Ballarat Health Services
Putting your health first

Allied Health Clinical Documentation Guidelines

January 2020

Introduction

Ballarat Health Services (BHS) is required by law to create and maintain a documented record of a patient's health, illness or treatment in hard copy or electronic format. The Clinical Record is a tool for planning provision of health care and for contemporaneous tracking of the patient's condition, care, services and interventions performed by the care team. The clinical record allows for the transfer of important clinical information between healthcare professionals. Further, it creates a historical record of the care provided to the patient for later use for a variety of clinical, quality, audit, research, legal and funding purposes. It is also a potentially rich source of information about safety and quality of care that can be used to improve clinical and organisational systems, and for research.

The BHS policy on Clinical Documentation outlines the common and minimum standards of documentation for all clinicians contributing to the BHS medical record.

For Allied Health at BHS, clinical documentation at initial contact, assessment, progress and discharge is to be in the SOAP format. (*"Writing SOAP Notes 2nd Ed", Ginge Kettenbach, F.A Davis)*

What SOAP means?
SOAP is an acronym. Each of the letters in S.O.A.P. stands for the name of a section of the patient note. The patient note is divided as follows:

S Subjective
O Objective
A Assessment
P Plan

What goes where?

S SUBJECTIVE

The patient's emotions or attitudes
Complaint(s)
Verbal response about treatment
Client goals
Lifestyle or home situation
Reports from staff / team members

O OBJECTIVE

What therapy was offered and frequency this week
Results of measurement (reproducible data)
Therapist's clinical observations
Functional information
Type of treatment provided (i.e. specific exercises, independence level, number of repetitions, positions used, modification(s) necessary, education provided, etc.)

A ASSESSMENT

Justifications for goals/plan
Opportunity to identify inconsistencies between S and O
Opportunities to draw conclusions between S and O - Synthesis
Analysis of goals and hence plans for the patient
Progress in therapy - Opinion
Rehabilitation potential for further intervention
A problem list/issues list can be described in functional terms and in priority order
Summary statements
Short term and Long term goal setting

P PLAN

Frequency per day / week the patient will attend
The treatment modalities the patient will be offered
Location of treatment, if appropriate
Treatment progression outlined
Plans for further assessment or re-assessment
Plans for discharge
Patient and / or family education
Equipment needs and equipment to be ordered and / or supplied
Therapy and home assessment recommendations
Recommendations for other working with the patient
Referral to other services

Allied Health Documentation Standards – Frequency of documentation

Program	Initial Contact	Assessment	Frequency of Progress Notes	Discharge Summary Complete	External documentation sent
Emergency Department	Document on day of initial contact	Document outcome immediately after assessment / intervention	Outcome immediately after intervention	n/a	External referrals same day Information for on-going management if necessary/appropriate same day
Acute Inpatients	Document on day of initial contact	Day assessment completed	Outcome immediately after every intervention	Day of final intervention	External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge
Subacute Inpatients & Bed-based community care	Disciplines with a blanket referral. document initial contact within 1 working day of admission Disciplines requiring a referral document within 1 working day of referral	Day assessment completed	Progress note minimum of once per week, or when patient status changes	Day of final intervention	External referrals within 1 day of discharge Information for on-going management if necessary/appropriate within 1 day of discharge
Residential Services	Document on day of initial contact	Day assessment completed.	Progress note for every contact	Day of final intervention	Information for on-going management if necessary/appropriate within 5 working days of discharge
All ambulatory care	Initial needs identification/priority documented by therapist at triage	Day assessment completed	Progress note for every contact	Within 5 working days of final intervention	Information for on-going management if necessary/appropriate within 5 working days of discharge

Allied Health Discharge Documentation

Documentation of discharge event shall include the following mandatory elements:

S: Patient's response to readiness for discharge - inpatients
Subjective satisfaction with condition

