PTA DOCUMENTATION GUIDELINES
Writing SOP Notes

Abbreviations and Medical Terminology Use

- Appropriate abbreviations and use of medical terminology are expected. At present the QEII HSC does not have a list of accepted abbreviations available for staff use therefore it is best to check with the attending Physiotherapist if you have questions about using a specific short form or term.
- Complete and correct spelling of a word is necessary if not abbreviated.
- Full sentences are not necessary if the idea is complete and concise.

Example:

Possible
The pt. states pain in right shlder. began 3 wks. ago Wed.

Preferred
Pt. states onset of pain on (date).

Writing Subjective (S)

The subjective part of the note is the section which states the information received from the patient that is relevant to the patient's present condition.

Items Included Under Subjective

An item belongs under subjective if:

- The patient tells the therapist or assistant his or her **emotions or attitudes** (Example: "I'm really angry about…").
- The patient voices a **complaint.**
- The patient reports a **response to treatment** (Example: a decrease in pain intensity).

Use of Verbs

- S statements frequently contain a verb, which indicates that the statement is subjective and not taken from the chart.
- Verbs frequently used are *states, describes, denies, indicates, c/o.*

Use of the Word "Patient"

The S section of the note should be brief, concise and complete. The word "Patient" may be abbreviated to "Pt." After it's initial use, it does not need to be repeated in each sentence. It is assumed, unless otherwise stated, that the information in this section came from the patient.

Example:

Possible:
Pt. c/o pain in □ low back area. Pt. denies pain at rest. Pt. states is unable to work or perform most ADLs because pt. cannot sit >5 min due to pain.

Preferred:
Pt. c/o pain in □ low back area. States pain ↓'s with rest; is unable to work or perform most ADLs because cannot sit > 5 min. due to pain.

Quoting the Patient Verbatim

At times, quoting the patient is the most appropriate method of conveying subjective information. Some reasons for using direct quotes from the patient or a family member might be

- To illustrate **confusion or loss of memory**. (Example: Pt. frequently states, "My mother will make everything all right. I want my mother." The patient is 80 years old).
- To illustrate **denial.** (Example: Pt. states, "I don't need home health PT. I'll be fine once I'm in my own home." The patient is dependent in amb & lives alone.)
- To illustrate a patient's **attitude toward therapy**. (Example: Pt. stated, "I don't think any therapy can get rid of my pain.")
- To illustrate the patient's **use of abusive language**. (Example: Pt. stated to therapist, "Keep your __ hands off of me.")

Writing Objective (O)

The objective part of the note consists of objective observations and measurements. Testing procedures should be repeatable and comparable to previous notes.

Items Included Under Objective

An item belongs under objective if:

- It is an **objective measurement or observation** or a **part of the treatment** given to a patient such as, number of repetitions tolerated, pain relieved or caused. This documentation provides information to anyone who might treat the patient as to what was done in therapy on a certain date. It is also done to inform those who might read the medical record as a legal document of what specifically was done with the patient.
- It is a **patient education** activity (particularly specific exercises taught to the patient).
- It outlines the **patient reaction** to treatment.

Example:
O: Pt. Ambulated 40 meters in 5 min. period with a single cane indep.

Example:
O: Treatment given: Isometric hams & gluts, 10 reps x 3
QOR, 10 reps x 2
SLR, 10 reps x 3

Example:
O: Home exercise program reviewed. Pt indep. with exercises provided.

Further Examples:

Example:

O: Pt. received 30 min. of gait training. Responded well to verbal cues.

Example:

O: Treatment provided: US 1.0W/cm, 3 mhz pulsed x 5 min.
□ ant. shlder.

Organization

Information should be organized, easy to read, and easy to find.

Example:

Possible

O: Pt. tolerated exc. program well. Ambulating with crutches PWB □ LE x 6 meters SBA. Exercises completed include:
QOR, 10 reps x 3
SLR, 10 reps x 3
Education given re. gait – encouraging step through instead of step to pattern.

Preferred

O: Ambulating with crutches PWB □ LE x 6 meters SBA. Education given re. gait – encouraging step through instead of step to pattern. Exercises completed include:
QOR, 10 reps x 3
SLR, 10 reps x 3
Pt. tolerated exc. program well.

