Chapter 1- Introduction

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Writing a S.O.A.P. Note

Writing a S.O.A.P. Note

Progress notes are the chronological record of the patient's presentation, treatment, and response to care, as well as a record of any telephone conversations with patients and notations on missed appointments. The system utilized to record patient progress/office visits involves notations pertaining to current subjective data, objective data, assessment, and procedures done on that day and plans for further management (SOAP).

Always keep in mind that the patient chart is a legal document, therefore you should start your note right after the last note in the chart so it will be chronological. Cross out extra space at the bottom of a page. Also, records must be written in blue or black ink.

While writing your note, do not leave blank lines in between text. This will prevent someone else from writing something in the blank space. Similarly, if you make a mistake, simply cross out the word with a single horizontal line, and initial it. Do not scribble out a mistake. Anyone auditing the records must be able to see your mistakes and know that you personally crossed the word or sentence out and what was being crossed out.

There should not be communication to students in the progress notes, in regards to "business affairs". This should be located on a separate paper kept in the file reserved for clinician intern communication. Notes to interns regarding patient treatment can and should be written in the progress notes, in the "P" section.

Complete sentences are not necessary and abbreviations are frequently appropriate. If non standard medical abbreviations are utilized, a key should be included.

Initial S.O.A.P.

A patient new to the facility:

SOA will be part of the comprehensive exam form, and can be documented as such on Progress notes.

12/18/2006	S: See compre. exam form O: See compre. exam form A: See compre.exam form – the patient responded well to the tx, pt noted decreased px and demonstrated increased ROM in C-Spine. P: HMP C/T spine 10 mins, STM post c-spine musculature B, CMT-D C-spine. Pt will return on 12/20/06.

Although **P** is on the comprehensive exam form the **P** (management plan) could differ from what was done, **P** (procedures), on initial visit. Also, the **A** on the progress note should state the patient's response to treatment. See example above. Report of findings given, Informed Consent performed.

For a patient not new to the clinic, but not seen in 6 months, or for an established patient with a new chief complaint. The examination or re-examination notes should be written within the progress notes, using the S.O.A.P. format.

Components of the Initial S.O.A.P. note:

The following must always be included for a new chief complaint, whenever possible answers to questions should be quoted in patient's own words.

An additional source for SOAP and history acronyms:

http://medinfo.ufl.edu/year1/bcs96/clist/history.html

Subjective – the following will guide you in the taking of a pain history for a new patient/complaint:

Location- Where the patient describes the complaint is, and where the patient points to the complaint (and what the patients utilizes such as broad hand contact, etc)

Mechanism of Injury – How the symptoms started – if the patient denies trauma, (s)he should be questioned as to new activities and repetitive activities (work and home).

Onset – Date of injury (not "last Wednesday") should be recorded as day/ month/year – If the patient cannot give a specific then "insidious onset" should be recorded with an approximate time of initiation of symptoms such as days, weeks, months, years, ago.

Palliative/Provocative - What makes it better (palliative)? What makes it worse (provocative)? May have to prompt the patient e.g. ice? Heat? Hot shower? Bending? Sleeping? Looking over shoulder to back up? Make sure to take note as to things that did not work.

Quality – Patient's description of pain "ache" "toothache" "crampy" "ouchy" "nagging" etc.

Radiation or referral– Radiating, if not "patient denies radiation or referral of symptoms" or "symptoms remain local"

Severity – severity of sx's "0-4" scale "0-10" scale – Pain diagram – Visual Analogue Scale

Temporal factors – Is chief complaint worse in the morning or evening? Is it constant or intermittent? Worse before or after specific activities? Getting worse since onset? Associated with mealtimes (before)? Worse seasonally? Associated with menstrual cycle?

Unrelated symptoms – Associated symptoms e.g. Headaches any other "unrelated" symptoms.

Various other health care providers– Seen any other healthcare providers for this condition, tried any other therapies, medications, chiro care before? Results? Happened before? First time or (re)exacerbation?

Progression of symptoms: Is the condition getting worse, better, or remain the same. If better or worse, describe.

Has the patient ever had the same or similar condition? Obtain past history of same or similar conditions. Note if this is an acute exacerbation, chronic recurrent condition, etc.

– if a MVA or Work Comp Case detailed information should be attained regarding the accident i.e. time of day it happened, where it happened, seatbelt being used, weight object being lifted, was it reported (to supervisor or police), etc. If the complaint is of a visceral nature, then you will need to follow-up with appropriate questions outside the outline given above.

Objective:

Findings from Doctor/Intern's exam to include:

- Findings from physical exam procedures
- Neurological tests
- Orthopedic tests
- Inspection – of area of chief complaint, posture, gait, habitus, etc.
- Palpation – of soft tissues, subluxation/intersegmental dysfunction findings
- Imaging studies.
- *Outcomes assessments scores? (for this some say Subjective others say objective data)*

Assessment:

- The current Diagnosis; the conclusion as to what the patient's condition is, as gleaned from reviewing both subjective and objective data. The patient's response to treatment (current day and overall) can be stated here as well. In regards to diagnosis a change in severity or stage should also be noted here e.g. a change from acute sprain/strain to sub-acute sprain/strain.
- Prognosis, Impediments to recovery? ADL limitations/Changes. Short and long term clinical/patient goals.

  *Medicare requires the primary diagnosis be the intersegmental dysfunction/subluxation diagnosis code (739.X) followed by a secondary code from a list of diagnoses approved by Medicare for chiropractors to treat.