O: Discharge destination - inpatients
Current status (physical / functional / cognitive / social)
Summary of intervention (can include equipment provided)
Detail of follow-up therapy / services arranged / referrals
Patient / carer instructions / education / home program arranged

Reference to previous documentation which covers these criteria is acceptable

A: Goals achieved
Reasons for goals not being achieved
Reasons for planned intervention incomplete

Reference to previous documentation which covers these criteria is acceptable

P: "Discharged from AH discipline"
Name / Signature / Pager

Discipline-Specific Examples of SOAP notes

These SOAP documentation guidelines cover the general headings and inclusions of documentation across the disciplines. Some inclusions may not be appropriate for every area, but the general headings should be covered.

Dietetics

S - Subjective

Includes any information that is reported by the patient or family. This may include client's perception of problems.

This could include areas such as:

Appetite
Nausea
Abdominal comfort
Bowel habits
Reported weight history (can be included in the Objective section with other anthropometric information for consistency)
Reported past treatment

O Objective information

Objective information, such as relevant history, clinical findings and measurements.

For example:

Anthropometry
- Actual weight
- Weight history (obtained from previous admissions)
- Measured height (or estimated from knee height or arm span)
- Body Mass Index
- Health Weight Range

Bowel Chart Information
Fluid Balance Chart totals
- Total intake
- Urine output

Biochemistry
Dentition
Diet history (although this does not need to be written in the record)
Documented past treatment
Current treatment / recommendations by other health professionals

A - Assessment / Analysis

Your assessment of the patient and the information recorded in the Subjective and Objective sections.

Including:

Estimated nutritional requirements
Summary of diet history information
Analysis of a food and fluid chart and its comparison to the patient's requirements
Comments about the objective information
- what the biochemistry indicates
- weight change, comparison to healthy weight range
- whether or not the FBC indicates adequate fluid intake
- comment about bowel function

Overall assessment summary

P - Plan/Management Recommendations

In this section you document what the patient requires / what you plan to do.
This section will include:

- goals and therapy foci (usually written on the Rehabilitation Care Plan)
- type of diet
- nutritional supplements
- enteral nutrition regimen
- education planned and completed
- education material provided
- further education needs
- referral to other professionals / program
- follow up plan / discharge planning

Exercise Therapy

Following Initial Assessment

S – Subjective

Any information reported to the therapist by the patient, patient's family, carers, or from the medical, nursing staff or other allied health team.

This should include:

- Any new issues or concerns
- How the client recovered after initial assessment or previous treatment session
- Patients perceptions of progress and therapy
- How the patient feels eg. Pain, anxiety, depression etc.

O – Objective:

Objective information includes information that is observable and is measurable and reproducible.

This information may include:

- Clinical Observations
  - BP, HR, SPO2
  - Posture
  - Gait
  - General (i.e. pale, unwell, anxious)
- Treatment provided
  - List exercises if program start or if exercises have been added, removed or modified.
  - Refer to exercise card if no changes
  - Specific cueing or feedback required
  - Feedback from patients during session (ie pain during exercise)
  - Description of home exercise program (HEP) if applicable

A – Assessment / Analysis:

The assessment or analysis of the patient in your clinical judgement based on the subjective and objective information. No new information should be included here.

This section should include the following:

- The Problem List:
  - a summary of the patient's major problems
- Progress made
- Goals
- How patient tolerated treatment session and current status

On Discharge:

- Summary of whether the problems listed prior have been resolved
  - Indicates which short and long term goals have been achieved and which ones are yet to be achieved.

P – Plan

Should include:

- Treatment plan including frequency per day/week patient will be seen.
- Any planned exercise changes/progressions.
- Treatment patient will receive including potential modifications of treatment.
- Frequency of home exercise program (HEP) if applicable.
- Instruction/advice given to the patient and family/carers.
- Plans for discharge, including estimated time frame, destination, and any follow up EP sessions.
- Referrals made to other services and reasons why you have referred the patient to these services.

