
# Case Management Toolkit
# Skill Building Resources for SOAP Note Documentation

the Omni Family of Services

# Learning Objectives

- To present and clarify Omni's model of documentation of our case management activities
- To increase awareness in staff of the appropriate information to include in a client's record and to increase knowledge regarding the purpose of effective documentation
- To confirm Omni's commitment to continuously improve quality and outcomes

# Case Notes

*Case notes tell the story of your interactions with and on behalf of the clients. They document what has been accomplished and point the way to what still needs to be done.*

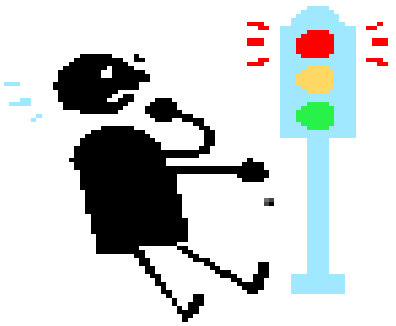
# Tips for Writing Good Case Notes

- Think about what you are going to write and formulate it before you begin
- Be sure you have the right client file!
- Use a simple and direct style; be thorough but concise
- Write/record notes within 24 hours
- Describe what you directly observed; use precise and descriptive terms
- Record as "late entry" anytime it doesn't fall in chronological order
- Think about how the client comes through on paper

- Describe what happened; keep use of client quotations to a minimum
- Use proper spelling, grammar, punctuation, and sentence structure; use spell checks
- Use respectful language and avoid slang
- Proofread
- Document all contacts or attempted contacts
- Relevant significant information ONLY

# Never Include:

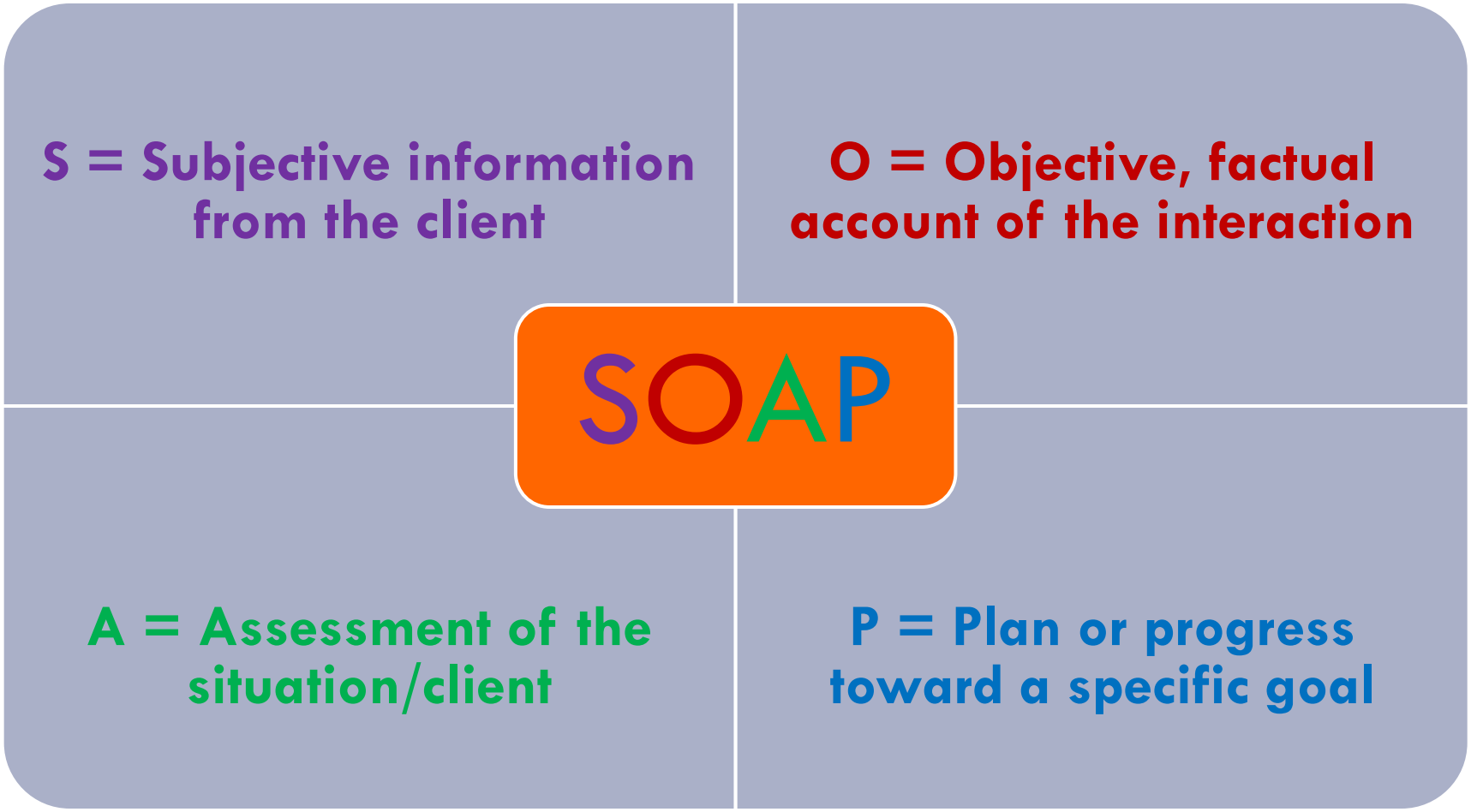
- Intimate or personal details that have no bearing on the client's needs or situation
- Gossip
- Venting of own frustration or other feelings
- Incriminating information to you or the agency
- Inappropriate entries such as your own personal view of religion, politics, etc.
- Derogatory statements about other professionals involved in the case



