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Best Practices in SOAP Notation

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Taking proper and comprehensive SOAP notes is as important a clinical skill as where to place acupuncture pins and what herbs to prescribe. In training as health care professionals, SOAP notes are introduced as an efficient and thorough method to compose a legal document known as a patient chart. Diligence to this method is largely taught as a means to avoid clinical error and provide evidence of patient interaction should records be requested by other medical practitioners, insurance companies, or subpoenaed by a judge.

These are very important reasons to learn effective SOAP notation, but can charting be elevated to a practice that empowers patient care? What if a chart were more than a document of the past, but also provides a forecast of the future? Patients rely on holistic health care practitioners to think deeply about their case. In turn, taking detailed notes documents clinical success (or failure), guides intervention, and informs continual adjustment of a treatment plan. In this way, SOAP notes can be a living, vibrant extension of clinical skills.

Remain cognizant that individual practitioners are not islands separate from the sea of medicine in which patients swim (and sometimes tread). Many patients will be seeking answers from a number of medical practitioners and allied health professionals. As trusted members of this community, it is possible to gain valuable clues from the chart notes of other practitioners and vice versa.

As an extension of holistic medicine, charting exists in service to the patient; a practice that helps create the most conducive environment for healing. Refining the art of SOAP notation is a key contributor to that success.

The Time Machine of SOAP Notation

Before jumping into the nuts and bolts of exemplary SOAP notation, it is helpful to take a step back and examine how a commitment to holism is reflected in the process. Think of SOAP notes as a walk through time. A record of a patient's chief concern will detail the history of their problem. Detailed notes create a snapshot of the patient's past, an ever-present reminder of the various physical and emotional contributions to their health challenge(s).

The present is documented by observations in real-time. What is the character of the patient's shen and how is it influencing their prognosis? What is their posture and body-language communicating? Is it hopeful or downtrodden? Framing the present moment in chart notes provides a baseline to gauge progress in all aspects of a patient's wellbeing.

Devising and recording a treatment plan frames the future, setting the stage for success with the documentation of a stepwise plan. As ideas converge during a new patient intake, notate all the

different interventions and potential referrals that may be necessary to holistically address the patient's condition.

Similar to the practice of creating a vision for the day or a business plan for the year, frame out a future vision for the patient, highlighting elements of a plan to empower participation in the therapeutic process.

The Four Elements of SOAP

#1: Subjective

SOAP is an acronym for subjective, objective, assessment, and plan. Each are a critical aspect of charting that together make up a concise yet detailed description of the patient encounter. There is a natural flow to SOAP notes starting with the patient's story in subjective, observations in objective, diagnosis in assessment, and ending with treatment and recommendations in plan.

After welcoming a patient into a confidential space to discuss their case, invite a sharing of their story in full. Sometimes a patient is forthcoming, other times the setting of their health challenges must be gently coaxed out. To probe with intention and compassion is a skill all of its own, but one that will flesh out the subjective section of chart notes with valuable and sometimes highly visual information.

Consider for a moment the description of a motor vehicle accident. Limited notes on such an incident might read, "MVA Oct. 2012". Although the cause and time frame of a patient's neck pain (whiplash for example) is documented, it is possible to miss key features of their story that can change treatment strategy. It is a good idea to have a patient explain the accident with as much detail as possible.

Did the car flip and was their head hit at a specific acupuncture point? Were other cars involved, other injuries? Is the patient in a legal battle due to this incident? Can the patient describe the events of that day without eliciting a stress response? If an emotional charge accompanies the memory of the collision, consider treatment to address the patient's emotional pain in addition to physical pain.

Subjective is not simply the facts as they happened. Subjective notes are the story of a patient's disharmony, the emotional and spiritual landscape where facts are rooted. Waking with neck pain might be due to a new pillow, but it might also be intertwined with the residual jaw tension from an unresolved argument a patient had with their spouse the night prior. Subjective notes are the base of the pyramid on top of which the most effective treatments are built.

Begin building this pyramid with a patient's "CC" or chief concern/complaint. This is typically a word or phrase that describes the reason why the patient sought help. Oftentimes (but not always), this information will be clear from new patient paperwork.

In some cases, the patient may articulate one concern on paper but may actually be interested in treatment for something else. There is a certain amount of censorship that occurs when a patient fills out new patient paperwork. Chronic headaches is written down as the reason for care, but the patient is actually more affected by debilitating depression, not wishing to express this concern until having confidence in their practitioner's skills, compassion, and confidentiality. Other times, a patient may omit certain information to be left undocumented for fear of being labeled with a pre-existing condition for chart notes that will later be requested by an insurance company or law office.

After recording this chief concern, the conversation can then move toward discovering the story of the patient. The most important question to ask in this regard is, "What was happening at the time?" For acute and chronic pain, this may be a description of the events that lead up to or precipitated a trauma. This is critical information but often woefully inadequate. A patient typically needs to be coaxed to share the mental and emotional aspects of that time in their life, information all the more important for physical pain that lacks a clear cause (also called "insidious onset"). Was the patient under a lot of stress? Major life changes? Did they adopt a new diet or move into a new house? These questions may take the conversation on seemingly random tangents, but they might also lead to a causative factor that was not previously in the patient's conscious awareness.

