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Introduction to SOAP notes

Each day in the clinic, physical and occupational therapists, physical therapist assistants, occupational therapy assistants, and many other health care professionals document what they do with patients. One of the methods they use is a form of patient care not called a SOAP note. The SOAP format for writing notes has been widely used at Ballarat Health Services for decades, and is still well accepted as an appropriate method for documentation.

What SOAP means?
SOAP is an acronym. Each of the letters in S.O.A.P. stands for the name of a section of the patient note. The patient note is divided as follows:

S  Subjective
O  Objective
A  Assessment
P  Plan

Types of clinical notes
During the course of a patient’s care, the patient is initially assessed, reassessed constantly, and finally assessed upon discharge from the therapist’s care. Each of these types of assessment results in a type of SOAP note. An initial note is written after the initial patient assessment. An interim or progress, note is written periodically, reporting the results of reassessment. A discharge note is written at the time that therapy is discontinued.

The origin of SOAP notes
Dr Lawrence Weed as part of a system of organising the medical record call the problem-oriented medical record (POMR) introduced the SOAP note format. The POMR has one list of patient problems in the front of the chart, and each HealthCare practitioner writes a separate SOAP note to address each of the patient’s problems. This workbook will teach you a comprehensive method of writing SOAP notes than can be adapted to meet the requirements and needs of this health facility.

The purposes of documentation
All HealthCare professionals document their findings for several reasons:

1. Notes record what the therapist does to manage the individual patient’s case. The rights of the therapist and the patient are protected should any question occur in the future regarding the care provided to the patient. SOAP notes are considered legal documents, as are all parts of the medical record.

2. Professionals providing services after the patient is discharged from one therapist’s care may find the therapist’s notes to be very valuable in providing good follow up treatment.

3. Using the SOAP method of writing notes helps the therapist to organise the thought processes involved in patient care. By thinking in an organised manner, the therapist can better make decisions regarding patient care. Thus, the SOAP note is an excellent method of structuring thinking for problem solving.

4. A SOAP note can be used for quality improvement purposes. Certain criteria are set to indicate whether quality care is occurring. Within a limited time frame, the SOAP notes from all patients with a certain diagnosis can be assessed to see whether the preset criteria have been met.
The Relationship of SOAP Notes to the Decision Making Process
As mentioned previously, using SOAP notes helps the therapist organise and plan quality patient care. Following the SOAP note format presented in this workbook provides structure within which good problem solving can occur.

1. The therapist reads the patient's chart (medical record) or referral (if either is available). Test results such as x-ray examinations and laboratory findings as well as the physician's impression of the patient's problem can assist in planning the patient interview and identifying measurements to be performed.

   The results from this portion of the process are stated in the section called Problem or Diagnosis.

2. The therapist then interviews the patient. Information is gathered regarding the patient's history, complaints, home situation and goals for therapy. The subjective information thus gathered comprises the Subjective, or S, portion of the note.

3. From the information gathered from the medical record and the patient, the therapist plans the objective measurements to be performed. Then the planned measurements are completed. The results of these measurements performed are recorded in the Objective, or O, portion of the note.

4. Once the therapist has completed the interview and measurement process, they interpret the information recorded and identifies factors that are not within normal limits for people in the same age range as the patient. From these factors, the therapist formulates a list of the patient's problems, including functional limitations and impairments.

   The patient's problems are recorded in a section of the note called Functional Limitations or the Problem List, depending on the facility and what it includes in this section. Functional Limitations or the Problem List is part of the Assessment, or A, portion of the note.

5. After formulating a list of the patient's functional limitations or problems, the therapist and the patient together establish goals that correspond to the patient's functional limitations or problems. The first set of goals, or functional outcomes, states the final result of therapy, or the extent to which each of the patient's functional limitations or problems should be resolved following a program of therapeutic intervention.

   The goals stating the intended outcomes of therapy are called Functional Outcomes or Long Term Goals. The Functional Outcomes or Long Term Goals are also included in the Assessment, or A, portion of the note.

6. Once the goals are established, the therapist and patient consider what can be achieved within a short and long period of time.

   The goals stating what can be achieved in a short period of time are called Short Term Goals. The Short Term Goals are written into the Assessment, or A, portion of the note.

7. Once the therapist and the patient together make decisions regarding the anticipated outcomes or goals of treatment, the therapist formulates impressions of the patient's problems and conditions. Justifications of unusual goals or patient parameters that could not be measured or cannot be treated as listed.

   The therapist's Summary and/or Impressions are listed in the Assessment, or A, part of the note.

8. After setting goals with the patient, the therapist outlines a treatment plan to achieve them. The plan for treatment is listed as the Plan, or P, part of the note.
Summary
The SOAP note is one of the more commonly used forms of note writing. The SOAP format lends itself well to writing an initial note, as well as to writing interim notes and a discharge summary for each patient seen in therapy. It is probably the most comprehensive form of document encountered by most practitioners. Dr Lawrence Weed’s POMR format contained the original of the SOAP format that is more commonly used today.

Documentation has many purposes, from assuring quality care to communication to discharge planning. It has become very important in a HealthCare atmosphere that includes lawsuits and the need of third-party payers to obtain clear and accurate information. The SOAP method of writing notes serves as a guide to thinking through problems, demonstrating accountability for quality patient care, and documenting patient care.

Adapted from “Writing SOAP Notes 2nd Ed”, Ginge Kettenbach, F.A Davis Cop.
S.O.A.P. Clinical Documentation

S  SUBJECTIVE
- The patient’s emotions or attitudes
- Complaint(s)
- Verbal response about treatment
- Client goals
- Lifestyle or home situation
- Reports from staff / team members

O  OBJECTIVE
- What therapy was offered and frequency this week
- Results of measurement (reproducible data)
- Your clinical observations
- Functional information
- Type of treatment given (i.e. specific exercises, independence level, number of repetitions, positions used, modification(s) necessary, education given, etc.)

