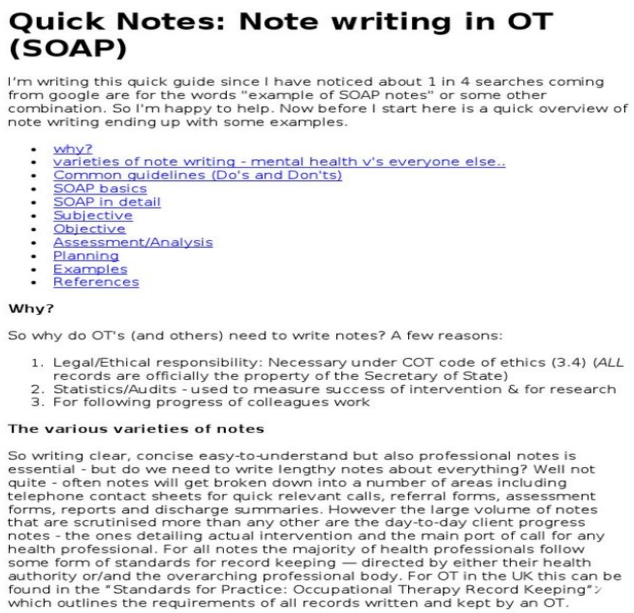
Documentation Manual for Writing SOAP Notes in Occupational Therapy 2ND EDITION



Quick Notes: Note writing in OT (SOAP)

I'm writing this quick guide since I have noticed about 1 in 4 searches coming from google are for the words "example of SOAP notes" or some other combination. So I'm happy to help. Now before I start here is a quick overview of note writing ending up with some examples.

- why?
- varieties of note writing - mental health v's everyone else..
- Common guidelines (Do's and Don'ts)
- SOAP basics
- SOAP in detail
- Subjective
- Objective
- Assessment/Analysis
- Planning
- Examples
- References

Why?

So why do OT's (and others) need to write notes? A few reasons:

1. Legal/Ethical responsibility: Necessary under COT code of ethics (3.4) (*ALL* records are officially the property of the Secretary of State)
2. Statistics/Audits - used to measure success of intervention & for research
3. For following progress of colleagues work

The various varieties of notes

So writing clear, concise easy-to-understand but also professional notes is essential - but do we need to write lengthy notes about everything? Well not quite - often notes will get broken down into a number of areas including telephone contact sheets for quick relevant calls, referral forms, assessment forms, reports and discharge summaries. However the large volume of notes that are scrutinised more than any other are the day-to-day client progress notes - the ones detailing actual intervention and the main port of call for any health professional. For all notes the majority of health professionals follow some form of standards for record keeping — directed by either their health authority or/and the overarching professional body. For OT in the UK this can be found in the "Standards for Practice: Occupational Therapy Record Keeping", which outlines the requirements of all records written and kept by an OT.

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