Once the skeleton of the chief concern is documented, begin asking very specific questions that will flesh out the patient's story. This will provide the detail needed to proceed to the diagnosis in the assessment section of SOAP notes. Subjective lines of inquiry include the famous "10 questions" of traditional Chinese medicine that provide insight into a patient's constitution. For a problem in a specific area of the body, note its location in detail using one or more spatial descriptors such as muscle groups, joint articulation, and channel distribution. Then, ask specific questions to glean additional information about the chief concern. A helpful mnemonic to guide this inquiry is "O, P, Q, R, S, T".

A Mnemonic Guide

"O" stands for onset, and details the what, when, how, and why of the problem's origin. An example of the onset for chronic migraines may include such phrases as "since first menstruation and occurring before each cycle," or, "began with neck trauma following fall off a ladder."

"P" stands for provocation and palliation, a fancy way of saying what makes the patient's problem worse and what makes it better. This is the section to list previous modalities that have benefited the patient or were unsuccessful. Inquiring about previous modalities will clarify what the patient has tried and act as a reminder of what may be a potential referral. Examples of phrases that can be recorded include, "heat improves pain" or "head rotation to the left worsens pain."

"Q" stands for quality. For chronic pain conditions, the quality of the pain may be "achy" or "sharp". Perhaps it vacillates between the two. Try not to put words in the patient's mouth, recording their full experience of body sensations. Descriptors can always be suggested later if the patient is having trouble finding the words to characterize their experience. Perhaps the patient uses the word "aggravating," leading the clinical detective to question what or who else might be aggravating them?

"R" stands for radiation. It details any movement in the location of the problem to other areas of the body. For a nerve impingement in the shoulder, that might be "shooting sensation down the ulnar nerve in the forearm, along the small intestine channel." Perhaps a patient experiences anxiety in their chest but also describes a tightness in their shoulders when under periods of high stress. If it moves, make a note of it; clinical clues can be gleaned from this information when contemplating the patient's case in the weeks ahead.

"S" stands for severity. This can be overt and ascribed, such as a rating along a pain scale between 1-10, or subtle in description, such as "intolerable" or "so bad I can't play golf." These latter descriptors are extremely relevant in speaking to the needs of the patient. It can be an empowering point of focus of treatment outcome for a patient to work toward being able to play golf without pain. This is a far more rallying visualization than simply the absence of pain. Compliance to treatment,

especially in the face of erratic improvement, is often won in leveraging the language of the patient and mirroring their definition of success.

"T" stands for timing. If their problem occurs at a certain time of day or night, this is important to note. It is quite common for a patient, detached from their emotions and ungrounded in their body, to be unaware of the situational influences of their health. It may be obvious such as "pain worsens at work." Other times it is helpful to provide a tool to track changes such as a diet diary to establish a pattern of gas and bloating that follows the ingestion of a certain food. Knowing when is sometimes more important for clinical resolution than what, where, and how.

Depending on the comprehensiveness of a clinic's new patient paperwork, it may be best to document relevant medical history under subjective. This may seem misplaced as a formal diagnosis, list of medications, or a time line of surgeries is fairly objective, but keep in mind that case history is reliant on the patient's memory. New patient paperwork is replete with misspelled drug names, wrong dates for surgery, and imprecise diagnoses suggested by other healthcare practitioners.

The notes for a subsequent visit with the same patient will naturally have less detail than their initial visit. The thrust of new notes will entail treatment progress. Occasionally a patient will have an epiphany, recalling a relevant feature of the onset of their problem. If so, highlight this revelation so that it is not missed when referring back to the elements of the patient's story.

A new test result, diagnosis, or medication from another healthcare practitioner may arise along the treatment course. Notate this in the subjective section of the chart and refer back to the original evaluation to see if it changes the treatment approach.

Treatment progress will be the most common entry in the subjective section of a chart for follow-up visits. If using a rating scale for a particular problem during the initial consultation, ask the patient to rate the problem on a subsequent visit and compare the number.

It is also wise to note a patient's general well being as it changes over time. Is the patient optimistic or feeling helpless? Are they excited about a future trip or worried about a pending stress? These subjective comments are valuable inroads to relationship building. Notate these aspects of a patient's life and ask about it at future visits. In addition to collecting valuable information about how the patient is relating to and coping with the ebbs and flows of life, this information helps with relating to the patient on a personal level, separate from their disease/pain. Building trust is a slow and methodical process of showing care; chart notes are a ready reminder.

#2: Objective

After recording the patient's story and teasing out all the clues needed to form a diagnosis, proceed with documenting impressions of their case. It is a mistake to skip the practitioner's observations in objective and jump from the story detailed in subjective to the diagnosis in assessment. The first meeting with a new patient is priceless, seeing with fresh eyes and hearing with open ears. It is possible to intuitively sense something during an initial appointment that later may be elusive after becoming friendly with the patient, or conversely, fatigued by their personality.