Occupational Therapy

Title of Entry:
This may include reason for referral, when referral was received, and sender's details. The primary diagnosis may also be included in the title.

Examples: Initial
Contact Initial
Assessment
Home Assessment
Phone Call to Equipment Supplier
OT Discharge Summary

S - Subjective

Any information reported by the patient and/or family.
This could include:

Patient's stated perception of progress and therapy
Patient's report of the way they are feeling e.g. pain, depression
Goals expressed by patient
Information provided about

- previous level of function in personal, domestic and community ADL
- perceived problems with return home
- details of home environment and previous home modifications
- previous leisure/work activities
- services used to assist with ADL tasks

Reference to IDA if information documented in IDA

O - Objective

Objective information including information that can be observed and is generally considered beyond dispute.

Relevant history/information obtained from UR/previous OT intervention
Your clinical observations

- Functional status in mobility/transfers, PADL, DADL, CADL including tasks able/unable to do, level of assistance, required aids/equipment used and position in which task undertaken
- Cognitive deficits observed in functional tasks
- Results of cognitive, physical and sensory assessments eg. ROM, strength, patterns of sensory loss
- Orientation
- Ability to learn new techniques and strategies, level of memory loss, dyspraxia etc.

Reference to IDA if information documented there
Type of treatment undertaken/no. of times completed
Education given

A - Assessment

Clinical reasoning about patient's condition and situation
Opportunity to comment on:

1. Progress and improvements
2. Likely prognosis/potential to achieve goals
3. Major deficits/abilities impacting on progress
4. Inconsistencies between what you observe and the patient reports

Summarise functional status
Short term and long term goals

P- Plan

- Intervention planned – new and ongoing and duration if known
- Reference to IDA goal sheet if appropriate
- Plans for discharge including destination
- Plans for further assessment/reassessment – ongoing OT involvement post discharge
- Education/liaison planned with other team members/family/patient
- Referrals to be made to other agencies

Physiotherapy

S – Subjective

Any information reported to the therapist by the patient, patient's family, carers, or from the medical, nursing staff or other allied health team.

This should include:

- Patients goals
- Patients complaints/issues
- Patients perceptions of progress and therapy
- How the patient feels eg. Pain, anxiety, depression etc.

On Initial Assessment Subjective should also include:

- Reference made to the interdisciplinary assessment form if applicable.
- History of Presenting Condition (HOPC)
- Past History (PHx)
  - Medical
  - Therapeutic
- Social History (SHX)
  - Home environment
  - Previous mobility
  - Previous level of functioning eg. ADL's, assistance from services/family etc.
  - Family/Social supports

On Discharge the Subjective should include:

- Summary of patients response to therapy
- Summary of patients complaints
- How the patient feels about their discharge destination eg. Whether they feel ready for rehabilitation or discharge home.

O – Objective:

Objective information includes information that is observable and is measurable and reproducible.

This information may include:

- Clinical Observations
  - Nursing observation chart
  - Patient position and any lines/drains etc
  - Auscultation
  - Cough – strength, productivity, colour of sputum
  - Oxygen saturation and level of oxygen therapy if applicable
  - Joint ROM – goniometry
  - Muscle strength – 0-5 Scale and/or dynamometry
  - Muscle tone
  - Sensation
  - Neurological Assessment
  - Balance Assessment
  - Valid and Reliable Assessment tools and questionnaires
    Eg. MAS, Oswestry Questionnaire, Neck disability questionnaire, WOMAC, Berg balance Scale etc.

- Mobility – observation of quality, distances, level of assistance required, gait aid used, and timed measures if possible.
- Transfers – observation of quality, level of assistance required, equipment used, etc.
- Medical Investigations undertaken eg. X-ray, US, MRI, CT, ABGs, LFTs, Pathology, etc.

- Treatment:
  - Exercises / Intervention
  - Rate
  - Intensity
  - Positions used
  - Modifications required
  - Education/Advice given
- Response to Treatment

On Initial Assessment
- Reference to an inter-disciplinary assessment form may be applicable

On Discharge:
- Summary of patient's status on discharge.

