Introduction to Documentation and Notetaking: The SOAP Note

There are various ways of keeping notes and tracking information on your clients and students. Documentation is an important aspect of professionalism and is necessary for consultation with other healthcare practitioners. This is especially true in the case of identifying red flags in clients and referring them to others for care beyond our scope of practice. Along with the type of note taking introduced below you may as well wish to keep a running narrative of each session, and/or a journal of your own thinking about your decision-making process, or engage in other methods of developing your process as you refine your work. For the purpose of integrating with western medical practice, SOAP Notes are a healthcare industry standard, and so it is important for you to be able to use them - even if they do not become your main note-taking method down the road.

"SOAP" in SOAP note is an acronym for a widely used method of documentation for healthcare providers with the letters standing for: Subjective, Objective, Assessment and Plan. A SOAP note provides a helpful framework for clinical reasoning based on the information provided to and gathered by you. It provides you with a standardized order in which to document information and a way of quickly and succinctly sharing this information with another, like someone to whom you may refer.

In medical practice, SOAP notes are used for admission notes, medical histories at shift changes, and in other ways. Many hospitals use electronic medical records, which often have templates that plug information into a SOAP note format. Most healthcare clinicians including nurses, physical and occupational therapists and physicians use SOAP notes.

SUBJECTIVE

The first section consists of what the client verbally says is their concern or concerns. (This could be expressed by a client's associate as well, like a family member.) They describe, from their own experience, features of the complaint and related issues. Below are some helpful guides for gathering relevant information.

<u>Typical Information Gathered Under Subjective</u>

1. Record the client's sex, age and primary concern or chief complaint (CC), along with additional concerns if expressed. This is the client's own description or subjective experience (how I remember this is that they are the "subject".) They may have multiple complaints and sometimes the first one is not the most significant, so get them all down.
2. This is written as the *History of Present Illness (HPI)* which is a straight forward one-line statement including the patient's age, sex and reason for the session with you.

   For Example: 47-year old female presenting with abdominal pain.

Next have your client elaborate on their chief complaint. Their description of their experience of it, in this context is called a **symptom.** An acronym often used for organizing these details is "OLDCARTS":

- Onset: When did the CC begin?
- Location: Where is the CC located?
- Duration: How long has the CC been going on for?
- Characterization: How does the patient describe the CC? (sharp or dull pain, etc.)
- Alleviating and Aggravating factors: What makes the CC better? Worse?
- Radiation: Does the CC move or stay in one location?
- Temporal pattern: Is the CC worse (or better) at certain times of the day?
- Severity: Using a scale of 1 to 10, 1 being the least, 10 being the worst, how does the patient rate the CC? This is instead sometimes "Symptoms Associated", like sweating, brusing, etc.

3. Check your Intake Form regarding historical information about:
   - Pertinent medical conditions and surgeries with dates
   - Pertinent family history
   - Pertinent s history such as employment, drug and alcohol use, etc.
   - Current medications (name, dose, route, how often) and/or herbal or other supplements.

OBJECTIVE

The objective component in a medical setting will include vital signs like pulse, temperature, and blood pressure, as well as lab diagnostic results like x-rays, MRIs and lab reports. Measurements like height and weight are taken, and any other examination facts like swelling or skin color (paleness, rashes, bruising) that can be objectively observed. This could also include review of information shared from other healthcare providers.

This is an area that we, as yoga therapists, can include our observations of the physical and energetic domains. Questionnaires and scales on which a client can record their answers, such as from a *dosha* quiz can also be included here. If you set up an area of increase such as range of motion testing, strength (how long one can hold a position such as chair pose), repetitions, or the like, you can record starting point and later results here as well. This of this as the place for signs that can be measured. A **sign,** as distinguished from a symptom, is any objective evidence of disease or state of imbalance. (A **symptom** is a phenomenon experienced by the affected individual, while a **sign** is a phenomenon detected by someone other than that individual.)

We also note physical observations like swelling or bruising. At times, clients arrive with medical reports so this information is recorded here as well.

ASSESSMENT

This section records our synthesis of the subjective and objective evidence given above allowing us to arrive at an analysis of the things in play that are contributing to and creating in whole, or in part, the presenting problem or problems.

In some instances, there may be one clear thing. At other times, a client may have several concerns. There are times where a definitive recognition of the problem's features or source(s) cannot as yet be made. When more than one factor is in play, these should all be included in the process of assessment.

In the western medical system, the assessment is the diagnosis of the patient's condition. It is arrived at through a process of supposition and elimination based on the knowledge base of this system. This process seeks to yield a name as a cause of the chief complaint. These are listed in order of importance from most likely to least likely each having its own thought process. Consideration of harm to the patient is also made. (Think *House*. ☺) In western medicine, this process if called **differential diagnosis**. It is the distinguishing of a particular disease or condition from others that present similar clinical features. It results in a list of possibilities: conditions or diseases that could be causing the symptoms. After developing a differential diagnosis, a physician may then ask for additional tests to rule out specific conditions or diseases in order to arrive at a final diagnosis. There may be other complaints as well for which this process may be repeated.

For the practice of yoga therapy, we identify causative factors and recognize imbalances derived from *our own knowledge base*. We discover or detect and identify determining factors of imbalances in our clients in relation to the manifest concern or presenting condition.

Using the Interactive Assessment Guide for SYMT we can discern which activities would be useful to the client's chief complaint or complaints and assess accordingly. In terms of ruling out, by consulting our red flags resources we can ascertain whether or not the client should be referred to their primary care provider (PCP) prior to working with us or at the same time as working with us. Remember the maxim, "when in doubt, refer out!" ☺

PLAN

Like the name implies, this is what you plan to do to help the client with their condition(s) and/or concern(s). In western medicine this may include:

- laboratory and/or radiological tests to resolve any diagnostic ambiguities (and ideally next steps if positive or negative.)
- medications ordered
- treatments performed (ex. minor surgery)
- patient referrals
- patient disposition (home care, bed rest, days excused from work, admission to hospital

- patient directions (ex. elevate foot, apply ice)
- follow-up directions (see us in 2 weeks).

In our work as yoga therapists, we will devise a plan based in one or more of our *koshically*-oriented Assessment Domains. In SYMT, our nine domains are: Skeletal Alignment, Somatic Dynamism, Autonomic Activation and Balance, Energetic, Outward Facing Mental-Emotional, Inward Facing Mental-Emotional, Intuitive, Openness to Ananda, Interwoven.

Our plan may and often does include a combination of practices spread across these domains. But it may also focus on only one. Or a plan may include several domains, but implementation of it may need to take place across many sessions as the client is able accept, understand, to take on, and find benefit from the tailor-made protocol designed by the therapist for that individual. And of course, the process is ongoing, as each plan can and most like will be adjusted and perhaps even re-envisioned over time.