How to write a Progress Note or a SOAP Note

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Documentation is an essential component in healthcare. Proper documentation is more likely to be expected from any healthcare professional. It is also an important communication tool in today’s healthcare system. Our US billing system relies heavily on proper documentation. It serves as the only protection for any legal issue that might arise later on secondary to your healthcare intervention. For employers, poor documentation means potential loss since it serves as the only record that could back up any auditing. In this edition, I will focus mainly on progress notes in the therapy practice since it is within my scope of expertise and my clinical skills. The article will go over the main requirements to have an effective progress note that shows your qualification and your professional skills. A good progress note shows how competent and qualified clinician you are.

This edition is very helpful to our international trained and educated clinicians. It gives them an idea of how the healthcare system and rehabilitation practice work in the US.

The effective progress PT, OT, Speech daily note should cover four main aspects of the care:

A. Subjective
B. Objective
C. Assessment
D. Plan

That is known as SOAP

Now, let’s take each section and take a closer look of what information we should include in each section.

- Subjective section is basically the conversation that you have with your patient when he/she comes to see you. It should include answers to the questions that you might be asking your patient. Now let’s take a look at what questions we might ask the patient that are considered to be subjective questions.

1. How are you feeling today?
2. Do you have any pain or complains, if so, what is it?
3. How would you rate your pain on a scale between 0 and 10?
4. Where do you hurt?
5. Does your pain increase in certain positions? Does it decrease in certain positions?
6. How did you feel after last visit?
7. Did you do your home exercise program?
8. Are you familiar with everything we did last time?

These are basic and simple questions that you should ask your patients when they come to see you. However, if you write your answers to these questions in the subjective section, you are definitely writing an effective subject component of your SOAP.

- Objective section is what you have done during the visit with your patient. It is very essential to write that section with as much details as possible. This section gives the other healthcare providers an idea of what your patient can or can’t do. It also helps your coworkers to continue what you have started working on with your patient. Let’s take a look at some rehabilitation interventions that should be documented in this section.

1- ROM exercise; what body part, how many times, what position, how much assistance, how many rest breaks, and the use of any assistive devices.
2- Strengthening exercises; what body part, how many times, what position, how much resistance, how many rest breaks, and physical assistance to complete the exercise.
3- Balance exercise; what test, how many times, what position, how much physical assistance, the reaction of the patient, how many rest breaks, and timing.
4- Fitness equipments; what machine, what level, what speed, what position, how much weight, how many sets, how many rest breaks, how many times in each set, and for how long.

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5- Gait training; what assistive device, how far, how many rest breaks, the need for a wheel chair to follow, and how much assistance

If you can document all the possible answers to the above questions, you successfully are able to provide simple but detailed objective.

- Assessment section talks about your professional assessment to everything your patient has done during the visit. In this section, you will need to document how your patient is responding to each intervention you included in your objective. You should also evaluate the patient’s progress towards the goals. This evaluation is being done by comparing the current status of the patient to the goals that need to be met.

Here are few things that you can include in your assessment:

1- ROM intervention; the quality of the ROM exercise, verbal cues, measurement, the end feel, and the pain level.
2- Strengthening exercise; the quality of the movement, verbal cues, the ability to tolerate the resistance, and the need to stop the exercise secondary to pain or discomfort.
3- Balance exercise; the quality of the exercise, verbal cues, and the progress that the patient is making comparing to the previous visit.
4- Fitness equipment; posture comments, verbal cues, presence of pain or discomfort, and the fatigue level.
5- Gait training; the posture assessment, verbal cues, description of the gait, description of the balance while using the assistive device, and the need for frequent breaks or a wheel chair.

The assessment section can take from few lines to a one full page or even more. However, every clinician will evaluate things from different perspective based on his/her background in the clinical and educational aspect of the practice.

If you just follow the mentioned assessment tools, you will have a strong assessment section.

- Plan of care section could one of two things either continue the plan of care or simply discharge the patient. In order to have a justified plan of care you should be able to answer the following questions in this section:

  Why should you see that patient again?
  What do you need to work on next visit?
  Why are you discharging the patient?

These are the main points that should be included in your plan of care. In order for your plan of care to be effective, it should have an answer to the above questions.

I hope that our March edition was very helpful. I hope that our international trained and educated clinicians were able to gain better understanding of how to write an effective progress note according to the US standards and MASA Healthcare practice codes.

Please feel free if you have any questions, you can email me at mali@masahc.com

Thank you

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