A  ASSESSMENT
- Where you write justifications for goals/plan
- Opportunity to identify inconsistencies between S and O
- Opportunities to draw conclusions between S and O - Synthesis
- Involves your professional judgment - Clinical Reasoning
- Analysis of goals and hence plans for the patient
- Where you comment on progress in therapy - Opinion
- Where you comment on rehabilitation potential for further intervention
- A problem list/issue list can be described in functional terms and in priority order
- You may refer to “Refer to IDA- Analysis page” (as relevant)
- Analysis of patient/family comprehension and integration of education given
- Summary statements
- Short term and Long term goal setting

P  PLAN
- Frequency per day / week the patient will attend
- The treatment modalities the patient will receive
- You may document “Refer to IDA Plan” (as relevant)
- Location of treatment, if appropriate
- Treatment progression outlined
- Plans for further assessment or re-assessment
- Plans for discharge
- Patient and / or family education
- Equipment needs and equipment to be ordered and / or supplied
- Therapy and home assessment recommendations
- Referral to other services

Clinical documentation
Mandatory to use all components of S: O: A: P:

Operational / Administrative documentation
Use relevant S: O: A: P: components
Allied Health Clinical Abbreviations, Acronyms & Symbols

BACKGROUND/RATIONALE
Language and expression is evolutionary, particularly in scientific and technical professions. In medicine and health, terminology changes constantly. Accordingly, new ways to truncate, abbreviate or express sometimes complex or compound terms can become unwieldy in documentation.

EXPECTED OUTCOME
Terms, acronyms and symbols contained in this dictionary are not prescriptive. The publisher and contributors recommend that if abbreviations are used that the adoption of terms in the Allied Health dictionary is the preferred choice.

DEFINITIONS
Terms which are frequently written in truncated forms, have been included in the dictionary in lower case followed by a full stop. Where abbreviations have more than one meaning or interpretation, alternate meanings have been included.

INDICATIONS
It should further be noted that all care should be taken in documenting clinical, treatment and other notes which comprise medical records and that abbreviations and symbols should be kept to a minimum.

ISSUES TO CONSIDER
This dictionary is not accredited by HIIMM or professional associations; rather it is a reference of commonly used abbreviations which have been approved by Ballarat Health Services Directorate of Allied Health.

ACTIONS
The abbreviations in this resource are ordered in alphabetical order and by meaning of term.

RELATED DOCUMENTS
Internal: S:\Allied Health\Allied Health\Resources\Allied Health Clin. Document\Abbreviations\Dictionary of AH Abbreviations & Symbols.pdf
Allied Health E Progress Notes

The generic Allied Health Progress Note is available for use when you do not have access to the correct discipline or program specific E Progress Note.

N.B. For the Generic AH progress note the most important thing is to make sure it is linked to an appointment for the correct department (e.g. Occupational Therapy, Podiatry). This will ensure that the document is filed in the correct folder in the DMR.

For Discipline specific progress notes the episode choice is less important as these forms have criteria built into them which ensure they always file in the correct AH sub folder in the DMR.

Finding the patient for your E Form Entry

Select the patient either by searching for the UR number using “Advanced Search’ and selecting the correct episode from the list displayed, or finding them in your patient list.

Open the required E Form.

From the patient list.

Single Click on the Patient bar to bring up the navigation box

Hover over the EMR button to bring up the E Forms box.

Click on Other E Forms to bring up your full list of E forms and click on the required Form, OR

Select the short cut icon to go directly to the E Form you need. This shortcut will only appear after you have used the E form once.
**From Within the EMR**

Single Click on the Patient bar to bring up the navigation box. Click on the EMR button

Click on the Blue E button at the top of the screen

Select the required E form from the list displayed

The Progress Note will load.

**Changing the episode once the E Form is Open**

Within the **Generic Allied Health E Progress Note**, you can change the episode you wish the Progress note to file against, using the “Select a different episode drop down list” (Outpatients → Department → Episode Details).

**N.B.** Make sure you actually click on the episode details and they appear in the field. You also need to make sure you complete this step before you enter any data, otherwise your data will be lost when the form refreshes against the new episode.

**Completing the E Forms**

Complete the **Contact details** field with your pager number or phone number (In some discipline specific forms these details are auto populated)
Complete the Profession field (In some discipline specific forms these details are auto populated).

The Clinic name populates automatically in the Generic Allied Health E Progress Note only and this is another way to check you have selected the correct episode.

Clinic Name: CAMHS
Clinician: Claire Bridson
Clinician Contact:

Date: 20 May 2010 08:12

Complete the body of the Progress Note using the approved SOAP Format.

Each note will include a heading to highlight the purpose of the documentation. There is no need to type the discipline at the top of the progress note, nor add your name and designation at end of the P: PLAN; nor time, as this is ‘stamped’ at the time of writing. However, if the note relates to a specific program, eg. Pain Management, type the program name at the top of the note.

Where the clinical documentation relates to a joint assessment, the names, designations and contact details of both clinicians will be sited at the end of the progress note. The clinician NOT logged in for the joint documentation will then proceed to log own Progress Note in the same folder as the colleague and will reference the prior document location, date and other relevant specifics of the joint assessment.

This field is expandable, this means you can type as much data as you require into this field. The form will save as many pages as necessary to display all the data entered into it.

Saving your E Form

At the bottom of the page there are 3 buttons:

- **Submit**: Clicking this button submits/saves the document to the DMR. You can no longer modify this document.

- **Save & Continue**: Clicking this button will save a draft of the data you have entered into the e form and allow you to continue work on your entry. This is useful if you are typing a long entry and want to make sure data is saved as you work.

- **Save (my draft)**
Clicking this button will save a draft of the data in your e form and close the form down. This allows you to return to a document and finish it/edit it later. This document is not saved to the DMR so is not visible to other staff.

**Reviewing submitted documents**

When you have completed the document, Click Submit at the bottom of the page. You will be returned to the DMR View.

To check your document has saved correctly click on Allied Health Ambulatory, click on the relevant sub folder and check for the document by date.

![Image](AlliedHealthAmbulatory.png)

**Retrieving a draft document**

To retrieve a draft document, select the relevant patient and episode again. Click on the relevant Allied Health Progress note button again.

The following dialogue box will appear. To open your draft document, click on the “Use my existing Draft Document”. All previously saved data will appear in the e form when it loads, you can now keep working on your entry.

![Image](ExistingDraft.png)

If you want to start a new document click “Start a New Document” button.

**N.B.** If you select this option any drafts for that e form will be lost.

**EHR Warnings Worklist**

You can now also access drafts E forms via the EHR Warnings work list.

Click on the Worklists button to on the left hand side of the screen to display the worklist options.

Open the EHR Warnings work list by clicking on the blue icon or the grey arrow.

![Image](EHRWarnings.png)

A list of draft documents you have created will be displayed.
Click on the red and white cross to delete a draft. A pop up box will display to confirm you wish to proceed with deletion. To proceed with deletion, click Yes. To cancel click deletion, click No.

To open a draft, click on the grey and white arrow. The Existing Draft Box will display.

Click on Use my existing Draft Document to retrieve data previously entered on the selected form for the patient identified in the list. The E form will load in a new IE window.

Click on Start a new Document, if you want to discard any previously entered data on the selected form and start with a blank form. The E form will load in a new IE window.

