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Learning to Write Case Notes Using the SOAP Format

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This article discusses how to use the SOAP (subjective, objective, assessment, and plan) note format to provide clear and concise documentation of the client's continuum of care. Not only does this format allow for thorough documentation, but it also assists the counselor in representing client concerns in a holistic framework, thus permitting practitioners, paraprofessionals, and case managers to better understand the concerns and needs of the client. Whereas counselors working in certain settings (e.g., public funded institutions) are likely to find various recommendations in the article easy to incorporate into their current practice, the authors believe the recommendations are relevant to a wide array of settings.

In every mental health treatment facility across the country, counselors are required to accurately document what has transpired during the therapeutic hour. Over the course of the past few years, the importance of documentation has gained more emphasis as third-party payers have changed the use of documentation "from something that *should* be done well to something that *must* be done well" (Kettenbach, 1995, p. iii). In this era of accountability, counselors are expected to be both systematic in providing client services (Norris, 1995) and able to produce clear and comprehensive documentation of those clinical services rendered (Scalise, 2000). However, in my experience (i.e., first author), both as director of a mental health clinic and as one who audits client records, few counselors are able to write clear or concise clinical case notes, and most complain of feeling frustrated when trying to distinguish what is and is not important enough to be incorporated in these notes. Well-written case notes provide accountability, corroborate the delivery of appropriate services, support clinical decisions (Mitchell, 1991; Scalise, 2000), and, like any other skill, require practice to master. This article discusses how to accurately document rendered services and how to support clinical treatment decisions.

When counselors begin their work with the client, they need to ask themselves, What are the mental health needs of this client and how can they best be met? To answer this question, the counselor needs an organized method of planning, giving, evaluating, and recording rendered client services. A viable method of record keeping is SOAP noting (Griffith & Ignatavicius, 1986; Kettenbach, 1995). SOAP is an acronym for subjective (S), objective (O), assessment (A), and plan (P), with each initial letter representing one of the sections of the client case notes.

SOAP notes are part of the problem-oriented medical records (POMR) approach most commonly used by physi-

cians and other health care professionals. Developed by Weed (1964), SOAP notes are intended to improve the quality and continuity of client services by enhancing communication among the health care professionals (Kettenbach, 1995) and by assisting them in better recalling the details of each client's case (Ryback, 1974; Weed, 1971). This model enables counselors to identify, prioritize, and track client problems so that they can be attended to in a timely and systematic manner. But more important, it provides an ongoing assessment of both the client's progress and the treatment interventions. Although there are alternative case note models, such as data, assessment, and plan (DAP), individual educational programs (IEP), functional outcomes reporting (FOR), and narrative notes, all are variations of the original SOAP note format (Kettenbach, 1995).

To understand the nature of SOAP notes, it is essential to comprehend where and how they are used within the POMR format. POMRs consist of four components: database, problem list, initial plans, and SOAP notes (Weed, 1964). In many mental health facilities, the components of the POMR are respectively referred to as clinical assessment, problem list, treatment plan, and progress notes (Shaw, 1997; Siegal & Fischer, 1981). The *first* component, the clinical assessment, contains information gathered during the intake interview(s). This generally includes the reason the client is seeking treatment; secondary complaints; the client's personal, family, and social histories; psychological test results, if any; and diagnosis and recommendations for treatment (Piazza & Baruth, 1990). According to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO, 2000), with special populations, as in the case of a child, the clinical assessment contains a developmental history; for individuals who present with a history of substance abuse, a drug and alcohol evaluation is included.

From the clinical assessments, a problem list (*second* component) is generated, which includes an index of all the problems, active or inactive, derived from the client's history. Problems

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are defined as either major areas of concern for the client that are not within the usual parameters when compared with others from the client's same age group or as areas of client concern that can be changed through therapeutic intervention (JCAHO, 2000). As problems are identified, they are numbered, dated, and entered on the list, and this problem list is attached to the inside cover of the client's file, for easy reference. As the identified problems are resolved, they are dated and made "inactive."

The *third* component of the POMR is the treatment plan, which is a statement of the possible therapeutic strategies and interventions to be used in dealing with each noted problem. Treatment plans are stated as goals and objectives and are written in behavioral terms in order to track the client's therapeutic progress, or lack thereof (Kettenbach, 1995). The priority of each objective is expressed either as a long or a short-term goal and corresponds to the problems list. Long-term goals are the expected final results of counseling, whereas short-term goals are those that can be accomplished within the next session or within a very limited time frame.