When the Patient Status has Not Changed

When writing a **progress note** for the patient whose status is unchanged the present status should be outlined.

Example:

Possible

O: Transfer: Unchanged from last treatment session.

Preferred

O: Transfer: Requires mod + 1 assist Supine ↔ sit.

Use of the Word "Appears"

If something cannot be stated in measurable terms, the word ***appears*** instead of ***is*** should be used.

Example:

O: □ knee ROM not measured on this date but appears functional for transfers w/c ↔ mat.

The term ***appears*** should be used cautiously; third party payers will not provide reimbursement for intervention that "appears" to be needed.

Common Mistakes in Recording Objective Data

Some of the most common mistakes in recording objective data are

1. Failure to state the affected part
2. Failure to put things in measurable terms

Objective Measures and Observations for Use in
Recording Objective Data

May include but not limited to the following:

Edema: Circumferential measurements
Pitting

Endurance: Vital signs (BP, respirations, pulse) before treatment, after treatment, and recovery times
Signs of fatigue
Activity (describe) and amount of activity tolerated (time)
Perceived exertion scale
Walking test, amb. profile (using a form or data base sheet)

Gait analysis:
Always include: Type & amount of assistance
Equipment needed
WB status
Distance
Include as necessary:
Time
Type of surface (level, rough, inclines, stairs, 1-step elevation)
Gait pattern/deviations

General appearance: Atrophy
Skin condition

Method of transport to PT: Cart/stretcher
W/C
Assistive device
Assistance necessary

Muscle tone: Increased or decreased tone and where
Normal, hypotonic, hypertonic, spasticity, rigidity

Posture: Sitting, standing, supine, prone
Pulse: Beats/minute

Respiration: Side/position
Area
Minutes

ROM: Active or passive or active assisted
Degrees (using goniometer)

Sensation: Absent, intact
Temperature

Skin/wounds: Size
Color/ appearance (pink/ red, purplish)
Drainage (green, none)
Odor (none, moderate, foul)
Location

Transfer ability: Type and amount of assistance
Type of transfer
Equipment needed

Recording Treatment

Here are some things to consider and include when recording the patient's treatment.

Modalities:
Which modality
Where
How long
Intensity, frequency
What position
Examples:
US: W/cm, time, where, position, reaction
Electrical stimulation: Type of current, type of contraction, where, time, position

Ambulation:
Distance
Level of assistance
Assistive device(s)
Ambulatory aid(s)
Time
Wt. Bearing status
Type of gait pattern

Exercise:
Extremity or trunk
Position of patient
Types – active assisted, active, resisted
Repetition - number
Resistance or wgt. used
Equipment used

Writing Plan (P)

The plan portion of the note contains the plan for the patient's treatment. This differs from the situation of describing the treatment and reaction to treatment in the objective portion of the note.

Example:
O: Tolerated 10 reps each of quad sets & SLR
to □ LE; on 10th repetition of SLR pt's quadriceps were
fatigued & pt could no longer perform SLR.
P: Cont. with quad sets & SLR 3x /wk.

Items Included Under Plan

The following information may be included in the plan section of the note:

1. **Frequency** per day or per week that the patient will be seen
2. The **location** of the treatment (at bedside, in the department, in a pool).
3. The **treatment progression** as determined in conjunction with the Physiotherapist.

Example:
P: Will be seen 3x/wk. as an outpatient. Will receive pulsed US
to □ anterior shoulder at 1.5 W / cm^2 for 5 min. PTA to
discuss introduction of exc. with PT.

Example:
P: Daily PROM & AROM exercises to □ shoulder at bedside.
Exercises will be followed with an ice pack to □ shoulder for
15 min.

If there is no change in the treatment plan initiated by the Physiotherapist, the plan outline may be simplified.

Example:
P: Continue with established treatment plan.

Example:
P: Continue with present treatment.

Reference: Kettenbach, G: *Writing SOAP Notes 2nd.ed.* FA Davis, Philadelphia, PA, _____.