Use the form as usual and click Submit or Save (my Draft), when you have finished entering required data into the form.
Guidelines for Allied Health Action Plan

Purpose

An Action Plan is used by Allied Health staff to enhance service delivery to enable:
- a coordinated team approach to care
- a well-planned discharge to community
- family / carer involvement in ongoing care
- open communication with community agencies
- the achievement of agreed therapy goals
- the achievement of self-management goals
- the timely review by relevant health professionals
- accountability by all parties involved in plan

Usage

1. Goals are developed by the client, carer, team and service providers. The Client Centered Goal (CCG) Setting process may be used to elicit client carer and team goals.

2. An Action Plan is required if an agreement between Allied Health professionals and patient and/or carers needs to be documented with timelines and signed off by the person responsible for the task to signify agreement.
Usage, storage and disposal of Allied Health Clinical Working Files

BACKGROUND/RATIONALE

Allied Health working files are any unofficial notes that are kept by the clinician to assist patient care throughout an admission (inpatient or outpatient). This information is disposed of at patient discharge.

Examples of these include: demographic information that is useful to the admission, treatment notes, rough drafts and handover notes.

ACTIONS

1. Storage
   • These notes should be stored in a secure place, not for public viewing.

2. Access
   • Ensure that discipline colleagues are aware of secure location of working files in the event of staff absence.

3. Disposal
   • Working files are disposed at time of discharge in the confidential documentation bin
Inability to respond to referral

BACKGROUND/RATIONALE

Patients may not be seen in a timely manner due to a number of reasons, e.g.

a. No availability of staff
b. Low priority referral
c. Inappropriate to discipline referral
d. Low impact on discharge outcome
e. Low risk of adverse event

ACTIONS

1. Indicators for intervention / referral (IFI / IFR) are intended to prevent inappropriate referrals

2. All referrals that meet IFI / IFRs must be screened, priority established and documented

3. During period of low staffing, low priority patients will not be seen. Refer to specific Allied Health discipline prioritisation systems for further details

4. Where NO IFI / IFR exists, the clinician is required to document the following explanatory note:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Discipline Sticker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Treatment is not indicated at this time”</td>
</tr>
<tr>
<td></td>
<td>Time / Name / Signature / Designation / Pager</td>
</tr>
</tbody>
</table>

5. Where there is a work force issue, the clinical is required to confirm the workforce issue with their Clinical Manager, and if confirmed will document the following explanatory note:

<table>
<thead>
<tr>
<th>Date:</th>
<th>Discipline Sticker</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“Referral received dd/mm/yy and time. Unable to see patient during this admission. Referral has been made to outpatient services.”</td>
</tr>
<tr>
<td></td>
<td>Time / Name / Signature / Designation / Pager</td>
</tr>
</tbody>
</table>
Usage, storage and disposal of Allied Health Correspondence

BACKGROUND/RATIONALE
Allied Health correspondence needs to be securely stored, in the medical record or where appropriate the shared S:/Allied Health

ACTIONS
- All program assistants to send any typed patient related correspondence back to their clinician to save on the S:/ drive, not P:/ drive (my documents), as required
- Hard copy of the correspondence is to be sent to one or both of the Health Information Offices – as relevant to service provided
- The sent documents need to be identified as a copy using the standard COPY stamp
- All program assistants to delete this patient information completely from their computers once the document has been filed.
Usage, storage and disposal of Allied Health Clinical Raw Data

BACKGROUND/RATIONALE

Clinical raw data is any objective information obtained through measuring, testing and observing patients, which must be stored electronically.

ACTIONS

1. Storage
   - All raw data is scanned and electronically stored in the relevant and secured disciplines S/: drive folder which contains patient information
   - Each file needs to be named and dated to ensure retrieval is easy
   - Archiving of files is done in accordance with discipline rules
   - Once the paper raw data has been scanned, it is then disposed of, in the confidential documents bin
   - Once the data is filed, document the type and location of the clinical raw data in the medical record
   - This patient information is never to be stored on personal computers

2. Access
   - Discipline specific information is only accessible to same discipline clinicians
   - Raw data pertaining to a multi-disciplinary team is stored within its program folder on the shared S/: drive

3. Disposal
   - Files to be disposed in accordance with BHS Clinical Documentation Policy 2006
Therapy Groups – Frequency of Documentation

BACKGROUND/RATIONALE

Frequency of documentation of group intervention relates to the classification of the group type. These are divided between groups that focus on therapeutic intervention or maintenance of function.

EXPECTED OUTCOME

Allied Health staff in group programs will comply with the documentation standard.

DOCUMENTATION GUIDELINE

<table>
<thead>
<tr>
<th>Remediation</th>
<th>Compensatory</th>
<th>Adjustment</th>
<th>Identity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remedial - work done at impairment level to minimise impairment</td>
<td>Work done at disability level to decrease the effect of re mediated impairment</td>
<td>Adjustment - Psychological and emotional process undertaken to facilitate adjustment to impairment / disability</td>
<td>Identity - Process through which an adjusting person begins to build a new life</td>
</tr>
</tbody>
</table>

(Getting better)

- Initial contact / assessment completed in accordance with program standards
- Attendance recorded
- Record change in status (improvement / deterioration in medical, physical, social, psychological status)
- Summary status at 1 week
- Summary status at 2 weeks

(Getting around it)

- Initial contact / assessment completed in accordance with program standards
- Attendance recorded
- Record change in status (improvement / deterioration in medical, physical, social, psychological status)
- Summary status at 2 weeks

(Getting over it)

- Initial contact / assessment completed in accordance with program standards
- Attendance recorded
- Record change in status (improvement / deterioration in medical, physical, social, psychological status)
- Summary status at 3 months

(Getting on with it)

- Initial contact / assessment completed in accordance with program standards
- Attendance recorded
- Record change in status (improvement / deterioration in medical, physical, social, psychological status)
- Summary status at 6 months
## Allied Health Documentation Standards – Bed Based

