PROBLEM ORIENTED PROGRESS NOTES FOR SOAPS

Problem oriented progress notes include four components:

S - subjective information
O - objective information
A - analysis (assessment) of objective information
P - plan

BEGINNING OF TREATMENT SOAP NOTE(S) (i.e., re: initial testing and/or baseline testing)

Your initial SOAP note will provide (S) subjective impressions, (O) initial assessment information and/or baseline information (A) analysis of your initial information that leads to your (P) plan for treatment.

Subjective (S) = The family or client's subjective judgment of the problem; information re; client or family's attitude (if available or relevant) ; statement about client behavior if it might have positive or negative effect on assessment/testing/intervention.

Objective (O) = the initial assessment information or baseline data for on-going objectives. Example:

Mean Length of Utterance (MLU) = 1.43. One word declarative statements composed 75% of the 100 utterance sample. In the remaining 25 utterances, the following semantic relations were present. Nomination - 15%; Recurrence - 50%...(etc.)
Baseline of J's use of /s/ in initial and final position in words in spontaneous speech:
Initial: 16/20 opportunities (70%)
Final: 10/20 opportunities (50%)

Assessment (A) = an analysis and /or comparison (to previous semester performance) of the objective information. Example:

J. exhibits a severe delay in semantic/syntactic skills (word and sentence use.) At her age one would expect her to be using sentences of greater length and complexity (a Mean Length of Utterance of 3.5). Last semester goals addressed the use of /s/ in initial position in words. Today's testing indicated that J. is now using /s/ in word-final position in spontaneous speech, though not at mastery level. Some generalization to the use of /s/ in word-initial position also occurred, which is a significant improvement over last semester.

Plan (P) = recommendations to continue assessment if not completed or outlines the intervention plan. Justify therapy needs based on (O) and (A) information. Indicate frequency and duration of therapy. State long term goals and at least the first short-term objective for the term. Long Term Goals = semester goals; Short Term Objectives = steps to reach the goals. Example:
J. needs to improve functional use of his communication board to enable him to effectively convey needs, problems, thoughts. Therefore, therapy is recommended for 2x/wk for 60 minutes. Long Term Goals (LTG) and Short Term Objectives (STO) are as follows:

LTG#1: J. will use his communication board 5x spontaneously to make requests/comments within 4 functional activities, over 3 therapy sessions each.
STO1a: J. will use his communication board independently, following clinician modeling/demonstration and question (eg., What do you want?) within activity, 5x over 2 sessions.

Because S. is demonstrating a severe delay in language and speech production skills therapy is recommended for 2x/wk. , 30 min./session. Long Term Goals (LTG) and Short Term Objectives (STO) are as follows:
LTG #1: S. will use the following - 2-term semantic relations: recurrence, actions, object and agent, spontaneously, 5x each over 4 sessions.

STO1a: S. will use the following 2-term semantic relations: recurrence, actions, object and agent , following clinician modeling during play, 5x each over 4 sessions.

LTG #2: S. will use most final consonant sounds spontaneously in conversational speech.

STO2a: S. will produce final sounds /m,p,f,d/ in nonsense syllables, following clinician model, 90 % of 20 consecutive trials for each sound.

ON-GOING SOAP NOTES:

Subjective (S) data: Same as above. List subjective impressions of the client and client behavior regarding the goals and objectives. This may include your feelings and impressions or parents or client's feelings with respect to the problem. Also include client/family reports of relevant information. Generally this will consist of information which may account for unexpected changes, either negative or positive, in your (O) data. Examples:

" J. was very quiet today. Mother reports that J. did not sleep well last night. Or, Mother reports a 'big increase' in J's use of her communication board."

Objective (O) data: This section includes baseline data (for the step you are on) plus progress on your objectives. List the STO, written in behavioral, objective terms. This means that anyone could examine the measures and come up with the same information. This may include percentages, numbers, amount of time engaged in particular behavior, etc. No interpretation of the data is necessary - rather, just report the results. You will do analysis in the next section (A). Write your data in a chart format. Date your baseline info. in your chart. This way it will be clear when you have changed STO's (and hence have a new baseline for the new step.)

