

# Soap notes



**ASSIGN  
BUSTER**

Why is documentation important? Because if it isn't written, it didn't happen. Documentation is anything written that gives information or supplies evidence. SOAP NOTES SPECIFICALLY FOR YOU FOR ONLY \$13.

90/PAGE Order Now documentation is the assembling of documents; the using of documentary evidence to support the original work... the classifying and making available of knowledge as a procedure. Why do we document? - To increase the quality of patient care

+ communication

+ authenticates/ provides evidence

+ holds caregiver accountable - studies/ outcomes

- To protect the rights of the patients and caregiver (it's a legal report)

- to help with reimbursement from 3rd party payers. What are important

things to remember when writing in the medical record? accuracy, brevity, clarity, punctuation, correcting errors, signing notes, not referring to

yourself, no blank or empty lines, no writing orders. Top Rules for

Documentation

1. Timeliness

2. Objectivity - avoid opinion

3. Legibility

4. Finished - sign every page of everything

5. Thoroughness - leave no blanks

6. Accuracy

7. Spelling accuracy

8. Approved (standard) abbreviations

9. Errorless - do not obliterate

10. Meaningfulness - use only the facts

11. Courtesy - do not joust

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12. Authenticate - sign only what is yours
  13. Write everything that is pertinent - including phone calls and conversations with caretakers
  14. Follow department policies and procedures
  15. Use proper forms
  16. Follow rules of confidentiality
  17. On electronic documentation identify users
- Top reasons for third party denials of payment
1. Inadequate documentation
  2. Imprecise documentation
  3. Illegible documentation
  4. Good documentation in the wrong place
  5. Bad documentation
  6. Errors in eligibility such as:
    - not medically necessary
    - goals - unreasonable or did not relate to functional needs
    - goals - not achieved in a reasonable time
    - treatment continued too long
  7. Omission of identifying information
  8. Incorrect form submitted
  9. Treatment required pre-approval
  10. Treatment exceeded approved limit of visits
  11. Authorization for specific tx., diagnosis, or body part obtained but treatment to other provided
  12. Non-approved provider
  13. Diagnosis did not match intervention
  14. Billing info did not match intervention

history/ problems

S: subjective

O: objective

A: assesment

P: plan What do you document for S: (subjective)? what the patient or

significant other describes List examples of things you would put under S:-

Prior level of functioning

- Patient history (only what patient says, if from chart can be in hx or O:  
section)

- Lifestyle or home situation/ environment

- Emotions or attitude

- Their goals of therapy

- Complaints

- Response to treatment

- Anything relevant to the case or present condition

- PAIN - USE AN OBJECTIVE TOOL List headings you can use for S:

organization- C/O

- Hx

- Home situation

- Prior level of function

- Do not include irrelevant information just for the sake of writing

something Why is it important to quote verbatim? - To show confusion/  
memory loss

- To illustrate denial

- To relate the patient's attitude toward therapy

- To illustrate abusive language Subjective - interim notes- Optional - write if

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there is something new or meaningful

Examples of what is meaningful:

- response to treatment
- pain scale - if it was a goal or if new pain, what level?
- compliance and possible reasons why not compliant
- level of functioning at home

#### FUNCTIONAL STATUS

If the patient's functional status has not improved since the last assessment, be sure all methods for measuring change have been considered

- Consider using headings when documenting function in O: to clarify
  - DESCRIPTION OF TREATMENT PROVIDED
  - TREATMENT - RESPONSE
  - TREATMENT - FUNCTIONAL DETAILS
  - PATIENT EDUCATION
- What do you list under FUNCTIONAL STATUS?- The function you are talking about (ambulation, transfers, stair climbing, sitting, standing, etc.)
- Description of the quality of movement (even weight bearing, correct body mechanics, speed, even stride, smooth movement, etc.)
  - Level of assistance needed (CGA, SBA, Min, Mod, Max, etc.)
  - Purpose of assist (verbal cues for gait pattern, CGA for balance, SBA to monitor weight bearing status, etc.)
  - Description of equipment needed (ambulation devices, orthotics, supports, rails, wheelchair, sliding board, etc.)
  - Distances, heights, lengths, times, weights (300 ft., 10 minutes, top cabinet standard kitchen cabinet, 20 lbs., etc.)
  - Environmental conditions ( level surface, thick carpeting, dim light, outside,

gravel drive, ramps, low seat, etc.)

- Cognitive status and any complicating factors ( pt. understanding, ability to follow instructions, fainting, blood pressure drops/ rises)What do you list under DESCRIPTION OF TREATMENT PROVIDED?- Identification of the activity, exercise, or modality
- Distance, repetitions, and dosage
- Identification of exact piece of equipment, if applicable
- Settings or programs on equipment
- Target tissue or treatment area
- Purpose of treatment
- Patient positioning
- Duration, frequency, and rest breaks
- Anything the therapist needs to do or be aware of that is outside standard procedure or protocol
- Anything that is unique to the treatment of that particular patientWhat should be included in TREATMENT- RESPONSE?- The treatment description should include or be combined with a description of the patient's response to treatment.

