

Learning to Write Case Notes Using the SOAP Format

Susan Cameron and Imant Bartle-Song

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 current status 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 physicians, nonprofessionals, and case managers to better understand the concerns and needs of the client. Although 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 much emphasis as the industry pays have changed the use of documentation from something that should be done well to something that must be done well (Kortelbach, 1995, p. 12). In this era of accountability, counselors are expected to be both systematic in providing client services (Nixie, 1995) and able to produce clear and comprehensive documentation of those clinical services rendered (Seidman, 2000). However, in our experience (i.e., first authors), both as directors of a mental health clinic and as case video quality checkers, few counselors are able to write clear or concise clinical case notes, and most complaints of feeling frustrated when trying to distinguish what is and is not important enough to be represented in their notes. Well-written case notes provide accountability, corroborate the delivery of appropriate services, support clinical decisions (Mitchell, 1990; Seidman, 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 a counselor begins 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 writing (Griffith & Igartua, 1996; Kortelbach, 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 (Kortelbach, 1995) and by assisting them in better recalling the details of each client's case (Hyback, 1974; Masi, 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 (FCR), and narrative notes, all are variations of the original SOAP case format (Kortelbach, 1995).

To understand the nature of SOAP notes, it is essential to understand 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; Seidman & Fischer, 1993). The first component, the clinical assessment, contains information gathered during the intake interview(s). This generally includes the reason the client is seeking treatment, concerns/ complaints, the client's personal, family, and social histories, psychological test results, if any, and diagnosis and recommendations for treatment (Piacos & Baruch, 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 assessment, a problem list (problem 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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