ACAC Successful Charting Series

SOAP Notes: The Foundation of Demonstrating Treatment Legitimacy

In the Practice Review program, we have seen demonstration of many ways of recording daily chart notes. We have seen excellent daily treatment notes that capture the S (subjective), O (objective), A (assessment) and P (procedures proposed, or change in treatment plan) of the day. We have also seen inconsistently recorded or an absence of some or most of the SOAP elements, cryptic abbreviations, diagrams, and check marks. We have seen electronic charting modules that do little to assist in ensuring that Standard meeting information is being recorded. In many instances, variations from the standard SOAP note provide little of the practitioner support that patient progress notes are supposed to provide.

Health care professionals are undergoing increasing scrutiny by third party payors and court liability assessments, and we are coming to see that appropriate chart notes are the foundation of the demonstration of treatment legitimacy and practitioner competence in these venues. We can rest assured that the importance of excellent patient chart notes will continue to become more and more important as time goes by. To ignore this reality places both patients and practitioners at increased jeopardy.

There may well be other progress note conventions other than the SOAP approach that can be acceptable. At a minimum, the critical information that must be recorded is:

1. the patient's perspective on progress (subjective)
2. the clinician's perspective on progress (objective)
3. the clinical activities engaged that day (including recommendations)

The whole point of patient progress (SOAP) notes is to document the specific events of the day, document that appropriate ongoing review and evaluation is occurring, and document the specific treatments provided at that visit. This is the only legal record that is meaningful to the courts or to professional discipline tribunals. It is expected that the practitioner will be able to refer to his notes and answer very specific and pointed questions.

Subjective

The subjective component of the SOAP is perhaps the easiest to write. It is the basic reason the patient is in your office, written in the patient's own words. The subjective component is the patient's description of why they are there, how they are feeling, their response to treatment and any other pertinent information they give you or you garner from your first few moments of the visit. The subjective component can be viewed as a mini-history and is the key initial component, when reviewing a chart, in developing an understanding of what went on in the visit.

An example of a follow up appointment:

> Mr. Jones presents for follow up of his low back complaint. He states that he is 60% better. He says he is still having trouble getting in and out of his truck, but is able to do so more easily and with less pain. He has no secondary complaints today and is in good spirits.

An example of a patient familiar to your practice with a recurrence of a known problem:

> Mr. Jones presents with mild low back pain. He states his pain is in the same area of his low back as previous visits. He was lifting a garage door and felt a sharp pain when he went to straighten

> up. His pain is left side low back. He denies any radiation into his lower extremity and denies any numbness tingling or weakness into his leg. He has had no changes in his bowel or bladder habits. He is in a good mood and states his pain as minor with a verbal pain scale of 3/10. His pain is aggravated with standing from a sitting position but is almost absent after standing for a few minutes.

It should be noted that the information is the patient's words. Medical terminology, or phrasing that the patient didn't use, should not be recorded here. It should also be noted that much of this verbiage can be abbreviated, provided there is an abbreviation key in the patient's chart.

Objective

The objective component can be made up of many different varieties of tests and retests to help determine any difference in the patient's condition from the last visit. This portion of the SOAP note can be the most difficult to write. There is no set number of items to record here. We basically want to be consistent with rechecking the components of our physical exam that helped us determine our working or differential diagnosis. It is also important to include anything that you may have done to investigate any change in your clinical impression from your subjective component of your SOAP note. For example, if the patient had a new complaint of numbness in their foot and pain radiating to the leg, it would become pertinent to test or retest lower extremity neurology to help determine if the problem is worsening, or now presenting differently than the last visit.

For non-complicated complaints, this is also the component of the chart where we should strive to change up the information a little. The nature of chiropractic, with the cumulative nature of improvements with serial visits, makes it a challenge to produce notes that are specific to the day and not sounding repetitive or copied.

It should also be noted that the objective portion of your SOAP note helps determine whether you agreed with the patient's subjective information. A patient that says they are 80% improved, but can't get out of his chair and now has foot drop, would be worth paying close attention to.

For example:

> Spasm 2+ right levator scapula. Tenderness +1 on palpation at C5-6 on the right. Positive cervical Kemp's with pain +1 at C5-6. Tight and tender upper trapezius at C2 on right. Segmental restrictions at C2, C5 and C7.

This daily note does not have to be complicated. The big point here is how does this visit compare to the 7 or 8 other visits that you saw this patient for? It is unlikely that this portion of the chart would be exactly the same as previous visits.

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Assessment

This portion of the chart is where you give your opinion. Your patient has given theirs. You have checked/re-checked the information you used to determine your initial working diagnosis. Now, what do you think?

Your assessment must address your patient's diagnosis as well as any new problems presented in the subjective component of the chart that you examined and recorded in the objective portion.

For example:

> John's low back shows improvement. He has less pain on palpation and an increase in active range of motion. The swelling over his left SI joint is no longer present.

Procedures/Plan

We have covered what the patient told us. We have covered what we found. We covered what we thought so far. Now, what are we going to do, and how are we going to follow up? This portion of the note should be a cut-and-dry list of what you did. If you performed a manipulation at L5, then just say that. If you have a variety of techniques or modalities available to you, include which technique or modality was used. There is no reason to write a novel here. The most important thing, however, is whether the treatment you provided is clinically relevant. For example, what if your patient has a low back complaint, you evaluated it and wrote down your assessment of that complaint, and then did ultrasound on their ankle? Your records would be confusing to read at this juncture. The ultrasound treatment may be relevant to the patient's undocumented complaint, but throws up a huge red flag as to the completeness of your clinic documentation to date.

For example:

> CMT L4-5. Stretch piriformis bilaterally. IFC L3-S1 80-120Hz

This last portion of the SOAP note ends with your plan for follow up. This also does not need to be complicated. You have already recorded your treatment plan in the patient's chart, and this is the portion of the daily notes where you are either sticking to that plan, or deviating from it – with reason. This is the portion of the daily note where you would add any home therapies, or advice and goals for these recommendations.

For example:

> Follow up in 2 days. Ice at home as needed, 15 min at a time to reduce pain and swelling.

It is important to note that your SOAP notes need not be long or wordy. What they must be is a detailed and complete document of the daily presentation of the patient.