Example:

Decreased muscle spasm was palpable following ice massage, to numbing response (7 min.), L. paraspinal mms., L3-L5, with patient prone over one pillowWhat should be included in TREATMENT - FUNCTIONAL DETAILS? The treatment details can be included to describe function.

Example:

- Following instructions, pt. safely ambulated with axillary crutches NWB on L. from bed to dining room (50 ft.) on tiled level surface with SBA for support

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for loss of balance x2. What should be included in PATIENT EDUCATION?

#### EXTERNAL ACCREDITING BODIES

- readiness to learn
- how do we know they understand?
- KISS principle

#### ANY EDUCATION TO PATIENT/ FAMILY/ CAREGIVERES

#### PHONE CALLS RE: PATIENT

List headings you can use for O: organization. TYPES OF ACTIVITIES:

- Ambulation
  - Transfers
  - Bed mobility
  - Balance
  - Manual interventions (massage, joint mobilization, etc.)
  - Exercise
  - + ROM
  - + Strength
  - + Endurance
  - Posture training
- What are some common mistakes of O: ?- failure to state the affected part
- failure to put things in measurable terms (ex. mid, mod, max)
  - failure to state the type of whatever it is that is being measured or observed (ex. PROM vs. AROM)
- ASSESSMENT or A:- Interpreting the objective portion of the progress note

NOTE: When writing a PROGRESS NOTE this section must always contain statements about the patient's progress toward accomplishing the goals listed in the initial or re-evaluation.

- The assessment section ( or interpretation of the data) is the MOST important section of the progress note. It should inform the reader about the effectiveness of the treatment plan and the progress the patient is making toward goals. Any comment made in this portion of the notes should be supported by information in the subjective and objective information in the note.

- The PTA does not design the treatment goals or the functional outcomes for a patient, but should work with the PT in offering suggestions, notifying the PT when goals are met, and recognizing when goals are met or need to be modified or changed. The PTA should know the goals and refer to them when writing the assessment portion of the progress note.

- The PTA should comment on patient progress through statement about improvement of functional abilities and in progress or achievement of goals. Lack of progress and a statement about possible reasons why are included in this section. Need to consult the PT can also be stated here, which will demonstrate the integrity of the team.

- Be careful about documentng inconsistencies in this section because it may appear as if you are accusing the patient of lying. This should be clear in the S: and O: sections.



What should be included in a DAILY NOTE?- In a daily treatment note the PTA should always document the patient's response to treatment.

- Use objective measures/ observations
- 'Tolerated well' is not a measurable statement. What are some common mistakes when documenting in the A: section?- Comments such as "tolerated treatment well" or "cooperated and motivated."
- Comments not previously mentioned in the S: or O: section (exception - comments on goals stated previously in the PT eval.)
- Progress notes that do not mention the goals or whether patient is progressing or meeting them. Comments only about data that measure the impairment level and about treatment procedures.
- Writing in a manner that is not organized and easy to read  
What MUST you include in the P: (Plan) section? The following MUST be in PLAN:
  - Frequency (per day or week)
  - Treatment to be received
  - If discharge or summary note include the # of times seen in therapy and where they are going

What are some frequently included items under P:?- The location of treatment (pool, bedside, gym)

- Treatment progression (car transfers in am)
- Plan for further assessment
- Plan for discharge
- Patient and family education (attach a signed and dated copy)
- Equipment needs and what was ordered
- Referral or plans to consult physician about need for further referral

are some things to consider when writing in P: (PLAN)?- Ambulation

- Exercise

- Home program What kinds of things would you write under AMBULATION in

the P: section? - Distance

- Level of assist

- Devices

- Time

- Weight bearing status

- Type pattern

- Type environment

- Stairs, steps, curbs What kinds of things would you write under EXERCISE

in the P: section? - To what?

- Types

- Repetitions

- Amount of resist

- Positions

- Equipment

- Modifications What kinds of things would you write under HOME PROGRAM

in the P: section? - Illustrations

- Position

- Directions - keep directions simple and in lay terms

- Progression

- Equipment

- Precautions Documentation by the PTA - Initial evaluation - PT must do - used

by PTA to understand problems, abilities, goals, and treatment plan

- Progress note - addresses progress towards goals

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- Can be written by PTA, but if re-evaluation goals change, the PT must write
- Daily notes - update on status - PTA's and PT's write
- Discharge summary vs. Evaluation with recommendations