A – Assessment/Analysis:

The assessment or analysis of the patient in your professional judgement

This section should include the following:
- The Problem List:
  - a summary of the patient's major problems

- Long Term Goals:
  - State the expected long term goals of therapy
  - Should be based on the problem list
    (Reference to interdisciplinary Goals sheet as required)

- Short term goals:
  - Steps to achieving long term goals
  - Are based on long term goals
    (Reference to interdisciplinary Goals sheet as required)

- Impressions or summary:
  - The physiotherapy diagnosis
  - Justification of goals and treatment plan
  - Clarification of major problems
  - Discussion on patients progress (or lack of)
  - Discussion of patients rehabilitation potential and why
  - Suggestions of further therapy, and referrals needed.

On Discharge:
- Summary of whether the problems listed prior have been resolved
- Indicates which short and long term goals have been achieved and which ones are yet to be achieved.

P – Plan

Should include:

- Intervention planned
  - Frequency per day/week patient will be seen.
  - Treatment patient will receive including potential progressions of therapy.
- Description of home exercise program (HEP) if applicable
- Instruction/advice given to the patient and family/carers.
- Any equipment needs of the patient for purchase/hire.
- Plans for discharge, including estimated timeframe, destination, and physiotherapy follow up if applicable.
- Referrals made to other services and reasons why you have referred the patient to these services.

On Discharge the plan should include a brief summary of:

- What the treatment was given to the patient.
- Instruction of home exercise program, and patients level of independence with HEP
- Any instructions/education to family/patient.
- Any referrals made on discharge.
- Patients discharge destination.
- Reason for discharge
- Recommendations for follow up treatment or care given to the patient.

Signed, (Designation and pager or ext. number)

Podiatry

S - Subjective

The patient's complaint(s)
Symptoms of fever sweats or shakes
Information in regards to pain (where applicable):

- When the pain started.
- The level of activity (intensity, duration) the patient was undertaking at the time
- Type of pain (sharp, shooting, deep aching)
- The time at which the pain is worst.

The patient's perception of progress and therapy
The goals the patient wants to achieve
Patients' level of reported activity
A change in a patient's overall health and/or Pharmacological intervention (presentation to other health professionals, antibiotic/pain medication usage, imaging)..
Response to treatment

O - Objective

Relevant history including vascular, neurological, dermatological and biomechanical status.
Results of measurements (eg Doppler, Ankle Brachial indices, Wound measurements, RCSP)
Clinical observations

- Functional status
- Foot health status
- Palpated pain
- Signs and symptoms of decreased circulation (e.g colour, temperature, dependent rubor)
- Skin Integrity
- Presence of inflammation/infection
- Presence of dermatological lesions
- Hygiene.
- Condition, style and fit of footwear.
- ROM of lower limb and foot joints
- Wear patterns on footwear

Treatment undertaken
Education given (e.g First aid, washing, drying, footcare, footwear)

A - Assessment

Your professional judgement about patient
Opportunity to comment on and draw conclusions between:
Progress
Likely prognosis/potential
Inconsistencies between what you observe and the patient reports
Clinical risk status
Overall assessment summary

P - Plan

Intervention planned - new and ongoing and duration if known. Include return period
Short and long term goals
Plans for discharge
Education/liaison with other health care professionals/team members/ family/ patient
Referrals to other services/agencies
Reference to IDA goal sheet if appropriate

Prosthetics and Orthotics (P&O)

S – Subjective

This section includes any information that is reported by the patient, family, carers, or from the medical, nursing staff or other allied health team. This includes client's perception of problems (therapist may use anatomical terms in documentation). This is typically any information that you hear.

This should include:

- Patients goals
- Patients complaints/issues
- Patients perceptions of progress, gait function, prosthetic problems, orthotic problems
- How the patient feels eg. Pain, anxiety, depression etc.