The *fourth* component is the progress notes, which are generally written using the SOAP format and serve to bridge the gap between the onset of counseling services and the final session. Using the SOAP format, the counselor is able to clearly document and thus support, through the subjective and objective sections, his or her decision to modify existing treatment goals or to fine-tune the client's treatment plan. For example, if a client who has been in counseling for 4 months experiences the unexpected death of a loved one or is diagnosed with a potentially life threatening health problem, by recording this information in the progress notes the counselor provides justification/documentation for the sudden shift in therapeutic direction and is immediately able to address what is now the more pressing issue for the client.

The SOAP note format also provides a problem-solving structure for the counselor. Because SOAP notes require adequate documentation to verify treatment choices, they serve to organize the counselor's thinking about the client and to aid in the planning of quality client care. For example, if the plan is to refer the client to a domestic violence group for perpetrators, the subjective and objective sections of the SOAP notes would chronicle the client's history of physical aggression and violent behaviors, thus supporting the treatment direction. Although the SOAP format will not assure good problem-solving skills, it does provide a useful framework within which good problem solving is more likely to occur (Griffith & Ignatavicius, 1986). Thus, the intent of SOAP notes is multifaceted: to improve the quality and continuity of client services, to enhance communication among mental health professionals, to facilitate the counselor in recalling the details of each client's case, and to generate an ongoing assessment of both the client's progress and treatment successes (Kettenbach, 1995; Weed, 1968).

USING THE SOAP NOTE FORMAT

There are four components to SOAP notes. Data collection is divided into two parts: (S) subjective and (O) objective.

The subjective component contains information about the problem from the client's perspective and that of significant others, whereas the objective information consists of those observations made by the counselor. The assessment section demonstrates how the subjective and the objective data are being formulated, interpreted, and reflected upon, and the plan section summarizes the treatment direction. What follows is a description of the content for each section of the SOAP notes, a brief clinical scenario with an example of how this approach might be written, and a short list of "rules" to remember when writing case notes.

Subjective

The data-gathering section of the SOAP format is probably the most troublesome to write because it is sometimes difficult to determine what constitutes subjective and objective content. The subjective portion of the SOAP notes contains information told to the counselor. In this section the client's feelings, concerns, plans or goals, and thoughts, plus the intensity of the problem(s) and its impact on significant relationships in the client's life are recorded. Pertinent comments supplied by family members, friends, probation officers, and so forth can also be included in this section. Without losing accuracy, the entry should be as brief and concise as possible; the client's perceptions of the problem(s) should be immediately clear to an outside reader.

It is our opinion that client quotations should be kept to a minimum. First, when quotations are overused they make the record more difficult to review for client themes and to track the effectiveness of therapeutic interventions. Second, when reviewed by outside readers such as peer review panels, audit committees, or by a client's attorney, the accuracy and integrity of the notes might be called into question. According to Hart, Berndt, and Caramazza (1985), the number of *verbatim* bits of information an individual is able to retain is quite small, 2 to 20 bits, with most estimates at the lower end. Other research suggests that information retained in short-term memory is only briefly held, 30 seconds to a few minutes at best, unless a very conscious effort is made to retain it (see Anderson & Bowers, 1973; Bechtel & Abrahamsen, 1990). This means that at the close of an hour-long counseling session, unless a quote is taken directly from an audio- or videotaped session, it is very unlikely that someone could accurately remember much information verbatim. In short, given this research, it seems a prudent practice to keep the use of quotations to a minimum.

If and when quotations are used, the counselor should record only key words or a very brief phrase. This might include client words indicating suicidal or homicidal ideation, a major shift in the client's well-being, nonconforming behaviors, or statements suggesting a compromise in the type and quality of care the client will receive, such as when a client is unwilling or fails to provide necessary information. Quotations might also be used to document inappropriately aggressive or abusive language toward the counselor that seems threatening. Comments suggesting a potentially lethal level of "denial"

should be documented. For instance, a father accused of shaking his 6-month-old daughter when she would not stop crying says, "I only scared her when I shook her, I didn't hurt her." Because the child's life might be in jeopardy should the father repeat his behavior, his comments need to be recorded. For example, the counselor might write: "Minimizes the effects of shaking infant daughter. States, 'I only scared her.'"

