Presented by:

Your Guide to Writing Better SOAP Notes

table of

CONTENTS

What are SOAP Notes? 02

Subjective 05

Objective 08

Assessment 10

Plan 12

Why SOAP Notes are important? 14

SOAP Note Examples 18

Psychiatry 19

Individual Therapy 20

Group Therapy 22

Tips for Better SOAP Notes 23

What are SOAP Notes?

A SOAP note is a common documentation format many health care professionals use to record an interaction with a patient.

SOAP notes are a type of progress note.

SOAP format includes four elements that match each letter in the acronym:

Subjective - Objective - Assessment - Plan

These four sections remind counselors of the information they must document when providing appropriate treatment.

This highly organized format also allows staff to find patient information quickly and recall essential details when needed.

In this guide, we'll show you:

- How to write SOAP notes
- Why SOAP notes are important
- Tips for better SOAP notes
- SOAP note examples

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The SOAP format includes four elements that match each letter in the acronym

S ubjective

O bjective

A ssessment

P lan

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SUBJECTIVE

The first step is to gather all the information the client has to share about their symptoms. The patient will tell you about their chief complaint, as well as what they perceive to be their needs and goals for treatment.

The **Subjective** summary should include direct quotes from the client. For example, a client might say, “I want to talk to my spouse about my anger.” The counselor would add this verbatim quote. It’s crucial to record the patient’s words, rather than paraphrasing them, so you cultivate the most accurate insight into their condition.

The Subjective category is also an appropriate place to list any comments made by the patient, their family members or their caretakers.

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OLD CHARTS Acronym

A smart way to cover a patient's presenting problem thoroughly.

Onset: *Determine when each symptom started.*
Location: *Find out the primary location of pain or discomfort.*
Duration: *Learn how long the patient has dealt with their symptoms.*
CHaracter: *Examine the types of pain: aching, stabbing, etc.*
Alleviating or aggravating factors: *What actions or interactions reduce or increase the severity of the patient's symptoms?*
Radiation: *Find out if the pain radiates to other locations in the body.*
Temporal pattern: *Do the symptoms appear in a pattern, like in the evenings or after meals?*
Symptoms associated: *Are there any secondary symptoms that accompany the patient's main complaint?*

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Although the SOAP note format for mental health may not always need to include physical details, the **OLD CHARTS** acronym can be helpful to counselors if they are coordinating care with a client's medical doctor.

Mental health and physical health go hand in hand, and often, one influences the other. For instance, according to the American Heart Association, up to 33% of heart attack patients develop depression.

Therefore, behavioral health professionals might also use the Subjective category to note any physical symptoms a client may express.

OBJECTIVE

The **Objective** portion of a SOAP note includes factual information. It may include detailed observations about the client's appearance, behavior, body language, and mood.

For example, you might write that the client arrived 15 minutes late to the session and slouched in the chair.

Write details down as factually as possible. The Objective phase is only about raw data, not conclusions or diagnoses on your part. Record any measurable data during the client's session, including applicable assessment scores.

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Documenting the **Objective** phase brings up the issue of separating symptoms from signs. Symptoms are the patient's experience of their condition, whereas signs are objective observations related to symptoms.

If a client reports having symptoms of anxiety, such as panic attacks, signs of that anxiety might include visible trembling or clenching of muscles, as well as hypertension, determined by a physical test.

You have a limited window for examination, so it's crucial to actively look for any signs that complement or contradict information documented in the Subjective section of the notes.

ASSESSMENT

Both the Subjective and Objective elements previously recorded come together in the **Assessment** phase. You will document your impressions and make interpretations based on the information you've gathered. For an initial visit, the Assessment portion of your notes may or may not include a diagnosis based on the type and severity of symptoms reported and signs observed.

For common conditions such as depression, the Assessment is fairly straightforward and can often lead to a diagnosis in the first visit or two. For rarer and more complex conditions or those that appear co-morbidly, you may need more time to gather information on the Subjective and Objective levels before arriving at a diagnosis.