On Initial Assessment Subjective should also include:

- History of Presenting Condition
- Past History (PHx)
  - Medical
  - Therapeutic
- Social History (SHX)
  - Home environment
  - Previous mobility, level of functioning
  - Family/Social supports

O - Objective

This section includes any information, which can be observed and is measurable and reproducible. This is typically any information that you see.

Information may include:

Clinical observations

- Patient position and any lines/drains etc (for inpatient)
- Skin condition / Residual limb condition
- Information re prosthesis/orthosis (description)
- Fit of existing orthosis / prosthesis
- Gait Observations
- Physical measurements, joint ROM (goniometry), muscle strength (0-5 scale), muscle tone, sensation,
- Valid and Reliable Assessment tools and questionnaires

Intervention provided:

- Modifications made,
- supply of product,
- cast taken,
- education provided etc.

Response to Treatment

A - Assessment / Analysis

This section contains the therapists' analysis and assessment of all the above information. Include conclusions made from the subjective and objective information?

This may include:
Impressions or summary:

- The diagnosis of condition diagnosis of problem
- Interpretation of gait analysis
- Justification of goals and treatment plan
- Clarification of major problems
- Discussion on patients progress (or lack of)
- Discussion of patients rehabilitation potential and why
- Suggestions of further treatment, and referrals needed.
- possible functional outcomes best treatment intervention
- short term goals
- long term goals

P - Plan / Management Recommendations

This section includes future tasks and actions to achieve these tasks.

This may include:

- future tasks
- prosthesis/orthosis to be provided
- when you plan to provide the prosthesis/orthosis
- correspondence to be completed
- funding to be arranged
- review date
- invoicing status
- next planned appointment
- education action
- referral to other services

Signed, (Designation and pager or ext. number)

Psychology

S - Subjective

Patients' description of

A) Presenting problem/s
   - Course
   - Onset
   - Duration
   - Frequency
   - Severity or Impact- (Interference and distress)
   - Precipitants, maintaining and protective factors

B) Goals- Immediate, intermediate and long-term.

C) Patient identified barriers to Goals

D) Established coping skills/resources

E) Responses to previous treatment/ assessment

F) Expectations of and attitude to current situation and to treatment/assessment

O - Objective

A) Clinician's observations of
   - Client's appearance/communication skills
   - Client's affect
   - Client's behaviour
   - Client's cognition

B) Results of assessment
   - Self-monitoring
   - Structured interviews (i.e. MSE/ADIS/SAWI)
   - Structured questionnaires
     - Mood- (BDI, POMS)
     - Behaviour (DEX, CBCL)
     - Personality (MMPI-2)
     - Health Status (GHQ/QOLI)
   - Cognitive assessments
     - Tests undertaken/results

C) Description of interventions and response to previous interventions

A – Assessment / Analysis

A) Diagnosis- using DSM 5, stating severity where appropriate and providing information about differential diagnoses where relevant.

B) Aetiology- Behavioural analysis of presenting problem
   - Identification of behaviours to be treated
   - Factors maintaining and precipitating problem behaviours
     - Long-standing
     - Medium-term
     - Immediate

C) Management
   - Further assessment
   - Immediate management strategies

Long-term management strategies
(Individual/supportive/systemic/ environmental)

D) Prognosis
Onset and course– acute v. chronic, persistent v intermittent
Previous responses to treatment/compliance
Predominant coping skills
Current level of adjustment/self-efficacy
Current social supports
Current levels of motivation
Availability of appropriate resources and services, internally and externally.

