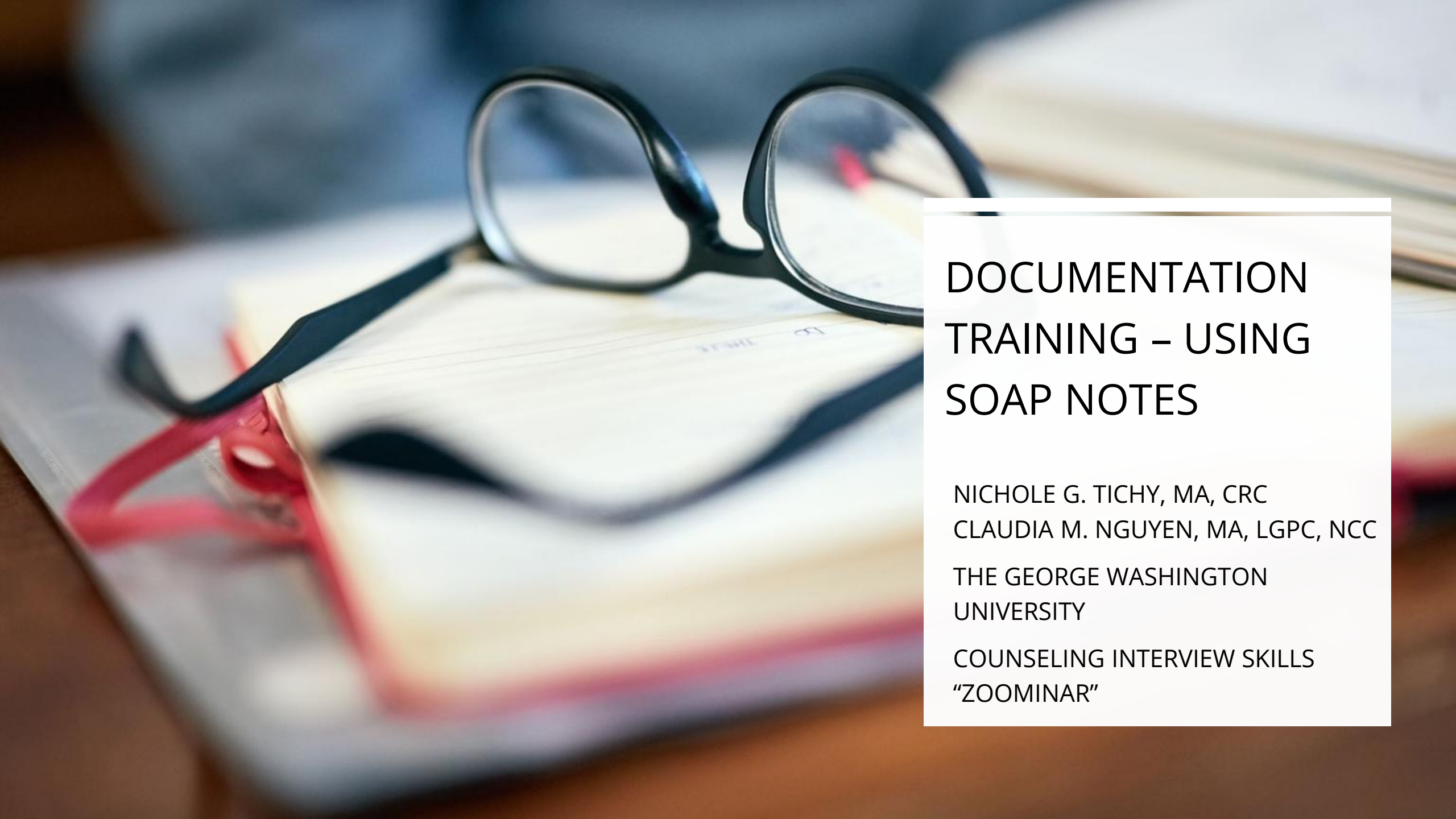

DOCUMENTATION TRAINING – USING SOAP NOTES

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COUNSELING INTERVIEW SKILLS "ZOOMINAR"

CLINICAL DOCUMENTATION – WHAT IS IT?