It is also important to document statements that suggest the client may be confused as to time, place, or person, or if he or she is experiencing a sudden change in mental status stability or level of functioning. For example, if during the session the client suddenly seems disoriented and unable to track the conversation, this information needs to be noted. To assess the client's mental status, the counselor might ask the client the name of the current U.S. president. If the client responds incorrectly, this discrepancy should be noted in quotations within the client file.

Finally, a client's negative or positive change in attitude toward counseling should be chronicled because it serves as a marker in the assessment of counseling effectiveness. A statement such as "Therapy is really helping me put my life into perspective" could be written as "Reports 'therapy is really helping.'" This information is especially important if the client was initially resistant to therapy. The goal is not to give a verbatim account of what the client says, but rather to reflect current areas of client concern and to support or validate the counselor's interpretations and interventions in the assessment and plan sections of the SOAP notes.

Given the open nature of client files to other health care professionals and paraprofessionals (e.g., certain managed care personnel), the counselor should be mindful of the type of client and family information included in the client's record. Unless insidious family life and political, religious, and racial views are the focus of the problem(s), secondary details of such views should be omitted (Eggland, 1988; Philpott, 1986). The counselor should not repeat inflammatory statements critical of other health care professionals or the quality of services provided because these comments may compromise the client's care by antagonizing the staff or might be interpreted as malicious or damaging to the reputation of another. Rather than using the names of specific people when recording the session, the counselor might use general words such as a "fellow employee" or "mental health worker," and briefly and concisely report the themes of the client's complaint(s). In addition, the names of others in the life of the client are typically unnecessary to record. It is important to remember that the names the client mentions during counseling (with few exceptions) are not a legitimate part of the client's care and, as such, should be omitted from the client's file.

The content in the subjective section belongs to the client, unless otherwise noted. For brevity's sake, the counselor should simply write, "reports, states, says, describes, indicates, complains of," and so on, in place of "The client says." For instance, instead of writing, "Today the client says 'I am experiencing much more trouble at home—in my marriage—much more marital trouble since the time before our last

session,'" the counselor might write "client reports increased marital problems since last session." Also, because it is implied that the counselor is the writer of the entry, it is not necessary for the counselor to refer to himself or herself, unless it is necessary to avoid confusion.

Objective

In a word, the "objective" portion of the SOAP format should be factual. It is written in quantifiable terms—that which can be seen, heard, smelled, counted, or measured. There are two types of objective data: the counselor's observations and outside written materials. Counselor observations include any physical, interpersonal, or psychological findings that the counselor witnesses. This could consist of the client's general appearance, affect and behavior, the nature of the therapeutic relationship, and the client's strengths. When appropriate, this might include the client's mental status, ability to participate in counseling, and his or her responses to the process. If they are available, outside written materials such as reports from other counselors/therapists, the results of psychological tests, or medical records can also be included in this section.

The counselor's findings are stated in precise and descriptive terms. Words that act to modify the content of the objective observations, such as "appeared" or "seemed" should be avoided. If the counselor feels hesitant in making a definitive observational statement, adequate justification for the reluctance should be provided. The phrase *as evidenced by* is helpful in these situations. For example, one day the client arrives and is almost lethargic in her responses and has difficulty tracking the flow of the session. This behavior is markedly different from previous sessions in which the client was very engaged in the counseling process. When questioned, the client denies feeling depressed. In recording this observation, the counselor might chart, "Appeared depressed, as evidenced by significantly less verbal exchange; intermittent difficulty tracking. Hair uncombed; clothes unkempt. Denies feeling depressed."

When recording observations, counselors should avoid labels, personal judgments, value-laden language, or opinionated statements (i.e., personal opinion rather than professional opinion). Words that may have a negative connotation, such as "uncooperative," "manipulative," "abusive," "obnoxious," "normal," "spoiled," "dysfunctional," "functional," and "drunk," are open to personal interpretation. Instead, record observed behaviors, allowing future readers to draw their own conclusions. For example, one should not record, "Client arrived drunk to this session and was rude, obnoxious, and uncooperative." Instead, one should simply record what is seen, heard, or smelled, for example: Consider, "Client smelled of alcohol; speech slow and deliberate in nature; uncontrollable giggles even after stumbling against door jam; unsteady gait."