<table>
<thead>
<tr>
<th>Program</th>
<th>Initial Contact</th>
<th>Assessment</th>
<th>Frequency of Progress Notes</th>
<th>Discharge Summary Complete</th>
<th>External documentation sent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE Emergency Department</strong></td>
<td>Document initial contact at time of contact</td>
<td>Document outcome immediately after assessment / intervention</td>
<td>Outcome immediately after intervention</td>
<td>Day of final intervention</td>
<td>External referrals same day Information for on-going management if necessary/appropriate same day</td>
</tr>
<tr>
<td><strong>ACUTE Inpatient</strong></td>
<td>Document initial contact if appropriate / possible. within 1 working day</td>
<td>Day assessment completed</td>
<td>Outcome immediately after <strong>every</strong> intervention</td>
<td>Day of final intervention</td>
<td>External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td><strong>Inpatient Complex Care Unit (ICCU – GEM)</strong></td>
<td>Disciplines with a blanket referral. document initial contact within 1 working day of admission</td>
<td>Day assessment commenced</td>
<td>Document change of patient status - minimum of once per week.</td>
<td>Day of final intervention</td>
<td>External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td><strong>Inpatient Rehabilitation Program IRP</strong></td>
<td>Disciplines with a blanket referral. document initial contact within 1 working day of admission</td>
<td>Day assessment commenced</td>
<td>Document change of patient status - minimum of once per week.</td>
<td>Day of final intervention</td>
<td>External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td><strong>Gandarra Palliative Care Unit</strong></td>
<td>Disciplines requiring a referral document within 1 working day of referral</td>
<td>Day assessment commenced</td>
<td>Document change of patient status - minimum of once per week.</td>
<td>Day of final intervention</td>
<td>External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td><strong>Transition Care (Bed Based)</strong></td>
<td>Document initial contact within 1 working day of admission</td>
<td>Day assessment commenced</td>
<td>Document change of patient status - minimum of once per week.</td>
<td>Day of final intervention</td>
<td>External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td><strong>Restorative Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GEM in the Home (GITH)</strong></td>
<td>Document initial contact within 1 working day of admission</td>
<td>Day assessment commenced</td>
<td>Document change of patient status - minimum of once per week</td>
<td>Day of final intervention</td>
<td><strong>External referrals within 1 day of discharge</strong> Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------------------</td>
<td>---------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Residential Services (RACS)</strong></td>
<td>Within 1 working day of referral</td>
<td>Day assessment completed</td>
<td>Outcome of intervention every contact</td>
<td>Day of final intervention</td>
<td>Information for on-going management if necessary/appropriate within 1 week of discharge</td>
</tr>
</tbody>
</table>
### Allied Health Documentation Standards – Recording Group Interventions – Ambulatory Care

#### SACS Groups:
- Balance
- Cardiac and Pulmonary
- Aquatic Physiotherapy
- Speech Pathology – Feeding and School Readiness
- Pain Management

#### Community Health (CH) Groups:
- ABI Social Communication
- BISCUIT (SP)
- Exercise Physiology (Gym, Pool, Balance)
- Healthy Weight Management
- Speech Pathology - Early Language Development, Speech Sound Remediation

#### DOCUMENTATION GUIDELINE

<table>
<thead>
<tr>
<th>Program</th>
<th>Initial contact</th>
<th>Assessment</th>
<th>Frequency of Progress notes</th>
<th>Discharge Summary Complete</th>
<th>External documentation sent</th>
</tr>
</thead>
</table>
| SACS    | Initial Needs Identification (INI) to be documented by therapist | Documentation is complete on day of assessment | Within one working day a progress note is required:  
  - If progress is not going in accordance to plan  
  - Clinically significant changes in status  
  - Unexpected response to treatment  
  - Issues related to risk  
  - Changes to program (not recorded elsewhere)  
  - Breaches to Attendance Policy | Within 10 working days of final intervention. | Within 10 working days of final intervention. |
| CH      | Triage by therapist or AHA is documented. | Documentation is complete on day of assessment | Within one working day a progress note is required:  
  - If progress is not going in accordance to plan  
  - Clinically significant changes in status  
  - Unexpected response to treatment  
  - Issues related to risk  
  - Changes to program (not recorded elsewhere)  
  - Breaches to Attendance Policy | Within 10 working days of final intervention. | Within 10 working days of final intervention. |
<table>
<thead>
<tr>
<th>Program</th>
<th>Initial Contact (includes Initial Needs Identification and Risk Screening)</th>
<th>Assessment</th>
<th>Frequency of Progress Notes</th>
<th>Discharge Summary Complete</th>
<th>External documentation sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>VACS</td>
<td>Document initial contact at time of contact</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Within 5 working days of final intervention</td>
<td>External referrals within 5 working days of final intervention Information for on-going management if appropriate within 5 working days of final intervention</td>
</tr>
<tr>
<td>Outpatient Specialist Clinics</td>
<td>Document initial contact at time of contact</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Within 5 working days of final intervention</td>
<td>External referrals within 5 working days of final intervention Information for on-going management if appropriate within 5 working days of final intervention</td>
</tr>
<tr>
<td>Community Rehabilitation Centre and Home Based</td>
<td>RISK Home Safety Checklist MR/262.3 FROPCom Initial Needs Identification</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Within 5 working days of final intervention</td>
<td>External referrals within 5 working days of final intervention Information for on-going management if appropriate within 5 working days of final intervention</td>
</tr>
<tr>
<td>Community Health (CH)</td>
<td>Document initial contact at time of contact</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Within 5 working days of final intervention</td>
<td>External referrals within 5 working days of final intervention Information for on-going management if appropriate within 5 working days of final intervention</td>
</tr>
<tr>
<td>Domiciliary Program</td>
<td>RISK Home Safety Checklist MR/262.3 FROPCom</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Within 5 working days of final intervention</td>
<td>External referrals within 5 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
<tr>
<td>HARP</td>
<td>RISK Home Safety Checklist MR/262.3 FROPCom</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Within 5 working days of final intervention</td>
<td>External referrals within 5 working days of final intervention Information for on-going management if appropriate within 5 working days of final intervention</td>
</tr>
<tr>
<td>Transition Care Program (Community)</td>
<td>RISK Home Safety Checklist MR/262.3 FROPCom</td>
<td>Day assessment completed</td>
<td>Outcome of every contact nb. Cancellations and all phone contacts are included</td>
<td>Day of final intervention</td>
<td>External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge</td>
</tr>
</tbody>
</table>
Allied Health Discharge Documentation

BACKGROUND/RATIONALE

To ensure the AHP recording of patient status at time of discharge from inpatient or outpatient is uniform and meets ACHS EQuIP standards 1.1.5 (discharge systems) and 1.1.8 (health record compliance).

ACTIONS

Documentation of discharge event shall include the following mandatory elements:

S: Patient’s response to readiness for discharge - inpatients
   Subjective satisfaction with condition

O: Discharge destination - inpatients
   Current status (physical / functional / cognitive / social)
   Summary of intervention (can include equipment provided)
   Detail of follow-up therapy / services arranged / referrals
   Patient / carer instructions / education / home program arranged

   Reference to previous documentation which covers these criteria is acceptable

A: Goals achieved
   Reasons for goals not being achieved
   Reasons for planned intervention incomplete

   Reference to previous documentation which covers these criteria is acceptable

P: “Discharged from AH discipline”
   Name / Signature / Pager
Physiotherapy

SOAP Documentation Guidelines

These SOAP documentation guidelines cover the general headings and inclusions of physiotherapy documentation across all areas of physiotherapy. Some inclusions may not be appropriate for every area of physiotherapy, but the general headings should always be covered.

