapists reverting to non-specific, overly brief descriptions that are vague to the point of being meaningless. There is no policy that dictates the length and detail of each entry, only that it is dependent on the nature of each specific encounter and that it should contain all the relevant information.



# Writing SOAP Notes

- Self-report of the patient
- Details of the specific intervention provided
- Equipment used
- Changes in patient status
- Complications or adverse reactions
- Factors that change the intervention
- Progression towards stated goals
- Communication with other providers of care, the patient and their family



# Subjective

- This component is in a detailed, narrative format and describes the patient's self-report of their current status in terms of their current condition/complaint, function, activity level, disability, symptoms, social history, family history, employment status, and environmental history. It may also include information from the family or caregivers and if exact phrasing is used, should be enclosed in quotation marks. The patient's goals and prior response to treatment intervention are also included. Medical information obtained from the patient's chart can also be included the therapist has not directly observed these findings.
- It allows the therapist to document the patient's perception of their condition as it relates to their progress in rehabilitation, functional performance, or quality of life.



# Objective

- This section outlines what the therapist observes, tests, and measures. Objective information must be stated in measurable terms. Using measurable terms helps in reassessment after treatment to analyse the progression of the patient and hindering as well as helping factors.
- The objective results of the re-assessment help to determine the progress towards functional goals, and the effect of treatment. The therapist should indicate changes in the patient's status, as well as communication with colleagues, family, or carers.



# Assessment /Analysis

- This is potentially the most important legal note because this is the therapist's professional opinion in light of the subjective and objective findings. It should explain the reasoning behind the decisions taken and clarify and support the analytical thinking behind the problem-solving process. A prioritized problems list is generated with impairments linked to functional limitations. International Classification of Functioning, Disability, and Health (ICF) is very useful to determine and prioritize problem lists and thus helps to make functional therapy diagnoses.
- Progress towards the stated goals is indicated, as well as any factors affecting it that may require modification of the frequency, duration or intervention itself. Adverse, as well as positive response, should be documented in re-assessment.



# Plan

- The final component of the note includes anticipated goals and expected outcomes and outlines the planned interventions to be used. Information should be provided concerning the frequency, specific interventions, treatment progression, equipment required and how it will be used, and education strategies. The plan also documents referrals to other professionals and recommendations for future interventions or follow-up care. The therapist should report on what the patient's home exercise programme (HEP) will consist of, as well as the steps to take in order to reach the functional goals. Changes to the intervention strategy are documented in this section.