Assessment

The assessment section is essentially a summarization of the counselor's *clinical thinking* regarding the client's

problem(s). The assessment section serves to synthesize and analyze the data from the subjective and objective portions of the notes. The assessment is generally stated in the form of a psychiatric diagnosis based on the *Diagnostic and Statistical Manual of Mental Disorders*, text revision (DSM-IV-TR; American Psychiatric Association, 2000) and is included in every entry. Although some counselors resist the idea of labeling their clients with a DSM-IV-TR diagnosis, third-party payers and accrediting bodies such as the Joint Commission on Accreditation of Hospitals require that this be done. According to Ginter and Glauser (2001), "Ignorance of the DSM system is not congruent with current expectations concerning counseling practice" (p. 70).

The assessment section can also include *clinical impressions* (i.e., a conclusion lacking full support) that are used to "rule out" and "rule in" a diagnosis. In more complex cases, in which insufficient information exists to support a particular diagnosis, clinical impressions work much like a decision tree, helping the counselor to systematically arrive at his or her conclusions. More important, when clinical impressions are used and stated, they enable outside reviewers and other health professionals to follow the counselor's reasoning in selecting the client's final diagnosis and treatment direction. When writing clinical impressions, counselors should identify them as such. For the sake of clarity, the relevant points from the data sections should be summarized. Doing this will assist the counselor in formalizing a tentative diagnosis and will demonstrate to outside reviewers the sequence of logic used to arrive at the final diagnosis.

There is debate regarding the use of clinical impressions. Piazza and Baruth (1990) and Snider (1987) recommended against their use, whereas Mitchell (1991) viewed the use of clinical impressions as a powerful entry. In place of clinical impressions, some counselors keep personal or shadow notes. These notes are kept separate from the client's file, and the counselor uses them to record tentative impressions (Keith-Spiegel & Koocher, 1995; Thompson, 1990). This practice needs to be carefully reconsidered. The logistics of maintaining a separate set of notes are almost nightmarish, given the quantity of documentation required in most mental health clinics. Also, there are serious legal and ethical considerations. For the protection of the practitioner, client records need to demonstrate the counselor's thinking and reasoning regarding the diagnosis selected and the elimination of other possible diagnoses (Swenson, 1993). Even though a counselor's set of personal or shadow notes may be subpoenaed by the courts, by recording separate sets of notes the client's record can lack a logical progression of evaluation, planning, and treatment of the problem(s). This leaves the counselor "with no evidence of competence when a lawsuit happens" (Swenson, 1993, p. 162). Simply stated, we believe that one set of notes should be kept and that it is appropriate to incorporate clinical impressions in the record.

An example of the appropriate use of clinical impressions is as follows. A counselor working in a family services agency is assessing a 7-year-old child who has been referred for possible attention-deficit/hyperactivity disorder. The report

from the child's teacher describes the child as being unable to stay on tasks for longer than 5 minutes, being frequently out of his chair, and not seeming to respect other children's needs for "personal space." When the case history is taken, the child's mother provides the information that there were times when she drank frequently and excessively, sometimes to the point of "blacking out," and the mother recalls that this "may have occurred" during the first trimester of her pregnancy. Although there is insufficient information with which to make a diagnosis, a reasonable clinical impression related to a tentative diagnosis is to "rule out fetal alcohol syndrome/effects (FAS/FAE)." Although the counselor is unable to make a definitive diagnosis, given the child's prenatal history, current level of hyperactivity, and decreased attention span, an entry subtitled "Clinical impression: Rule out FAS/FAE" clearly demonstrates the counselor's understanding of childhood psychopathology and developmental issues and supports a referral to a neurological team for evaluation. If the evaluation confirms FAS/FAE, this will determine the diagnosis rendered and the treatment direction.

The assessment portion of the SOAP notes is the most likely section to be read by others, such as outside reviewers auditing records. When making a diagnosis, the counselor needs to ask the question, "Are there adequate data here to support the client diagnosis?" If sufficient data have been collected, the subjective and the objective sections should reasonably support the clinical diagnosis. However, if the counselor is feeling uncomfortable or unsure regarding the accuracy of the diagnosis, this ambivalence might suggest that insufficient data have been collected or that a consultation with a senior colleague is in order.