S – Subjective

Any information reported to the therapist by the patient, patient’s family, carers, or from the medical, nursing staff or other allied health team.

This should include:
- Patients goals
- Patients complaints/issues
- Patients perceptions of progress and therapy
- How the patient feels eg. Pain, anxiety, depression etc.

On Initial Assessment Subjective should also include:
- Reference made to the IDA if applicable.
- History of Presenting Condition (HOPC)
- Past History (PHx)
  - Medical
  - Therapeutic
- Social History (SHX)
  - Home environment
  - Previous mobility
  - Previous level of functioning eg. ADL’s, assistance from services/family etc.
  - Family/Social supports

On Discharge the Subjective should include:
- Summary of patients response to therapy
- Summary of patients complaints
- How the patient feels about their discharge destination eg. Whether they feel ready for rehabilitation or discharge home.

O – Objective:

Objective information includes information that is observable and is measurable and reproducible.

This information may include:
- Clinical Observations
  - Nursing observation chart
  - Patient position and any lines/drains etc
  - Auscultation
  - Cough – strength, productivity, colour of sputum
  - Oxygen saturation and level of oxygen therapy if applicable
  - Joint ROM – goniometry
  - Muscle strength – 0-5 Scale and/or dynamometry
  - Muscle tone
  - Sensation
  - Neurological Assessment
  - Balance Assessment
  - Valid and Reliable Assessment tools and questionnaires
    Eg. MAS, Oswestry Questionnaire, Neck disability questionnaire, WOMAC, Berg balance Scale etc.
- Mobility – observation of quality, distances, level of assistance required, gait aid used, and timed measures if possible.
- Transfers – observation of quality, level of assistance required, equipment used, etc.
- Medical Investigations undertaken eg. X-ray, US, MRI, CT, ABGs, LFTs, Pathology, etc.

- Treatment:
  - Exercises / Intervention
  - Rate
  - Intensity
  - Positions used
  - Modifications required
  - Education/Advice given

- Response to Treatment

On Initial Assessment
- Reference to IDA may be applicable

On Discharge:
- Summary of patient’s status on discharge.

A – Assessment/Analysis:

The assessment or analysis of the patient in your professional judgement

This section should include the following:

- The Problem List:
  - a summary of the patient’s major problems

- Long Term Goals:
  - State the expected long term goals of therapy
  - Should be based on the problem list
    (Reference to IDA Goals sheet as required)

- Short term goals:
  - Steps to achieving long term goals
  - Are based on long term goals
    (Reference to IDA Goals sheet as required)

- Impressions or summary:
  - The physiotherapy diagnosis
  - Justification of goals and treatment plan
  - Clarification of major problems
  - Discussion on patients progress (or lack of)
  - Discussion of patients rehabilitation potential and why
  - Suggestions of further therapy, and referrals needed.

On Discharge:
- Summary of whether the problems listed prior have been resolved
- Indicates which short and long term goals have been achieved and which ones are yet to be achieved.
P – Plan

Should include:
- Intervention planned
  - Frequency per day/week patient will be seen.
  - Treatment patient will receive including potential progressions of therapy.
- Description of home exercise program (HEP) if applicable
- Instruction/advice given to the patient and family/carers.
- Any equipment needs of the patient for purchase/hire.
- Plans for discharge, including estimated time frame, destination, and physiotherapy follow up if applicable.
- Referrals made to other services and reasons why you have referred the patient to these services.

On Discharge the plan should include a brief summary of:
- What the treatment was given to the patient.
- Instruction of home exercise program, and patients level of independence with HEP.
- Any instructions/education to family/patient.
- Any referrals made on discharge.
- Patients discharge destination.
- Reason for discharge
- Recommendations for follow up treatment or care given to the patient.

Signed, (Designation and pager or ext. number)
Exercise Therapy

SOAP Documentation guidelines

S – Subjective

- Current health status
- Current physical/health problems
- Pain Scale
- Description of pain or condition eg. pain like a sharp stabbing knife digging in back that lasts up to 10 secs
- Current treatment
- Past history physical, medical conditions, treatment
- Exercise history, and current level of physical activity
- Goals - long and short term

O - Objective

- Height
- Weight
- BMI
- Waist
- Blood pressure
- SF36
- CVD risk assessment
- Posture assessment
- Active range of motion
- Passive and resistive range of motion
- Musculoskeletal special test

A - Assessment / Analysis

- Percentage body fat
- Hyper/Hypotension
- Cardiovascular risk status
- Biomechanical deficiencies
- Strength
- Flexibility
- Functional movement limitations

P - Plan

- Program outline-frequency, intensity, type, time (including home exercise program)
- Referral if necessary
- Education
- Reassessment
SOAP Documentation Guidelines

S - Subjective

Patients' description of
A) Presenting problem/s
   Course
   Onset
   Duration
   Frequency
   Severity or Impact- (Interference and distress)
   Precipitants, maintaining and protective factors

B) Goals- Immediate, intermediate and long-term.

C) Patient identified barriers to Goals

D) Established coping skills/resources

E) Responses to previous treatment/ assessment

F) Expectations of and attitude to current situation and to treatment/assessment

O - Objective

A) Clinician’s observations of
   Client’s appearance/communication skills
   Client’s affect
   Client’s behaviour
   Client’s cognition

B) Results of assessment
   Self-monitoring
   Structured interviews (i.e. MSE/ADIS/Sawi)
   Structured questionnaires
     Mood- (BDI, POMS)
     Behaviour (DEX, CBCL)
     Personality (MMPI-2)
     Health Status (GHQ/QOLI)

C) Description of interventions and response to previous interventions

A – Assessment / Analysis

A) Diagnosis- using DSM IV format-with level of severity-described as
   Mild/Moderate/Severe and numeric Global Assessment of Functioning Scale
   Differential diagnoses to be offered where relevant.

