SOAP Notes

SUBJECTIVE

Ask yourself: What is the pertinent information that the patient states that potentially could affect OT intervention?

- Patient has questions about the plan, treatment or outcomes
- Reflections of progress or current problems
- Current day's symptoms or complaints
- Direct quotes made by the patient

Example: *The patient states that she has not been able to use her wheelchair around her home due to her "hands hurting" and "I am not able to get a good grip."*

OBJECTIVE

Ask yourself: What did you do to make the treatment session skilled and not just what the patient did in the session. Don't just exclusively list out the completed activities and interventions that were done during the session unless it is directly related to the patient's end goal.

Example of What Not to Write: The patient completed Jenga game in standing with CGA.

- Address how the intervention is working toward their goals
- Where there any new interventions introduced?
- Objective measures and observations
- How you graded the activity
- Specific treatments instructed using skilled terminology - exercises, addressing body functions, purposeful activities, occupation based
- Quantifiable information compares findings to the initial evaluation or previous sessions

Example: *The OT assessed the wheelchair and modified it by building up the rims with self adherent tape. Instructed in propelling wheelchair over carpet and thresholds of the home. The patient demonstrated ability to self propel 100' with min VC while reporting 0/10 hand pain after adaptation.*

ASSESSMENT

Ask yourself: What is the patient's current condition/level (today) and how does it affect the achievement of their goals? Am I on track with the goals, do I need to modify them or change direction of my treatment interventions?

- Is the patient making progress? Why or why not
  - What can we do about limited progress?
    - try a new intervention?
    - discuss with MD/family/healthcare team?
    - cognitive factors? etc.
- What are the patient's barriers to progress and how can they be addressed?
- Social emotional impacts - motivation, participation, effort, etc.
- Carryover of instruction by patient/staff/care partners

Example: *After adaptation and instruction, patient improved in self propulsion and increased independence in functional mobility within her home environment. She is motivated to return to being independent in her home and is very receptive to instruction.*

PLAN

Ask Yourself: Why does this patient need continued skilled occupational therapy treatment and are there any changes that need to be made to the plan of care?

- Be specific on modifications to treatment plan or direction of treatment plan
- Notifications, communications or referrals made to RN/MD/PT/SLP, etc that need to be addressed
- Recommendations/plan for changes of frequency, duration, etc and why
- Future trials including equipment, strategies, etc. that you would like to address

Example: *Patient would benefit from continued skilled OT intervention to educate the pt on utilizing wheelchair down the ramp to access her living area. Will acquire ultra grip built up rim covers for trial at next visit to see if that is a better long term solution vs the tape.*