Long-Term Care Survey Alert

Care Planning: Clean Up Your Documentation With The SOAP Approach

Zero in on a problem's status... fast

Using a SOAP approach for documentation can help your facility keep an organized medical record where a reader can easily see how the interdisciplinary care staff are assessing and managing a resident's identified problems.

How does it work? Using a numbered problem list, nursing staff documents the status of each problem by following the SOAP acronym, which is as follows:

Subjective data that you use to record what the resident or family member communicates about a problem or issue. This can include nonverbal communication -- for example, the resident who shows signs of pain through his body language.

Objective data (what you see, touch, hear smell, measure, etc.). The more objective the data, the better. For instance, if the therapist uses a SOAP format for the weekly progress note, document how the resident is responding to therapy interventions based on objective tests, says **Pauline Franko, PT**, a consultant in Tamarac, FL. If the resident were receiving occupational therapy, for example, the tests might include range of motion, muscle strength, gait improvement, or grip strength.

Assessment or analysis of the data. "The SOAP method forces you to do some critical thinking [because] you have to analyze the information gathered," observes **Joy Morrow, RN, PhD**, a consultant with **Hansen, Hunter & Co**., Beaverton, OR.

Plan to address the problem.

As a problem resolves, cross it off and add new ones as they evolve," says **Carol Job**, a consultant with **Myers & Stauffer** in Kansas City, KS, and board chair for the **American Association of Nurse Assessment Coordinators**. "By using that approach, everyone can quickly see what a resident's active problems are, what's resolved, what's new."