

Best Practices in Clinical Record Keeping: SOAP Notes

Introduction

In 1968, Lawrence Weed, MD, developed the problem-oriented medical record (POMR) "... to develop a more organized approach to the medical record..."* Although only a component of the POMR, the SOAP format has become the standard in clinical record keeping for daily chart notes in ambulatory settings.

Proper record keeping using the SOAP method improves member care and enhances communication between the provider and other parties: claims personnel, peer reviewers, case managers, attorneys, and other physicians or providers who may be involved in the care of your members.

Heraya does not require, but strongly encourages the use of the SOAP format. If SOAP itself is not used, the elements embodied in SOAP must be recorded.

The Basics

Chart notes must be legible, in legible handwriting or, preferably, typed. The provider's identification (name, address and phone) and member's name and unique identifier such as date of birth (DOB) or record number must be indicated on each side of every page. Every chart entry must be dated and signed by the person entering the note (this includes office personnel who make entries in the chart). Standard abbreviations are acceptable as long as they are easily understandable and interpretable by others (see articles on the Heraya website).

There are many styles of chart notes that can describe the critical elements of a properly documented member encounter, however narrative notes in SOAP format are the standard. Check-box formats, pre-printed forms, travel cards, computer-generated notes, bar code SOAP notes, and other automated systems can improve efficiency, but they can also produce notes that are clearly "canned," containing little clinical content and unfortunately substitutes for proper documentation of the clinical thought process.

Effective chart notes must reflect the four criteria required to document medical necessity.

1. The member's chart must reflect subjective complaints that are consistent with a lesion, injury, or condition.

* Weed L. Medical records that guide and teach. NEJM Vol. 278, No. 11 & 12. 1968.

2. The examination must confirm the existence of a lesion, injury, or condition that is consistent with the member's complaints and the exam findings must be documented in the chart.
3. The management of the case or treatment rendered must be considered appropriate for the condition.
4. The member chart should reflect overall improvement with time both subjectively and by clinical examination findings.

The Anatomy of "SOAP"

S = *Subjective or symptoms and reflects the history and interval history of the condition.* The member's presenting complaints should be described in some detail in the notes of each office visit. Using the member's own words is best. Routine use of one-word entries or short phrases such as "better", "same", "worse", "headache", "back pain" is not sufficient. In follow-up notes, "S" is an update of the chief complaints elicited during the initial evaluation of the member. The complaints should reflect change over time, e.g. duration, intensity and frequency of pain as well as responses to the previous treatment, resumption of daily or occupational activities, intervening injuries, and exacerbations. "S" should also describe any changes in the member's activities and physical capacities in the interim between treatments. Also included in this section are explanations for any hiatus in treatment and the member's compliance with recommended home care instructions.

The requirement of the treating physician to measure and record clinically meaningful functional capacity improvement has led to the development and use of O.A.T.S., an acronym for (O) Outcome (A) Assessment (T) Tools. This would include items like the Neck Disability Index, Oswestry, DASH, Pain Disability Questionnaire, etc. and should be recorded in this section also.

O = *Objective or observations.* This section includes inspection (e.g., "member still walks with antalgic gait") as well as more formalized reevaluations such as ranges of motion, provocative tests, and specialized tests. The extent of the reevaluation at each office visit is determined by the information gathered in "S" together with the original positive clinical findings as well as changes in "O" from previous office visits. Findings should be qualified and quantified in order to be able to ascertain progress/response to care over time. Indicators for treatment should always be included in order to document necessity of the treatment provided and described in the "Plan" section of the note, for example motion palpation findings, stagnation of blood and chi, or abnormal lab values.

A = *Assessment.* Initially this is the diagnostic impression or working diagnosis and is based on the "S" and "O" components of SOAP. On follow-up visits the "A" should reflect changes in "S" and "O" as a response to time, treatment, and other interim events (e.g., "Cervical strain, resolving" or "exacerbation of right sacroiliac pain"). "A" should be continually updated to be an accurate portrayal of the member's present condition. Other components of "A" may include

the following where appropriate: member risk factors or other health concerns; review of medications, laboratory or procedure results, and outside consultation reports.

P = Plan or Procedure. The initial plan for treatment should be stated in “P” section of the member’s first visit. A complete treatment plan includes treatment frequency, duration, procedures, expected outcomes and goals of treatment. An initial treatment plan may be for an initial trial of treatment over a short interval with a re-assessment and further treatment planning at that later time.

On each follow-up visit, “P” should indicate specific areas of treatment, e.g. C5 right rotation fixation/hypomobility, modalities (including specifics of type, duration/stop-start times, intensity) any procedures performed that day, and continuation or changes in the overall treatment plan. “P” should also describe what the member is to do between office visits, e.g. exercises, diet/nutrition/medication, what the expected course of treatment is, what further tests or consultations/referrals might be ordered (e.g., “Obtain cervical MRI or consultation with neurologist if upper extremity paresthesia persists”), and the disposition of the case (discharge, referral, etc.). It is also appropriate to include in this section any comments with respect to the member’s compliance.

Other items or events to be charted include:

- Any phone or personal contact with the member.
- Failed appointments, rescheduled appointments, or when the member is significantly late for an appointment.
- The receipt of important correspondence regarding the case.
- Requests for medical records sent or received.
- Transmittal of records, correspondence, etc.
- X-rays and other imaging studies, lab work, consultation reports.

Amending the Clinical Record

The patient record should never be backdated, erased, deleted or altered in any way. In the case of electronic patient records, corrections or amendments should be made using an addendum that is signed or initialed and dated. If corrections need to be made or addendums added to a written record, a line should be drawn through the original entry, the correction made or the addendum inserted, and the change initialed and dated. In both cases, the original record should be preserved.