Risk Tip: SOAP Note Format

What's the Story?

The progress note serves as a written medical-legal document, or story, that must be completed on a daily basis. It includes all "events" that occur during the visit. The note captures "events" in terms of subjective and objective findings, assessment and plan. Each patient's story should include a beginning, middle and ending.

During documentation audits, the assessment and plan—which are critical components of a complete note—are often short, incomplete or absent. Don't leave the reader guessing!

If your notes are missing the assessment and plan details, your patient's story is missing an ending. How will another healthcare team member know what occurred during the visit? How will they know what your thoughts were regarding the visit? How will they know about what you found and planned for the patient? End your note by telling the reader your plans for the patient.

A simple format to follow includes:

S=Subjective

- Record of subjective findings that occurred during the evening, overnight and morning patient that the patient was examined.
- Essentially record how the patient felt during the evening, nighttime and morning hours and what happened during those hours.

O=Objective (includes all the following)

- Physical exam: vital signs, focused physical exam and almost always:
    - Laboratory data
    - Diagnostic Imaging

A/P=Assessment and Plan:

THIS IS THE MOST IMPORTANT PART OF YOUR NOTE.

- The assessment section of the progress note should be organized by problems. Problems must be included in your assessment.
- Assess each problem and include any relevant differential diagnosis, evidence that suggests or doesn't suggest a diagnosis. It is essentially "what you think caused the problem and why you think that."
- Once the assessment has been made, a plan must be formulated to address each problem. This plan should be complete so that those who read your note will know exactly what you are doing and why.
- Some secondary problems are stable and do not need an assessment but rather just a plan.
- Include when the patient is to return for follow-up care.