Plan

The last portion of the SOAP notes is the plan. This section could be described as the parameters of counseling interventions used. The plan generally consists of two parts: the action plan and the prognosis. Information contained under the action plan includes the date of the next appointment, the interventions used during the session, educational instruction (if it was given), treatment progress, and the treatment direction for the next session.

Sometimes clients will benefit from a multiagency or multidisciplinary team approach. When such referrals are made, the names and agencies to which the client was referred are recorded (names involved in the referral should be recorded). If the counselor believes that a consultation is needed, it is documented in this section and includes the telephone contacts made to the consultant regarding the client.

The client prognosis is recorded in the plan section. The prognosis is a forecast of the probable gains to be made by the client given the diagnosis, the client's personal resources, and motivation to change. Generally, progress assessments are described in terms such as *poor*, *guarded*, *fair*, *good*, or *excellent*, followed by supporting reasons for the particular prognosis. The plan section brings the SOAP notes and the treatment direction full circle. Table 1 summarizes the SOAP noting format and provides examples for the reader.

TABLE 1
A Summarization of SOAP Definitions and Examples

Section	Definitions	Examples
Subjective (S)	What the client tells you What pertinent others tell you about the client Basically, how the client experiences the world	Client's feelings, concerns, plans, goals, and thoughts Intensity of problems and impact on relationships Pertinent comments by family, case managers, behavioral therapists, etc. Client's orientation to time, place, and person Client's verbalized changes toward helping
Objective (O)	Factual What the counselor personally observes/witnesses Quantifiable: what was seen, counted, smelled, heard, or measured Outside written materials received	The client's general appearance, affect, behavior Nature of the helping relationship Client's demonstrated strengths and weaknesses Test results, materials from other agencies, etc., are to be noted and attached.
Assessment (A)	Summarizes the counselor's clinical thinking A synthesis and analysis of the subjective and objective portion of the notes	For counselor: Include clinical diagnosis and clinical impressions (if any). For care providers: How would you label the client's behavior and the reasons (if any) for this behavior?
Plan (P)	Describes the parameters of treatment Consists of an action plan and prognosis	Action plan: Include interventions used, treatment progress, and direction. Counselors should include the date of next appointment. Prognosis: Include the anticipated gains from the interventions.

SCENARIO AND SAMPLE SOAP NOTES

The following is a very brief hypothetical scenario and a sample of how the SOAP notes might be written. Abbreviations have not been used because the use and types of abbreviations vary from institution to institution. *Finally, in this situation the counselor is responsible for the intake session.*

Scenario

Cecil is a 34-year-old man who was mandated by the courts to obtain counseling to resolve his problems with domestic violence. He comes into the office, slams the door, and announces in a loud and irritated voice, "This counseling stuff is crap! There's no parking! My wife and kids are gone! And I gotta pay for something that don't work!"

Throughout most of the counseling session Cecil remains agitated. Speaking in an angry and aggressive voice, he tells you that his probation officer told him he was a good man and could get his wife and kids back. He demands to know why you are not really helping him get back what is most important to him. He insists that "Mary just screws everything up!" He goes on to tell you of a violent argument he and Mary had last night regarding the privileges of their daughter Nicole, who just turned 16. You are aware that there is a restraining order against Cecil.

During the session, you learn Cecil was raised in a physically and verbally abusive family until he was 11, at which time he was placed in protective custody by social services, where he remained until he was 18. He goes on to tell you that he has been arrested numerous times for "brawling" and reports that sometimes the littlest things make him angry and he just explodes, hitting whatever is available—the walls, his wife, the kids, and three guys at work. Cecil also reports

prior arrests for domestic violence. He admits that at various times, he has been both physically and emotionally abusive to Mary and the children but insists that it was needed "to straighten them out." Just before leaving your office, Cecil rushes from his chair and stands within a foot of you. Angriily, with his fists and jaw clenched, he says, "This is the same old B.S. You guys are just all talk." He storms from the room.

