

Writing SOAP Progress Notes

From a legality standpoint, your SOAP notes are very specific in nature and can easily serve as proof of your interaction with any given client. SOAP notes are written to summarize and document the client's response to treatment during each session.

- SOAP notes have 4 sections: "S" = subjective information
"O" = Objective information
"A" = Assessment
"P" = Plan
- SOAP notes should clearly and concisely summarize the client's response to the intervention. It is not intended to describe each and every activity or event that happened in treatment.
- SOAP notes should provide the clinician's interpretation of the client's response to the intervention and a general plan for what should happen next.
- The notes will give a solid overview of what each session involved, how the patient is progressing, and what you anticipate working on in the near future.
- A clinician should write the notes during or immediately following the session, to best ensure accuracy. Most practicing clinicians have little more than a few minutes per client per day to document. You may need to practice in order to write a SOAP note quickly.

What to include in the SOAP note:

S: In this section, describe your *impressions* of the client, *supported by observed facts*. Examples:

"Client appeared frustrated by some tasks. Several times he stated 'I can't do this'".

"Client's mother/teacher reports that he did not want to come to therapy today".

"Client's wife stated that she believed his speech was improving as family members were able to understand him better".

"Client reports increased swelling in her knee. She attributes this to walking more than 20 minutes last night at the grocery store. States she is still hesitant to leave the house without her walker."

DO NOT: Make subjective statements *without* supportive facts. For example, don't say "Client was happy to come to therapy today" without a statement to support that opinion. Also, do not report information that is not useful (i.e. "Client was on time today").

TIP: The "S" section is an excellent section to report what the client or parent feels about the progress. (Example: "When questioned about her son's progress in speech, Tim's mom states 'I can tell that he is really improving'.")

O: Write *measurable information* about the client's performance. This is where your therapy data goes. Data may be bulleted. Data charts may be used. This section should be specific enough that another healthcare professional could pick up where you left off. Examples:

"Produced /s/ correctly in 20/25 sentences (80%) without cueing by clinician".

"Imitated 32/37 two-word utterances modeled by the clinician during a 5 minute play period".

"Posture: right scapula abducted and internally rotated while sitting."

"20 minutes late to group session, slouched in chair, head down, later expressed interest in topic."

DO NOT: Write general statements without data (i.e. "responded well to a bubble-blowing activity") or describe each and every activity (i.e. "correctly articulated /r/ when naming objects, naming picture cards, and playing a game". Instead say: "correctly articulated /r/ in single words _____% of trials".

A: Analyze and compare data (use info from S and O above) to make an overall assessment of the session. Write *interpretations* of data. Document cues/strategies that were or were not successful. The assessment could also note possible areas of further inquiry or testing to guide proper treatment of the individual or family members. Examples:

"Performance improved from 70% accuracy last session to 95% accuracy this session".

* "Without visual cues by clinician, success decreased significantly"

"Slowing rate of speech consistently resulted in increased speech fluency"

"Multiple verbal cues were required to remind the patient on proper walker placement and sequencing. Further gait training will be required for safe ambulation." "Needs support in dealing with scheduled appointments and taking responsibility for being on time to group."

DO NOT: Just re-state your O section by re-reporting data or *suggest clinician culpability (i.e. "clinician's decision to decrease visual cues worsened the client's performance"). This makes it sound as if you did something that had a negative impact on the client when, in fact, you were simply probing to see how they performed with less assistance, so state it that way.

P: Outline what should happen next in treatment. Contains the specific treatment the patient will receive to achieve the goals. This may include information such as referrals to outside agencies or consultations needed with another professional regarding the client. Examples:

"Introduce articulation of /r/ at sentence level."

"Attempt to elicit 3 word responses in a spontaneous play activity."

"Progress with increased resistance bands for standing exercises."

"Focus on quad strengthening through standing exercises and balance activities"

"Begin to wear a watch and increase awareness of daily schedule."

DO NOT: Re-write the treatment plan. Remember, your overall goals are already documented.