Plan(Management)/Procedures:

Management plan to include:

What is going to be done for the patient; management plan to include:

- Visit frequency and duration of care
- Frequency and parameters of any re-evaluations to evaluate effectiveness of care
- Specifics of the plan of care to include: What is going to be done, modalities, types of STM, type(s) of CMT, stretches, exercises, home care, modifications to ADLs, referrals, nutritional advice, lifestyle modifications, etc. Also a timeline for implementation of the aforementioned should be included if not started all at once.

Procedures to include:

- What was done for the patient at the current visit:
  - Report of findings given and Informed Consent performed.
  - Modalities - time, settings, and body part applied to
  - STM – where? Specific type?
  - Type of CMT, Flexion Distraction, Diversified, Drop Table, Activator, etc.
  - Home instructions – ice/heat when how long where? Stretches/ strengthening exercises – sets, repetitions, perform after ADL's? Perform when in pain?
  - Alteration of ADL's?
  - Referrals?
  - Next return visit, specific date, # of weeks, or p.r.n..

Components of the Follow-Up S.O.A.P. note:

Subjective:

Response to last treatment? Changes in symptoms? New symptoms? Pain scale? Changes in ADL performance? System review, if relevant. Anything else the patient may say pertaining to his/her condition – other therapies tried, other practitioners seen.

Objective:

Findings from physical exam procedures, neurological tests, orthopedic tests, inspection to include posture, gait, etc. and palpation. Imaging studies. Scores from retest on Outcomes assessment or results of parameters specified in the original Plan.

Assessment:

The current diagnosis; the conclusion as to what the patient's condition is, gleaned from reviewing both subjective and objective data. Can also state patient's response to treatment (current and past). Impediments to recovery to include compliance, prognosis, ADL limitations/changes. Changes in short and long term patient/clinical goals.

Procedures/management plan:

What was done for/to the patient:

- Modalities - time, settings, and body part applied to
  If new complaint with an established patient, report of findings given, and Informed Consent performed as needed (new dx, modality)
- Soft tissue massage – where? Specific type?
- Type of Chiropractic manipulative therapy – flexion/distraction, diversified, drop, Activator, etc.
- Home instructions – Use of ice or heat and when? How long? Where? Stretches/ strengthening exercises – sets, repetitions, times per day, perform before or after activities of daily living? Perform when in pain?
- Alteration of activities of daily living?

- Changes in treatment plan? Therapies/ modalities/ Chiropractic manipulative therapy techniques/ referrals?
- Next return visit specific date, number of weeks, or p.r.n.

Documenting Medical Necessity for Medicare The P.A.R.T Documentation System

*It is important to clarify in this section that we are using language to remain consistent with current Medicare documents only

*See NYCC protocols for subluxation algorithm
Medicare requires that subluxation be documented either by x-ray or physical examination. If done by physical examination, Medicare requires the use of the P.A.R.T. documentation system, which would be included in the **O**bjective findings section of the **S.O.A.P**. note. Medicare requires that at least 2 of the 4 components be documented and that at least one component of A or R is documented.

Medicare also has specific guidelines for documentation of the initial exam and follow-up visits for subjective information that is covered in the above guidelines for subjective information. It should be stated that Medicare does require that the record should document symptoms that bear a direct relationship to the level of subluxation. The symptoms should refer to the spine, muscle, bone, rib and joint and should be reported as pain, inflammation, or as signs such as swelling, spasticity, etc. Medicare also requires that family and past health history, including general health, prior illness, injuries, hospitalizations, medication, and surgical history be elicited from the patient and documented on initial examination.

The Components of P.A.R.T.

P - PAIN AND TENDERNESS
Identify using one or more of the following:

- Observation: You can document, by personal observation, the pain that the patient exhibits during the course of the examination. Note the location, quality, and severity of the pain.
- Percussion, Palpation, or Provocation: When examining the patient, ask them if pain is reproduced, such as, "Let me know if any of this causes discomfort."
- Visual Analog Type Scale: The patient is asked to grade the pain on a visual analog type scale from 0 -10.
- Pain questionnaires: Patient questionnaires, such as the McGill pain questionnaire or an in-office patient history form, can be used for the patient to describe their pain.

A - ASYMMETRY/MISALIGNMENT
Identify on a sectional or segmental level by using one or more of the following:

- Observation: You can observe patient posture or analyze gait.
- Static and Dynamic Palpation: Describe the spinal misaligned vertebrae and symmetry.
- Diagnostic Imaging: You can use x-ray, CAT scan and MRI to identify misalignments.

R - RANGE OF MOTION ABNORMALITY

Identify an increase or decrease in segmental mobility using one or more of the following:

- Observation: You can observe an increase or decrease in the patient's range of motion.
- Motion Palpation: You can record your palpation findings, including listing(s). Be sure to record the various areas that are involved and related to the regions manipulated.
- Stress Diagnostic Imaging: You can x-ray the patient using bending views.
- Range of Motion Measuring Devices: Devices such as goniometers or inclinometers can be used to record specific measurements.

T - TISSUE, TONE CHANGES

Identify using one or more of the following:

- Observation: Visible changes such as signs of spasm, inflammation, swelling, rigidity, etc.
- Palpation: Palpated changes in the tissue, such as hypertonicity, hypotonicity, spasm, inflammation, tautness, rigidity, flaccidity, etc. can be found on palpation.
- Use of instrumentation: Document the instrument used and findings.
- Tests for Length and Strength: Document leg length, scoliosis contracture, and strength of muscles that relate.

References:

American Chiropractic Association Commentary on Centers of Medicare and Medicaid Services (CMS)/PART Clinical Documentation Guidelines - www.acatoday.com/pdf/**part**_process.pdf accessed on 12/19/2006 at 6:30PM.

ACA Clinical Documentation Committee. (2005). ACA Clinical Documentation Manual, American Chiropractic Foundation: Author.