Long Term Goal numbers and Short Term Objective numbers should correspond. For example: STO 1a = the first step, STO 1b will be your second step, for LTG #1. **Be sure these correspond to lesson plan numbers and stay the same across soap notes.**

EXAMPLES:

STO1a: S will produce /s/ in final position in single syllable words independently, given picture and object stimuli, 90% of the time over 2 consec. sess.	Baseline 9/2/97: 4/100 (40%)	9/4/97 60/100 (60%)	9/9/97 65/100 (65%)	
STO2a: To improve phonological awareness, S. will mark syllables in 3 syllable words by clapping hands, following clin. model, 19/20 consec. trials		Baseline 9/4/97: 17/20	9/9/97 20/20	

Analysis/assessment (A): This is where you interpret your (O) as well as your (S) data. Note if child:

1.) Made progress on his goal or objective

2.) Performance was similar to previous session(s)

2a.) If performance has been unchanged over multiple sessions you need to discuss and indicate if a change in program is needed. (E.g., branch step, change in materials, etc.) Note the specific change in (P) plan section.

OR 3.) Performance decreased

3a.) If performance decreased note possible reason (e.g., from (S), child was tired) and/ or if program

change is needed (put specific change in (P) section.)

DO NOT RESTATE DATA IN (A). (E.g., **do not** say "S. increased her performance on production of /s/ from 60% to 65%" - this info. is already in your soap note and does not need repeating.Examples:

"J.'s progress on his /s/ production objective suggests he is beginning to master this skill. The addition of a visual cue to the lips has improved S.'s ability to produce the /b/ sound. T.'s behavior in therapy (based on reports in S) may be the reason for the decrease in correct responses this session."

DO NOT DESCRIBE YOUR SESSION IN THE (A) SECTION

This is also the place where you will indicate a need to make changes in treatment goals. For example, if you had been working on establishing an SVO syntactic structure on which the child had achieved productivity as indicated in the O data, you might have the following statement: "As productivity has been achieved on SVO, this structure will no longer be the main focus of treatment." A new goal will be addressed. Note that you will not specify what the new treatment goal will be; that information belongs in the plan. Other examples:

"W continues to make gains in therapy. He is using his picture communication board regularly to make comments during therapy and his mother reports at home as well. He is now able to produce a variety of initial sounds in word approximations and he will use his repertoire of sounds in conjunction with his comm. board to communicate basic needs and thoughts. Crying has decreased in therapy and at home."

NOTE:
All goals need to be discussed but they can be grouped for discussion. E.g., S. made progress on her production of /s/ and on her ability to mark syllables in words, indicating she is beginning to master these skills. Or, S.'s performance on most of her objectives today decreased, with the exception of /s/ production. This goal was addressed in the first activity and after that she was less willing to attempt activities. The decrease in performance may be due to fatigue, as reported by Mrs. S. (see S section above.)

Plan (P): This is where you identify your plan (goals and objectives); indicate whether to continue/discontinue treatment; indicate why therapy should be continued that you will be continuing with the goals and objectives as planned (you do not need to restate LTG/STO's. If appropriate indicate modifications, e.g., new LTG or STO.

Examples:

"J. is continuing to demonstrate progress indicating that treatment is effective, therefore speech and language therapy will continue. Will continue with Long Term Goals and Short Term Objectives as planned. (Or) Because S. has met criteria for short term objective #1a, her new objective will be:"

STO 1b. S. will use the 2 - word phrases: recurrence+object/action and attribute+object; spontaneously, 5x each, over 4 sessions.

Plans for parent programs, consultation with other professionals, referrals would also be included under this section.

Please keep your Soap Notes as short as possible without compromising your information. Initial notes might be as long as 2 pages. Daily notes should be one page or less. (8/00)