Writing Clinical Documents

Communication Sciences and Disorders
What are clinical documents?

- Reports that document what goes on in the clinical setting.
  - Diagnostic reports
  - Progress notes (SOAP notes)
  - Progress reports
  - Evaluation reports
Your audience for clinical documents

- Other speech pathologists
- Other audiologists
- Other health professionals
- Parents, caregivers
- Teachers, other educational professionals
- The client
- Insurance companies

- Other health professionals
  - Doctors, nurses, dentists
  - Other therapists (physical, occupational)
  - Psychologists
  - Social workers
General Guidelines

- How words work:
  - State facts -- good
  - Convey ideas -- maybe
  - Arouse emotions -- not for clinical documentation!
- Include all necessary information
- Be clear, concise, specific, objective
  - “Report what you observe, not what you think!”
- Focus on the client (Use the client’s name. Do not use first person; if you must refer to yourself, use third person)
Physical characteristics of Clinical Notes

- Brief
  - Not a narrative, even when chronological
- Describe client’s response to objectives
  - Report what happened, what client did
- Recommendations for the next session
  - Specific recs according to plan for client
- Follow proper format (varies according to task & organizational setting)
“Objective”:

1. The **TONE** you should use when writing clinical documents, free of all personal opinions
2. Another name for a **GOAL** that the client is attempting to achieve
3. The second **PART** of the SOAP note, where you record the data from the session
SOAP Notes

- Subjective
- Objective
- Assessment
- Plan
Subjective

- Any information about the client given to you by someone else that you cannot verify but has an impact on therapy
  - Ex: Mother reported A. missed 2 days of school during previous week.

- Your observations about the client’s behavior, attitude, and motivation during the session (BE OBJECTIVE!)
  - Ex: A. was cooperative during session and needed only 2 reminders to stay on task.
Objective

- Report the data (results) of the client’s therapy session.
- For each goal/objective attempted, report the results.
  - Ex: A completed an antonym exercise with 100% accuracy.
  - Ex: A identified source of sounds on “sounds in the world tape” with 55% accuracy.
Assessment

- Based on the data in the Objective section, evaluate the client’s performance.
- What has been mastered, and what will need additional practice?
  - A demonstrated progress in understanding word relationships.
  - A has not mastered identifying common sounds.
Plan

- Describe your plans for the next session.
- Describe strategies, suggestions, and any new goals.
- Use “client + target + criterion” format for goals (see next slide for example).
- In long SOAP notes, indicate frequency and duration of treatment.
Objective/Goal Format

Client + target + criterion

Who will do what to what with what % accuracy

A will close syllables on spontaneously produced monosyllabic target words on 90% of his attempts.
Well-written clinical documents

- Clear
- Comprehensive
- Accurate
- Complete
- Confidential
- Client-centered