Objective is not a statement of judgment and should never include personal bias. A new patient evaluation is the most impartial interaction with a patient and the challenge is to tell the story of that interaction with the highest integrity.

Objective notation is the collection of the practitioner's findings as a distinct perspective from the patient's story. For acute or chronic pain, it will include a patient's range of motion as well as the outcome of orthopedic tests. This is also the place to document findings in pulse and tongue diagnosis, areas of tenderness upon palpation, the sound quality of a patient's voice, and sentiments emoted.

Keep in mind that the nature of objective notes will be influenced by practice style and setting. A shared clinic that cross-refers to other acupuncturists will have far more emphasis on Chinese medicine diagnosis than a sports medicine clinic that is communicating back and forth with an orthopedist and physical therapist. Recall the need for observations to be understood by as wide a medical audience as possible. Even if not thinking or diagnosing in Western medical terms, it is prudent to write inclusive language in chart notes.

Objective entires for follow-up visits will contain detail on treatment efficacy in ways that any practitioner can gauge. Notate and compare the range of motion of an affected joint or a decreased sensitivity to palpation over trigger points. Monitor the effect of treatment on tongue and pulse and record constitutional changes.

#3: Assessment

After recording the elements of the patient's story or updates on their progress, the next step is to devise a diagnosis that logically lends itself to the treatment strategy to be outlined in plan.

While subjective is generally the longest section of SOAP notation, assessment is typically the shortest, usually expressed in a few words or a short phrase of formal diagnosis. Examples include "Liver Spleen disharmony" or "qi/blood stagnation in the bladder channel" from the cannon of traditional Chinese medicine.

Without an allopathic medical degree, there are limitations within scope of practice that legally prohibit expressing a diagnosis in conventional terms. This means that the assessment section of SOAP notes may be nonsensical to practically every other medical profession, but inclusive language in the subjective and objective section of chart notes should be sufficient to clue in an otherwise clueless practitioner. While a Chinese medicine practitioner can't make a diagnosis of "depression" (differing to the language of "shen disturbance"), documenting comments on the patient's affect, ongoing stressors, and life circumstances within the subjective section of chart notes will go a long way to elucidate their condition to a physician.

If a patient comes with a formal diagnosis, insert this in the subjective section of chart notes in quotes, delineating where the diagnosis originated. Following the above example, notate, "Patient diagnosed with 'depression'". If it is unclear whether a patient actually has a formal diagnosis, keep the language open-ended such as "patient claims depressive-like symptoms," inferring but not confirming a diagnosis.

There are exceptions of course, particularly when it comes to musculoskeletal conditions. There is no harm or legal conflict in charting the assessment of "piriformis syndrome" when properly documenting the indicating orthopedic tests in the objective section of chart notes.

Entries to assessment for follow-up visits will likely be the same and can be carried over from previous chart notes. If a new problem and new diagnosis present, add this assessment along with the previous diagnosis unless the previous condition has resolved.

#4: Plan

After distilling the richness of subjective and objective notes into one or more concise statements of assessment, freely articulate a plan for both the present and future sessions.

Begin by noting an acupuncture protocol with needling technique. Additional detail can include style if helpful to another practitioner treating the patient within the same clinic. If utilizing a different modality, such as moxibustion or electroacupuncture, be mindful of charting the details in terms of area of the body, length of time used, and any localized reactions.

When charting an acupuncture protocol, our profession was previously limited to lined paper or flat imprecise diagrams. With 3D body imaging software such as AcuCharting, the practitioner has the freedom to mark utilized point locations for a quick visual reference between treatments.

If prescribing an herbal formula or nutritional supplement, detail the formula name (ingredients if appropriate) and dosage. Specifics of dietary advice and movement therapies (qigong, taiji) should also be documented here.

Once a plan is in place, go beyond a brief summary of the therapy. Include any notes about a reasonable timeline of progress for the patient as well as ideas for future interventions. If there wasn't much time to review diet, and the patient mentioned a predilection for sweets, make a note to cover the inflammatory nature of processed sugar at a future appointment. Perhaps there was time to discuss a dietary intervention during the initial visit; include a note on the specifics and remind the patient of that recommendation during a subsequent intake.

Finally, detail a decision tree in case the current treatment strategy does not benefit the patient. Patients appreciate candor when establishing a course of treatment. Precisely articulating expectations (within reason) and outlining next steps (contingent upon outcome) builds confidence and reinforces lifestyle change.

Conclusion

The patient has left, happily paying for exemplary care. Notes have been made to further that high-level care with an attention to detail to keep both patient and practitioner on task.

Before a patient's follow-up next visit, consult their chart notes from a calm and clear place of reflection, becoming reacquainted with the patient's story and opening up channels of intuition to novel ideas and lines of inquiry. Through the process of looking back in review of these notes, its easier to quickly pick up where the last treatment left off, recapturing the mindset necessary to walk the path unique to that patient's needs. When welcoming a patient back, the sage practitioner becomes an anchor of mindfulness—grounded in the patient's past, cognizant of changes reflected in the moment, and open to future possibilities—in a vision framed by the commitment to making charting an active aspect of comprehensive care.

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