P - Plan

A) Immediate treatment: What, Who with, How, When, How long and Where
B) Further assessment/review
C) Where indicated, provide recommendations about working with patient and what may support their overall health outcomes
C) Referral on

Social Work

S - Subjective

Information gathered from the patient/carer about patient's history, complaints, home situation and goals for therapy. In situations where the patient does not have the capacity to give a reasonable overview of circumstances the carer/family can provide a subjective overview. Client's permission should be obtained where possible giving permission of contact with family/carer. This could include areas such as stated:

Perception of the home situation
Perception of problem/issues
Perception of their current emotional status/coping issues
Perception of how therapy/treatment is going
Perception of issues affecting discharge
Perception of other issues affecting them
Requests by patient for assistance
Patient and/or family's stated goals and desired outcomes
Family/carers' stated perception of issues and needed supports

O - Objective information (factual information)

Information gathered from the medical record, other professionals, family members.

This could include areas such as:

What is known about the home situation (factual not subjective)
Observations from which emotional status may be inferred and patient observed actions
Knowledge from the social worker about current status, issues and needs.
Knowledge of person's previous coping skills
Knowledge from the team about prognosis, progress and discharge plans
External services involved with patient and the frequency
Other supports both formal and informal

A – Assessment / Analysis

Your assessment of the patient is the utilization of the information in the subjective and objective area. This could include areas such as:

Any similarities and differences between subjective and objective
Any conclusions drawn
Your professional opinion on issues
Analysis of issues/goals
Analysis of how patient will cope on discharge given information provided in subjective and objective
Analysis of how issues will affect discharge planning
Analysis of current identified needs; ie family conference; current gaps etc.
Analysis of any counselling or work with patient given by social worker and its effectiveness/further work needed/barriers to comprehension, insight or acceptance.
A professional opinion drawn from analysis of objective and subjective
Information that evaluates patients' ability to implement recommended intervention plan.

P - Plan

This is your proposed intervention plan. This should consider indicators for intervention that will meet the patient's needs around the current admission and planned discharge:

- Recommendation of proposed intervention-services or supports required
- Continue to support the patient and family
- Date of next review or planned contact with patient and/or family/carer
- Planned review with other members of the treatment team
- Planned referrals of patient to other services
- Date/time referred workers plan to see patient
- Follow up with other professionals
- Follow up with family
- Develop discharge plan
- Provide education to patient and/or family
- Follow up after discharge

Speech Pathology

Initial assessment only – 1 line - reason for referral / history of presenting condition

S - Subjective

Information that is reported by the patient, family or others (carers, health care professionals etc) including the client's perception of the problems. This could include areas such as:

- Swallowing
- Eating
- Communication
- Cognition
- History of communication, swallowing and / or cognitive difficulties
- Relevant medical and developmental history
- Impact of communication, swallowing and / or cognitive difficulties on function
- Past Speech Pathology management
- Motivation for therapy
- Other agencies involved

O - Objective

Presentation, general observations

Clinical findings and measurements – Tests you have utilised and scores/measures derived must be documented.

The following assessment items may be commented on:

18yrs+

- Receptive Language (verbal, written)
- Expressive Language (verbal, written)
- Cranial Nerve Function
- Cognition
- Motor speech
- Swallowing
- Voice
- Pragmatics
- Fluency

0-18yrs

- Feeding, swallowing, saliva control
- Speech (Articulation, Phonology
- Receptive Language
- Expressive Language
- Literacy (reading, writing, spelling, phonological awareness)
- Voice
- Fluency
- Pragmatics

Nature and outcome of therapy is also documented here.

A - Assessment /Analysis

This section includes your overall summary and interpretation of subjective and objective information. You must state the level of impairment, disability and handicap and include severity levels for these such as mild, moderate and severe.

You may make comparisons with test results from other areas in your analysis here such as chest X-ray results, CT results, Apgar scores

This section will include:

- Goals and therapy foci
- Estimate length of treatment program and frequency of treatment

P - Plan / Management Recommendations

In this section you document what the patient requires/what you plan to do.

This section may include:

- Diet recommendations
- Communication, swallowing, and cognition recommendations and strategies
- Provision of information and education

On referrals eg. To Dietetics, Psychology, ENT, Paediatrician etc