B) Aetiology- Behavioural analysis of presenting problem
   Identification of behaviours to be treated
   Factors maintaining and precipitating problem behaviours
     Long-standing
     Medium-term
     Immediate

C) Management
   Further assessment
   Immediate management strategies
Long-term management strategies
(Individual/supportive/systemic/environmental)

D) Prognosis
Onset and course—acute v. chronic, persistent v intermittent
Previous responses to treatment/compliance
Predominant coping skills
Current level of adjustment/self-efficacy
Current social supports
Current levels of motivation
Availability of appropriate resources and services, internally and externally.
Consider short term and longer term prognoses. Also consider prognosis in terms of the capacity of proposed treatment/management strategies to assist in managing the identified problem not just the likely course—e.g. DAT has a quite poor prognosis but management strategies at the individual, supportive, systemic and environmental levels can effectively reduce patient distress, carer burden as well as effectively manage challenging behaviours.

P - Plan
B) Further assessment/review
C) Referral on
**Social Work**

**SOAP Documentation Guidelines**

**S - Subjective**

Information gathered from the patient/carer about patient’s history, complaints, home situation and goals for therapy. In situations where the patient does not have the capacity to give a reasonable overview of circumstances the carer/family can provide a subjective overview. Client’s permission should be obtained where possible giving permission of contact with family/carer. This could include areas such as stated:

- Perception of the home situation
- Perception of problem/issues
- Perception of their current emotional status/coping issues
- Perception of how therapy/treatment is going
- Perception of issues affecting discharge
- Perception of other issues affecting them
- Requests by patient for assistance
- Patient and/or family’s stated goals and desired outcomes
- Family/carers’ stated perception of issues and needed supports

**O - Objective information (factual information)**

Information gathered from the medical record, other professionals, family members. This could include areas such as:

- What is known about the home situation (factual not subjective)
- Observations from which emotional status may be inferred and patient observed actions
- Knowledge from the social worker about current status, issues and needs.
- Knowledge of person’s previous coping skills
- Knowledge from the team about prognosis, progress and discharge plans
- External services involved with patient and the frequency
- Other supports both formal and informal

**A – Assessment / Analysis**

Your assessment of the patient is the utilization of the information in the subjective and objective area. This could include areas such as:

- Any similarities and differences between subjective and objective
- Any conclusions drawn
- Your professional opinion on issues
- Analysis of issues/goals
- Analysis of how patient will cope on discharge given information provided in subjective and objective
- Analysis of how issues will affect discharge planning
- Analysis of current identified needs; ie family conference; current gaps etc.
- Analysis of any counselling or work with patient given by social worker and its effectiveness/further work needed/barriers to comprehension, insight or acceptance.
- A professional opinion drawn from analysis of objective and subjective
- Information that evaluates patients’ ability to implement recommended intervention plan.
P - Plan

This is your proposed intervention plan. This should consider indicators for intervention that will meet the patient’s needs around the current admission and planned discharge:

- Recommendation of proposed intervention-services or supports required
- Continue to support the patient and family
- Date of next review or planned contact with patient and/or family/carer
- Planned review with other members of the treatment team
- Planned referrals of patient to other services
- Date/time referred workers plan to see patient
- Follow up with other professionals
- Follow up with family
- Develop discharge plan
- Provide education to patient and/or family
- Follow up after discharge
Dietetics

SOAP Documentation Guidelines

S - Subjective
Includes any information that is reported by the patient or family. This may include client’s perception of problems. This could include areas such as:
- Appetite
- Nausea
- Abdominal comfort
- Bowel habits
- Reported weight history (can be included in the Objective section with other anthropometric information for consistency)
- Reported past treatment

O - Objective Information
Objective information, such as relevant history, clinical findings and measurements. For example:
- Anthropometry
  - Actual weight
  - Weight history (obtained from previous admissions)
  - Measured height (or estimated from knee height or arm span)
  - Body Mass Index
  - Health Weight Range
- Bowel Chart Information
- Fluid Balance Chart (FBC) totals
  - Total intake
  - Urine output
- Biochemistry
- Dentition
- Diet history (although this does not need to be written in the record)
- Documented past treatment
- Current treatment / recommendations by other health professionals

O - Objective
Objective information: such as relevant history, clinical findings and measurements. For example:
- Anthropometry
  - Actual weight
  - Weight history (obtained from previous admissions)
  - Measured height (or estimated from knee height or arm span)
  - Body Mass Index
  - Health Weight Range
- Bowel Chart Information
- Fluid Balance Chart (FBC) totals
  - Total intake
  - Urine output
- Biochemistry
- Dentition
- Diet history (although this does not need to be written in the record)
- Documented past treatment
- Current treatment / recommendations by other health professionals
**A - Assessment / Analysis**

Your assessment of the patient and the information recorded in the Subjective and Objective sections.

Including:

- Estimated nutritional requirements
- Summary of diet history information
- Analysis of a food and fluid chart and its comparison to the patient’s requirements
- Comments about the objective information
  - what the biochemistry indicates
  - weight change, comparison to healthy weight range
  - whether or not the FBC indicates adequate fluid intake
  - comment about bowel function
- Overall assessment summary

**P - Plan/Management Recommendations**

In this section you document what the patient requires / what you plan to do.

This section will include:

- goals and therapy foci (usually written on the Rehabilitation Care Plan)
- type of diet
- nutritional supplements
- enteral nutrition regimen
- education planned and completed
- education material provided
- further education needs
- referral to other professionals / program
- follow up plan / discharge planning
Prosthetics and Orthotics

SOAP Documentation Guidelines

S - Subjective
This section includes any information that is reported by the patient or family, including client’s perception of problems (therapist may use anatomical terms in documentation). This is typically any information that you hear. This part may include:

- events of injury,
- onset of pain etc,
- medication taken
- patient's recount of medical history,
- comments on gait, function, prosthetic problem, orthotic problem.
- patient's goals and wishes
- patient's quotations

O - Objective
This section includes any information, which can be observed and is generally considered beyond dispute. This is typically any information that you see.
Sub categories in prosthetics are: Stump condition, Fit of prosthesis, Gait Observations.
Information may further include:

- clinical signs, skin condition
- gait parameters
- physical measurements, ROM
- information from referral
- prosthesis/orthosis description
- intervention description i.e. modifications, supply of, cast taken, education completed etc.

A - Assessment / Analysis
This section contains the therapists' analysis and assessment of all the above information. For instance what conclusions can be made from the subjective and objective information?
This may include:

- diagnosis of condition
- diagnosis of problem
- interpretation of compensation mechanisms
- possible functional outcomes
- best treatment intervention
- short term goals
- long term goals

P - Plan / Management Recommendations
This section includes future tasks and actions to achieve these tasks.
This may include:

- future tasks
- prosthesis/orthosis to be provided
- when you plan to provide the prosthesis/orthosis
- correspondence to be completed
- funding to be arranged
- review date
- invoicing status
- next appointment
- education action
- referral to other services
SOAP examples:

Example 1

Prosthetics & Orthotics

Date

RA affecting feet- Review

S: Pt. stated that she had applied for A&EP funding for custom made insoles. She has noticed nodules in her heels and says they are uncomfortable. She thinks they might be due to the hardness of her foot orthoses.