- The recording of work within the counseling relationship between the client and the counselor
  - Methods of documentation can be written, digital, audio, or visual
- Used to remember client details and track progress
- Demonstrates competency
- If it wasn't documented, then it didn't happen
- Use of thorough documentation aides in decision making for clinical, ethical, and legal options
  - Provides rationales for treatment options

DOCUMENTATION AND ETHICS

- CRC Code of Ethics
  - B.6.a – “Rehabilitation counselors include sufficient and timely documentation in the records of their clients to facilitate the delivery and continuity of needed services…make reasonable efforts to ensure that documentation in records accurately reflects progress and services provided to clients.
- ACA Code of Ethics
  - A.1.b. – “counselors create, safeguard, and maintain documentation necessary for rendering professional services…include sufficient and timely documentation to facilitate the delivery and continuity of services…take reasonable steps to ensure that documentation accurately reflects client progress and services provided.”

DOCUMENT FORMAT – SOAP NOTE

S – Subjective or Statements made by client

O – Objective or observations made during session

A – Assessment, those used during the session or those made by the clinician

P – Plan, what is the plan for the next session? Homework assigned? When is it scheduled?

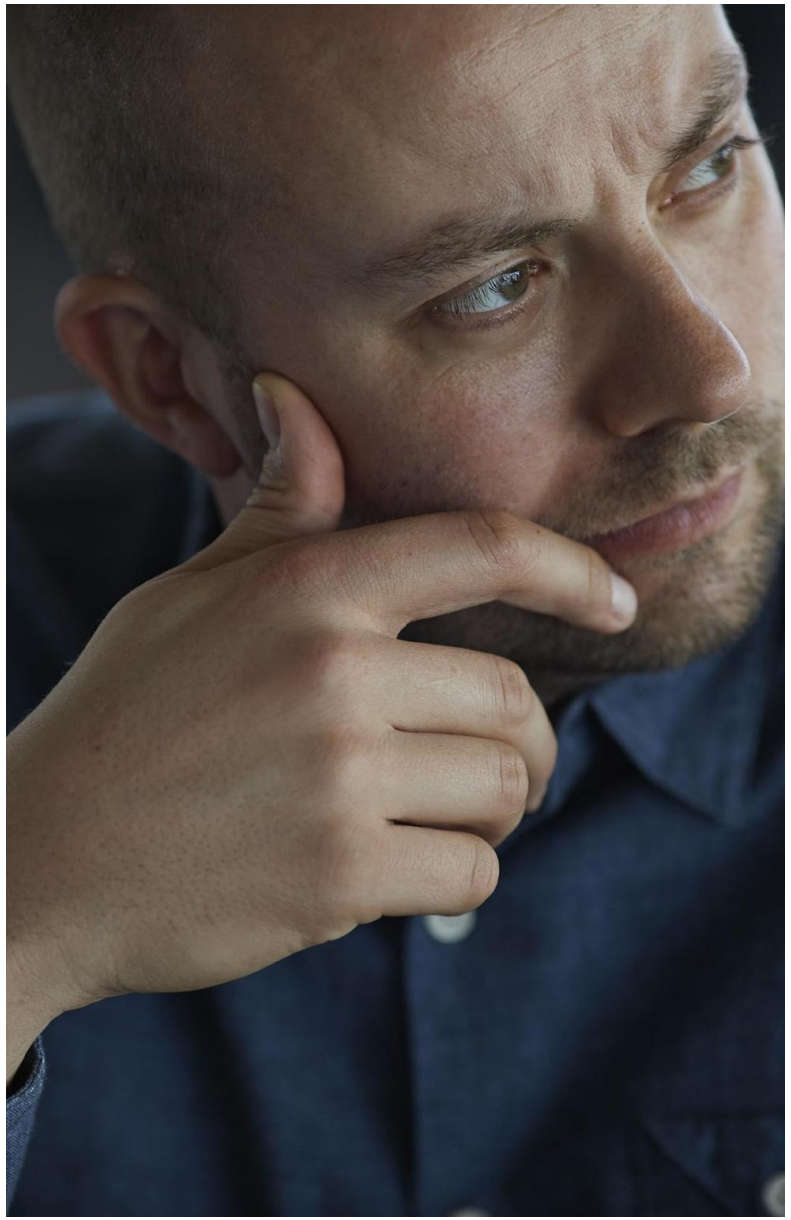
S – SUBJECTIVE/STATEMENTS

- Presentation of information regarding individuals presenting concerns
- In some medical/more clinical settings – recollection of history
- Counseling focuses on contents occurred within the session
  - In medical settings, mnemonics such as “old charts” (**O**nset, **L**ocation, **D**uration, **CH**aracter, **A**lleviating/**A**ggravating factors, **R**adiation, **T**emporal pattern, **S**everity)
- Use language such as “discussed,” ”talked about,” “client reported,”
- It is recommended to use direct quotes from session

S – SUBJECTIVE/STATEMENTS (2)

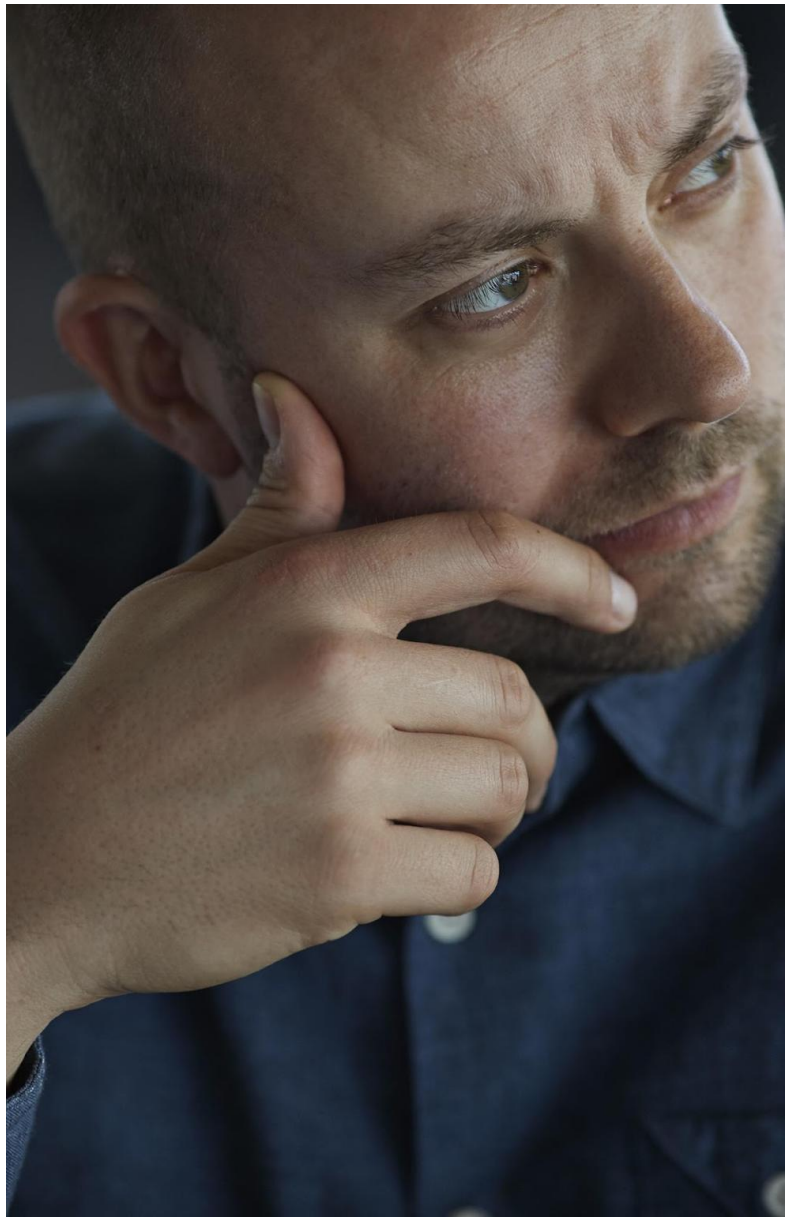
Case Example:

Ct reported feeling “super low” after learning that their employer is beginning to do cutbacks in their work department. Ct continued to describe their work history and explained “feeling on edge about having to job search again”. Ct also expressed concern about disappointing their family and friends.



O – OBJECTIVE/OBSERVATIONS

- Contains factual information
- Objective details include – diagnosis, vital signs/symptoms, client's appearance, orientation, behavior, mood and affect.
- Often good practice to note orientation of individual (x4 - person, place, time, and situation/environment).
- Information about risk/ evidence of substance use/abuse
- Present information about individuals' non-verbal communication
- Overall, how is the client presenting themselves?
  - How does this change over time?



O – OBJECTIVE/OBSERVATIONS (2)

Case Example:

Ct appeared appropriately dressed, aware, and responsive. Ct's speech grew rapid when discussing the potential loss of their job. Ct took long pauses between speaking when talking about their friends and family. Ct had inconsistent eye-contact throughout the session. Ct rhythmically and intensely wringed their hands for the majority of the session.

A - ASSESSMENT

- Document impressions and interpretation of information presented during session
  - How does it tie to previous sessions?
  - Conceptualize clients throughout sessions
- Record results of administered assessments
  - Briefly explain purpose of assessment and explanation of results
- What is YOUR (as the clinician or professional counselor) understanding of the individuals presenting concern
  - How does this session relate to previous sessions – beneficial for holistically understanding clients or tracking progress or patterns of behavior

A – ASSESSMENT (2)

Case Example:

Ct seemed to be distressed at the potential of losing their job and the impact the job loss may have on their relationships. Ct's fear seemed more noticeably fearful and nervous than past sessions involving anxiety-provoking events. Ct appeared to be more affected by the consequences of their employment and how they will be perceived.

P - PLAN

- Space to document intentions for next session
  - When is it scheduled?
  - Was the client assigned homework to complete?
  - Are there specific tasks that need follow – up (either by you or client) before next session
  - What are some of your goals for the next session
- The key component – ensure plan aligns with individual treatment plan or goals for counseling
- Great space in the overall note to keep track of thought process with client
  - Understanding where you want to go

P – PLAN (2)

Case Example:

Next session with ct in one week. Ct indicated feeling comfortable discussing the concern of job loss further, focusing more on understanding the fear of disappointing others. Ct also has homework to track moods on mood log 1x/day for the week.

OVERALL TIPS FOR NOTE WRITING

- Use clear language
- Produce/Submit notes in a timely manner – typically 24-48 hours, although immediately after is best
  - Consult agency policy
- Write notes as if you would need to defend its contents
  - Think – what if this was subpoenaed?
  - What if a supervisor/colleague had to take your place?
- Avoid naming other individuals (other than client)

TAKING TIME TO PRACTICE

Subjective

Client stated, “I didn’t sleep well last night and felt irritable all day.” We discussed his sleeping patterns and current stressors as possible reasons for lack of sleep.

Assessment

Client appeared unusually disheveled, exhibited anxiety and worry towards partner’s threat of abandonment and denial of autonomy

Objective

Client demonstrated orientation to time, place, and person. Individual actively participates in session demonstrated by positive responses and prompt replies.

PUTTING IT INTO PRACTICE

- Watch the video clip (scene from Grey's Anatomy)
  - Client focus: Dr. Miranda Bailey (she/her/hers)
- Create a SOAP note for the given acted scene
  - Provide details around Subjective and Objective data
  - Assert conceptualization or Assessment of client (Miranda)
  - Propose a plan as if you were working with this client