For follow-up visits, the **Assessment** portion of SOAP notes covers an evaluation of how the client is progressing toward established treatment goals. The Assessment will inform your current treatment course as well as future plans, depending on whether the patient is responding to treatment as expected. It's essential to reflect on whether your client is showing improvement, maintaining improvements already made, worsening or demonstrating patterns of remission.

Like the other sections of SOAP notes, your Assessment should only contain as much information as is necessary. Some Assessments will be significantly longer than others, based on the complexity of the patient's condition. Sometimes this section of your notes will contain only a few snippets of information like, "Patient is sleeping better, no change in the incidence of panic attacks." In other situations, there are more pieces to evaluate, and the Assessment portion of your notes should expand to include all the appropriate information.

PLAN

This is where the previous three sections all come together to help you determine the course of future treatment. The Plan section of your SOAP notes should contain information on:

- The treatment given during the session and your rationale for administering it
- The client's immediate response to the treatment
- When the patient's next appointment will be
- Any instructions you gave the client, including homework assignments
- Goals and outcome measures for new problems or problems being re-assessed

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Your **Plan** notes should include actionable items for each diagnosis. If your client is experiencing multiple conditions, such as post-traumatic stress disorder, in combination with a substance use disorder, your notes should include separate plans for each condition.

The goal of this section is to address all the specific problems listed in the Assessment. When done efficiently, the Plan sets a clear road-map for the patient's continuing treatment and provides insight for other clinicians to continue that treatment if need be. Consult the Plan on each new visit, and adjust it regularly based on the findings in the Assessment section.

Why Are SOAP Notes An Important Tool?

Medical and behavioral professionals widely use the SOAP format, and for a good reason. Since its development in the 1960s, the SOAP framework has been useful enough for health professionals of all disciplines. Of the many benefits SOAP provides, here are three of the most prominent.

- **Connectivity**
- **Accuracy**
- **Efficacy**

Connectivity

The adoption of electronic health record (EHR) software is on the rise, with 89.6% of primary care providers and 61.3% of psychiatric practices using some form of an electronic record. EHRs make integrated care possible by allowing medical and behavioral health professionals to access each other's notes on patients. Using the SOAP framework enables practitioners of all specialties to communicate in a streamlined fashion, providing better care for each patient.

Accuracy

When health care providers are not using the same framework for notes, critical information often gets lost in translation when the next provider accesses the information. SOAP notes emphasize clarity and brevity, which helps get every provider on the same page with minimal confusion.

The clear structure of SOAP notes also increases the accuracy of your notes in general. Rather than trying to remember everything that happens in an appointment and jotting it down stream-of-consciousness style, SOAP notes give you a way to structure your appointments to get the right information at the right time, making it easier to recall and accurately document in the patient's record.

Efficacy

SOAP notes help support your end goal of providing the most effective care and treatment for your clients. The focus on Assessment and Plan keeps progress at the forefront of your sessions and offers a history of efficacy you can evaluate to see what's working and what isn't.

SOAP notes also create a paper trail of documentation that may be useful in the case of a malpractice suit. More commonly, insurance companies require mental health SOAP notes for reimbursements in the case of a third-party audit. Switching to this note-taking technique is better for both your patients and your practice.

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SOAP Note Examples for Mental Health

You can incorporate the SOAP framework into any notes taken in a behavioral health care setting. To help you envision the ways you can integrate SOAP notes into your practice, here are three situations in which the SOAP approach can clarify and simplify your documentation.

Sample Counseling SOAP Note

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Psychiatry

Imagine you're treating a patient at an outpatient psychiatric clinic. We'll call him Mr. D. Here's what a psychiatry SOAP note might look like for a follow-up appointment.

Subjective: Mr. D. states that he has "generally been doing well." His depressive symptoms have improved, but he still feels "down" at times. Mr. D. says he is sleeping "better" and getting "decent sleep." He feels his medication is helping him without causing side effects.