O: A&EP funding ($220) has been approved for custom made foot orthoses. Patient presented with x-ray, noted small nodules in heel fat pads L > R. Elicited pain upon palpation of nodules at antero-medial calcaneum L>R. Examined current orthoses, cover worn and frayed and EVA compressed and hard. Plaster casts were taken of L and R feet with suspension technique.

A: Current foot orthoses are in disrepair, hard and ill fitting and require replacement. Pain on palpation at nodule site indicates that excessive pressure during WB aggravates pain. Joan will benefit from custom made FO with MLA, heel cup and spur cut-outs to decrease pressure under heels. This will aim to relieve pain associated with her heel nodules.

P: Fabricate new FO from plaster casts and fit in 2/52. FO to be fabricated from EVA (medium density). Signature, Print Name, (P&O), pager number

Example 2:

Prosthetics & Orthotics

Date

Bilateral Midfoot Pronation - Repair of footwear

S: Pt. dropped in 10.02.2002 and requested repair of his current footwear. He stated that custom FO and footwear have alleviated the pain in his feet. He wears FO and shoes all the time.

O: Pt presented with custom made foot orthoses and footwear. Footwear supplied by Essential Footwear in Oct.1999 and funded by A&EP. Footwear condition: heel of L and R shoes are worn down significantly on the medial edge. Leather uppers on footwear dry and cracked at toe crease. FO are compressed at the medial heel. Repairs made include resoling of L and R shoes, heel only and medial wedge to L and R FO, heel only. A&EP application forms filled out to apply for funding for a new pair of custom-made shoes ($450) and custom made insoles ($200).

A: Current footwear and orthoses are in need of repair in order to provide greater control of bilateral mid-foot pronation. Patient will benefit from second pair of footwear and insoles for longevity. Current Rx to be continued.

P: Invoice PADP for repairs $50. Contact client and make appointment once funding for new custom made footwear and insoles is approved. Signature, Print Name, (P&O), pager number
### Example 3:

**Date**  | **Prosthetics & Orthotics**
---|---

**S:** Pt reports that stump began bleeding 3/52 ago. RDNS treated wound with Duoderm dressing. Patient reports that nurse stated that there was a lesion on the bottom of the stump and a build-up of callous. Patient c/o unsteadiness and not enough heel strike during gait.

**O:** Weight = 75 Kg with prosthesis.

- **Stump:** Dry cracked skin anterior-distal stump, cutinova dressing in situ, some bleeding noted from the cracks.
- **Fit:** Attended consultation wearing very worn thin terry sock and 2x cotton socks.
- **Gait:** Some “drop off” at the end of stance.
  
  ↑ PF of foot to reduce the quick Hs→FF

**A:** Excessive distal pressure – dropping too far into socket. Changed sock combination to 1 cool wool and 1 soft cotton. Following change of socks there were good even sock marks on stump, none evident over anterior-distal tibia.

↑ PF of foot reduced ankle moment and improved gait with smoother transition from heel strike to toe-off.

**P:** Recommended pt use skin cream on dry areas of stump. Suggested Tom use his quadriceps muscle (tighten) during stance phase to address “drop off”

Pt to trial changes and review in 4/7.

Invoice for minor repair.

Signature, Print Name (P&O), pager number

### Example 4:

**Date**  | **Prosthetics & Orthotics**
---|---

**S:** Shelly reports: C-Walk foot feels like a really comfortable old pair of shoes.

**O:** Prosthesis comprises of Otto Bock polycentric joints, C-Walk foot, slip-socket and leather thigh- lacer with dark blue velcro straps.

Walked in the rails. Mal-alignment of knee joints noted at mid stance (good alignment during swing). No other gait deviations observed.

**A:** Fit of thigh lacer appropriate, alignment of joints is good when not weight bearing, but gap and flex under force. Thigh-lacer uprights should be more rigid for increased stability and durability. C-Walk providing Shelly with good shock absorbing mechanism and smoothing moments during stance phase.

**P:** Weld steel bands to joints for increased stability.

Laminate over socket and side irons to reinforce joint attachments.

Fit after reinforcements for field trial on 12 March 2002

Signature, Print Name (P&O), pager number
Example 5:

Prosthetics & Orthotics

Date

S: Ian reported that he has tried wearing his new prosthesis, but after only a few steps he gets a lot of pain distally and disto-laterally. He has been unable to wear it much at all and has spent most of the time in his old prosthesis which is also causing some pain.

O: Pt wearing old prosthesis.
Stump: very red, dry and calloused all over distal end. Lateral paratibial area is sore to touch and a small abrasion is evident. Heavy distal end callousing.
Fitting: New prosthesis – AP measurements are appropriate.
Posterior supracondylar measurement too wide in socket.
Patella bar too low – 5mm.
Lateral para-tibial region – too much loading.
Adjustments: Raised patella bar with petite packing to inside of socket.
Ground lateral packing down.
Heated socket at supracondylar area and pushed in to increase suspension during flexion.
After modifications – sock marks appropriate laterally however medially and posteriorly the sock marks were lacking. Packed medially with felt under the tibial flare, extending pad posteriorly.
Gave Ian heavy duty cool-wool socks to try.

S: Ian felt the prosthesis was feeling slightly more comfortable. He said that he wanted to take it home and try it.

A: Adjustments required to relieve areas described and to increase pressure where it was lacking. Prosthesis fitting ok following adjustments. – suspension improved – stump loading improved.

P: Ian to try the prosthesis with the changes and review appointment made for 2/52. Refabricate socket if all ok at this stage.
Signature, Print Name (P&O), pager number

Example 6

Prosthetics and orthotics

Date:

Pre treatment:

S: Patient reported that the current leg is slipping off and that he is experiencing pain on the end of the shin bone (cut end of tibia). He requested that a new cast and prosthesis be made, stating that previous designs have also fallen off.

O: Gait - prosthetic heel raised in standing
Fit – prosthesis dropping off in swing.
Residuum - healed lesion from previous skin breakdown at lateral/antero/tibial condyle. Distal fibula pressure evident. Distal pressure evident on anterodistal end of tibia. Pressure also evident at medial anterior and lateral trimlines.
Other - knee flexion contracture present on sound limb. Measured at 20 deg.