Sample SOAP Notes

7/7/01. 2 p.m. (S) Reports counseling is not helping him get his family back. Insists the use of violence has been needed to "straighten out" family members. Reports history of domestic violence. Recent history: States he met and verbally fought with his wife yesterday regarding the privileges of oldest child. Personal history: childhood physical and mental abuse resulting in foster care placement, ages 11–18. (O) Generally agitated throughout the session. Toward the end of the session stood up, with clenched fists and jaw, angrily stated that counseling is "same old B.S.!" Rushed out of office. (A) Physical Abuse of Adult [V61.1, DSM code] and Child(ren) [V61.21]. Clinical impressions: Rule out Intermittent Explosive Disorder given bouts of uncontrolled rage with non-specific emotional trigger. (P) Rescheduled for 7/14/01 @ 2 p.m.; prognosis guarded due to low level of motivation to change. Continue cognitive therapy. Refer to Dr. Smith for psychiatric/medication evaluation. Referred to Men's Alternative to Violence Group. Next session, introduce use of "time-outs." S. Cameron, Ph.D., LPCC (signature).

GENERAL GUIDELINES FOR SOAP NOTING

Client records are legal documents. For the most part, in a court of law, they represent the quality of services provided

by the counselor (Mitchell, 1991; Scalise, 2000; Thompson, 1990). To ensure both the quality and the accuracy of the notes and to safeguard the integrity of the counselor, the following guidelines should be observed when writing SOAP notes.

Record the session immediately after the session while it is still fresh in your mind. This avoids the uncertainty, confusion, errors, or inaccuracies that are most likely to occur when you try to complete all the files at the day's end. Start each entry with the date (month, day, and year) and time the session began. Make each entry legible and neat with no grammar, spelling, or punctuation errors. Finally, the client record should reflect the counselor's level of training and expertise. For example, the counselor's extensive use of psychoanalytic-based terminology without having received such training may cause other professionals to question the competency of the counselor. The American Counseling Association's (ACA, 1995) Code of Ethics takes a clear position on counselors limiting practice to level of competence, and because records may be reviewed by others, the record's language must be congruent with level of competence. These procedures will alleviate misunderstandings between professionals and minimize the potential of a lawsuit (Swenson, 1993).

All client contact or attempted contact should be recorded using the SOAP format. This includes all telephone calls, messages left on answering machines, or messages left with individuals who answered the phone. Letters that were mailed to the client would be noted in the record along with a photocopy of the signed letter.

When recording a session, keep in mind that altered entries arouse suspicions and can create significant problems for the counselor in a court of law (Norris, 1995). If an error is made, never erase, obliterate, use correction fluid, or in any way attempt to obscure the mistake. Instead, the error should be noted by enclosing it in brackets, drawing a single line through the incorrect word(s), and writing the word "error" above or to the side of the mistake. The counselor should follow this correction with her or his initials, the full date, and time of the correction. The mistake should still be readable, indicating the counselor is only attempting to clarify the mistake not cover it up. If not

typed, all entries should be written in black ballpoint pen, which allows for easy photocopying should the file be requested at a later date. Furthermore, notes should never be written in pencil or felt-tipped pen because pencil can be easily erased or altered, whereas felt-tipped pen is easily smudged or distorted should something spill on the notes.

At the conclusion of the entry, the counselor needs to sign off using a legal signature—generally considered to be the first initial and last name followed by the counselor's title. All entries, regardless of their size, are followed by the counselor's legal signature. There should be no empty space between the content of the SOAP notes and the signature. Blank spaces may later be interpreted (e.g., by a lawyer) to mean that there is missing information or that the counselor failed to provide "complete care" (Norris, 1995); even worse, empty spaces can be filled in by another person without the counselor's knowledge. Writing should be continuous with no lines skipped between entries or additional commentary squeezed in between the lines or in the margins. Table 2 offers readers a quick reference list of "do's and don'ts."

CONCLUSION

In this era of accountability, counselors are expected to use a more systematic approach in documenting rendered services (Ginter & Glauser, in press; Norris, 1995; Scalise, 2000) and demonstrating treatment effectiveness (JCAHO, 2000). Good documentation is a fundamental part of providing minimal client care, and needs to be mastered like any other counseling skill. As the standards for recording receive increased scrutiny by both managed care organizations and the National Committee for Quality Assurance, the importance of documentation has changed "from something that *should* be done well to something that *must* be done well" (Kettenbach, 1995, p. iii), especially if counseling is to survive in this age of managed resources. SOAP notes are a proven and effective means of addressing this new mandate. We hope that this article will help others fulfill this dictate, for there is no substitute for concisely written and well-documented case notes.