Objective: Mr. D. appears alert. His mood has improved, and he shows a range of emotions.

Assessment: Mr. D. has major depressive disorder without psychotic features.

Plan: Mr. D. will continue taking 10 milligrams of fluoxetine per day. If his symptoms do not improve in one week, we will consider increasing the dose to 20 mg. Mr. D. will continue outpatient counseling.

In this case, the SOAP note may also include data such as Mr. D.'s vital signs and lab work under the Objective section to monitor the effects of his medication.

Individual Therapy

As medications and lab tests are not regular components of individual therapy, SOAP notes are even more straightforward to document. Here's a SOAP note sample for an individual therapy session. With this example, imagine treating a patient named Mr. Smith, who suffers from substance use disorder.

Subjective: Mr. Smith states he has strong cravings for heroin, and he thinks about leaving his treatment program to get drugs "several times a day." Mr. Smith wants to stay sober and says he's "better, but still not strong enough." Mr. Smith states, "I can't stop thinking about using, and I can't seem to get it out of my head." The client says he's "improving overall."

Objective: Mr. Smith appears calm and interested during the session. He does not display any signs of withdrawal, such as sweating or tremors. Mr. Smith is still distractable, but his attention has improved, as indicated by talking about his wife for five minutes and reflecting on his past without difficulty.

Assessment: Overall, Mr. Smith is improving. He is learning to apply coping skills such as relaxation techniques, and he is more engaged in his treatment. His cravings have decreased from “all the time” to “about six times a day.” However, Mr. Smith continues to experience strong cravings and has a 30-year history of substance use. Therefore, he needs to learn new coping skills to manage his emotions. Considering the challenges Mr. Smith faces, he may be a candidate for medication-assisted treatment (MAT).

Plan: Mr. Smith has now received information about MAT to discuss during the next session. We will begin to use cognitive behavioral therapy techniques to address Mr. Smith’s anger issues. We will also continue to hold family sessions with his wife. Staff will continue to monitor the client closely.

Group Therapy

Creating group therapy notes is necessarily more complex than documenting individual sessions. You have multiple patients with multiple conditions that you must keep track of, making it even more crucial to be concise and precise in your notes. Each individual should have separate notes for each group therapy session, using the SOAP format.

Each individualized group therapy note should include:

- the group type
- the agenda for that session
- the group members present
- the interventions facilitated by the group leader

Creating individualized SOAP notes for group therapy can be somewhat time-consuming, but is essential for monitoring progress over time.

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Tips for Better SOAP Notes

SOAP notes are a crucial part of each client's treatment. To write effective SOAP notes that help you make the most of each session, consider the following tips and mistakes to avoid.

- **Consider timing:** To give your client your fullest attention possible, avoid writing SOAP notes during each session. If you need to jot down a few notes to help you remember what the client has said, you might keep them with your private psychotherapy notes. Enter SOAP notes into the EHR after each session, but avoid waiting too long to keep the details fresh in your mind.
- **Be concise:** Your SOAP notes should be easy to read, so you can quickly communicate the information to other staff members or future physicians. Avoid overly wordy statements, and be as brief as possible. Use active voice and proper grammar.
- **Be specific:** Your SOAP notes should be both concise and specific. By including precise details, you'll help prevent confusion and improve client treatment.

Tips for Better SOAP Notes

- **Avoid judgmental statements:** You'll want to maintain professionalism in your notes, and be as neutral as possible. That means avoiding overly positive or negative wording and focusing on giving accurate information. For example, instead of saying something such as, "The client, obviously lying, states their child could speak when they were 3 months old," you should write, "The client reports their child could speak when they were 3 months old."

- **Avoid naming others:** Avoid including the names of family members, other clients or anyone else named by your patient. Instead, you might use initials to indicate the person your client is talking about. By only stating your client's name, you make it clear to other staff members that your patient is the focus of the treatment. It also protects the privacy of others.

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