Prosthetic Intervention - Flared medial, lateral, and anterior superior trimlines. Relieved distal tibia in socket and liner. Changed suspension system from suprapatella cuff to silicon knee sleeve and valve suspension. Increased flexion of socket.

A: Insufficient flexion in the socket causing the heel of the prosthesis to be off the ground during standing.
Fit - Insufficient trimline flare and distal tibia space causing strong pressure marks on skin. Socket needs to be relieved over pressure areas described above. Prosthesis not suspending adequately with supra patella cuff.

Post Treatment:

S: Patient reported no anterodistal tibial pain, and secure suspension.

O: Gait - Patient had even pressure on heel and forefoot during standing. During walking, heel to toe gait achieved.
   Fit - Socket fitted with 1x nylon sheath, suspension was adequate.
   Residuum – Even skin marks after socket removal

A: Socket adjustments have decreased pressure marks on the skin. Increased socket flexion has allowed patient to obtain heel contact. Suspension sleeve/valve suspension design suspends prosthesis adequately.

P: Review in 2/52.
Signature, Print Name (P&O), pager number
**Occupational Therapy**

**SOAP Documentation Guidelines**

**Title of Entry:**
This may include reason for referral, when referral was received, and sender’s details. The primary diagnosis may also be included in the title.

Examples: Initial Contact Initial Assessment Home Assessment Phone Call to Equipment Supplier OT Discharge Summary

**S - Subjective**
Any information reported by the patient and/or family.

This could include:
- Patient’s stated perception of progress and therapy
- Patient’s report of the way they are feeling e.g. pain, depression
- Goals expressed by patient
- Information provided about
  - previous level of function in personal, domestic and community ADL
  - perceived problems with return home
  - details of home environment and previous home modifications
  - previous leisure/work activities
  - services used to assist with ADL tasks
Reference to IDA if information documented in IDA

**O - Objective**
Objective information including information that can be observed and is generally considered beyond dispute.

- Relevant history/information obtained from UR/previous OT intervention
- Your clinical observations
  - Functional status in mobility/transfers, PADL, DADL, CADL including tasks able/unable to do, level of assistance, required aids/equipment used and position in which task undertaken
  - Cognitive deficits observed in functional tasks
  - Results of cognitive, physical and sensory assessments eg. ROM, strength, patterns of sensory loss
  - Orientation
  - Ability to learn new techniques and strategies, level of memory loss, dyspraxia etc.
- Reference to IDA if information documented there
- Type of treatment undertaken/no. of times completed
- Education given

**A - Assessment**
- Clinical reasoning about patient’s condition and situation
- Opportunity to comment on:
  1. Progress and improvements
  2. Likely prognosis/potential to achieve goals
  3. Major deficits/abilities impacting on progress
  4. Inconsistencies between what you observe and the patient reports
- Summarise functional status
- Short term and long term goals
P - Plan

- Intervention planned – new and ongoing and duration if known
- Reference to IDA goal sheet if appropriate
- Plans for discharge including destination
- Plans for further assessment/reassessment – ongoing OT involvement post discharge
- Education/liaison planned with other team members/family/patient
- Referrals to be made to other agencies
Podiatry

SOAP Documentation Guidelines

**S - Subjective**
- The patients complaint(s)
- Information in regards to pain (where applicable):
  - When the pain started.
  - The level of activity (intensity, duration) the patient was undertaking at the time
  - Type of pain (sharp, shooting, deep aching)
  - The time at which the pain is worst.
- The patients perception of progress and therapy
- The goals the patient wants to achieve
- Patients’ level of reported activity
- A change in a patient’s overall health and/or Pharmacological intervention.
- Response to treatment

**O - Objective**
- Relevant history including vascular, neurological, dermatological and biomechanical status.
- Results of measurements (eg Doppler, Ankle Brachial indices, Wound measurements, RCSP)
- Clinical observations
  - Functional status
  - Foot health status
  - Palpated pain
  - Signs and symptoms of decreased circulation (e.g colour, temperature, dependent rubor)
  - Skin Integrity
  - Presence of inflammation/infection
  - Presence of dermatological lesions
  - Hygiene.
  - Condition, style and fit of footwear.
  - ROM of lower limb and foot joints
  - Wear patterns on footwear
- Treatment undertaken
- Education given (e.g First aid, washing, drying, footcare, footwear)

**A - Assessment**
Your professional judgement about patient
Opportunity to comment on and draw conclusions between:
- Progress
- Likely prognosis/potential
- Inconsistencies between what you observe and the patient reports
- Clinical risk status
Overall assessment summary

**P - Plan**
- Intervention planned - new and ongoing and duration if known. Include return period
- Short and long term goals
- Plans for discharge
- Education/liaison with other health care professionals/team members/ family/ patient
- Referrals to other services/agencies
- Reference to IDA goal sheet if appropriate
Speech Pathology

SOAP Documentation Guidelines

Initial assessment only – 1 line - reason for referral / history of presenting condition

S - Subjective
Information that is reported by the patient, family or others (carers, health care professionals etc) including the client’s perception of the problems. This could include areas such as:

- Swallowing
- Eating
- Communication
- Cognition
- History of communication, swallowing and / or cognitive difficulties
- Relevant medical and developmental history
- Impact of communication, swallowing and / or cognitive difficulties on function
- Past Speech Pathology management
- Motivation for therapy
- Other agencies involved

O - Objective
- Presentation, general observations
- Clinical findings and measurements – Tests you have utilised and scores/measures derived must be documented.
- The following assessment items may be commented on:

  18yrs+
  - Receptive Language (verbal, written)
  - Expressive Language (verbal, written)
  - Cranial Nerve Function
  - Cognition
  - Motor speech
  - Swallowing
  - Voice
  - Pragmatics
  - Fluency

  0-18yrs
  - Feeding, swallowing, saliva control
  - Speech (Articulation, Phonology
  - Receptive Language
  - Expressive Language
  - Literacy (reading, writing, spelling, phonological awareness)
  - Voice
  - Fluency
  - Pragmatics

- Nature and outcome of therapy is also documented here.

A - Assessment /Analysis
This section includes your overall summary and interpretation of subjective and objective information. You must state the level of impairment, disability and handicap and include severity levels for these such as mild, moderate and severe.
You may make comparisons with test results from other areas in your analysis here such as chest X-ray results, CT results, Apgar scores
This section will include:
- Goals and therapy foci
- Estimate length of treatment program and frequency of treatment
P - Plan / Management Recommendations

In this section you document what the patient requires/what you plan to do. This section may include:

- Diet recommendations
- Communication, swallowing, and cognition recommendations and strategies
- Provision of information and education

On referrals eg. To Dietetics, Psychology, ENT, Paediatrician etc