TABLE 2
Guidelines for Subjective, Objective, Assessment, Plan (SOAP) Noting

Do	Avoid
Be brief and concise.	Avoid using names of other clients, family members, or others named by client.
Keep quotes to a minimum.	Avoid terms like seems, appears.
Use an active voice.	Avoid value-laden language, common labels, opinionated statements.
Use precise and descriptive terms.	Do not use terminology unless trained to do so.
Record immediately after each session.	Do not erase, obliterate, use correction fluid, or in any way attempt to obscure mistakes.
Start each new entry with date and time of session.	Do not leave blank spaces between entries.
Write legibly and neatly.	Do not try to squeeze additional commentary between lines or in margins.
Use proper spelling, grammar, and punctuation.	
Document all contacts or attempted contacts.	
Use only black ink if notes are handwritten.	
Sign-off using legal signature, plus your title.	

REFERENCES

- American Counseling Association. (1995). *ACA code of ethics and standards of practice*. Alexandria, VA: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (Text rev.). Washington, DC: Author.
- Anderson, J., & Bowers, G. (1973). *Human association memory*. Washington, DC: Winston.
- Bechtel, W., & Abrahamsen, A. (1990). *Connectionism and the mind: Introduction to parallel processing in networks*. Cambridge, MA: Basil Blackwell.
- Eggland, E. T. (1988). Charting: How and why to document your care daily—and fully. *Nursing*, 18(11), 76–84.
- Ginter, E. J., & Glauser, A. (2001). Effective use of the DSM from a developmental/wellness perspective. In E. R. Welfel & R. E. Ingersoll (Eds.), *The mental health desk reference* (pp. 69–77). New York: Wiley.
- Griffith, J., & Ignatavicius, D. (1986). *The writer's handbook: The complete guide to clinical documentation, professional writing and research papers*. Baltimore: Resource Applications.
- Hart, J., Berndt, R., & Caramazza, A. (1985, August). Category specific naming deficit following cerebral infarctions. *Nature*, 316, 339–340.
- Joint Commission on Accreditation of Healthcare Organizations. (2000). *Consolidated standards manual for child, adolescent, and adult psychiatric, alcoholism, and drug abuse facilities*. Chicago: Author.
- Keith-Spiegel, P., & Koocher, G. P. (1995). *Ethics in psychology: Professional standards and cases*. New York: Random House.
- Kettenbach, G. (1995). *Writing SOAP notes*. Philadelphia: Davis.
- Mitchell, R. W. (1991). *The ACA Legal Series: Documentation in counseling records* (Vol. 2). Alexandria, VA: American Counseling Association.
- Norris, J. (1995). *Mastering documentation*. Springhouse, PA: Springhouse.
- Philpott, M. (1986). Twenty rules for good charting. *Nursing*, 16(8), 63.
- Piazza, N. J., & Baruth, N. E. (1990). Client record guidelines. *Journal of Counseling & Development*, 68, 313–316.
- Ryback, R. S. (1974). *The problem oriented record in psychiatry and mental health care*. New York: Grune & Stratton.
- Scalise, J. J. (1999). The ethical practice of marriage and family therapy. In A. Horne (Ed.), *Family counseling and therapy* (3rd ed., pp. 565–596). Itasca, IL: Peacock.
- Shaw, M. (1997). *Charting made incredibly easy*. Springhouse, PA: Springhouse.
- Siegal, C., & Fischer, S. K. (1981). *Psychiatric records in mental health*. New York: Brunner/Mazel.
- Snider, P. D. (1987). Client records: Inexpensive liability protection for mental health counselors. *Journal of Mental Health Counseling*, 9, 134–141.
- Swenson, L. C. (1993). *Psychology and law for the helping professions*. Pacific Grove, CA: Brooks/Cole.
- Thompson, A. (1990). *Guide to ethical practice in psychotherapy*. New York: Wiley.
- Weed, L. L. (1964). Medical records, patient care and medical education. *Irish Journal of Medical Education*, 6, 271–282.
- Weed, L. L. (1968). Medical records that guide and teach. *New England Journal of Medicine*, 278, 593–600, 652–657.
- Weed, L. L. (1971). Quality control and the medical record. *Archive of Internal Medicine*, 127, 101–105.



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