# Litmus Test for "Good" Documentation

- *If my client read the note, he/she would feel respected and would agree with my objective account of our interaction*
- *When I am unable to be present, a colleague can open the record and easily figure out the next step to help the client achieve their goals*

# Case Note Format



# S = Subjective Information from the client or pertinent others

- What the client tells you- In other words; what are they saying to you?
- His or her feelings and thoughts
- Concerns, issues, situations, problems
- The intensity of the problem(s) and its impact on significant relationships in the client's life
- His or her goals and plans
- What pertinent others (foster parents, teacher, birth family, etc.) tell you about the client

# O = Objective account of the interaction

- Factual information that can be seen, heard, smelled, counted, or measured
- What you personally observe/witness like general appearance, affect, behavior
- Key words include seemed, appeared, as evidenced by
- Client strengths and challenges or strengths and challenges as reported by pertinent others
- Avoid labels, personal judgments, value-laden language or opinionated statements; record observed behaviors and let others form their own opinion
- Can include outside written materials received, i.e., test results, materials from other agencies

# A =Assessment of the situation/client

- A summarization of your "clinical" impressions regarding the client's issues or problems
- A synthesis and analysis of the subjective and objective portion of the notes
- Issues that need to be further addressed
- Unhealthy patterns that need to be challenged
- Level of cooperation/insight/motivation
- How you would label the client's behavior and reasons for the behavior
- Effectiveness of treatment strategies (TFC, Life Book, trauma interventions)
- Client progress on treatment plans goals and objectives and setbacks

# P = Plan toward a specific goal

- Identification of the next step that you plan to take regarding the client
- Pinpoint the treatment direction and treatment interventions to be used (TFC, Life Book, trauma interventions)
- Identify the action plan to address issues noted in the A (assessment) section of the case note
- Document the date and time of the next session
- Identify any other referral activity that you will pursue; is a consultation needed?
- Identify any assigned homework
- Include the anticipated gains from the treatment interventions

# Sample Case Note 1: Subjective

- What the client tells you
- His or her feelings and thought
- Concerns, issues, situations, problems
- The intensity of the problem(s) and its impact on significant relationships in the client's life
- His or her goals and plans
- What pertinent others tell you about the client

***S = John came readily into the kitchen and indicated he had a great deal to talk about today. He identified that since my visit on Monday, he has completed all school homework assigned. He also attended his first anger management support group. He indicated he became more "down" as he listened to the group's discussion. He was disappointed that he just "passed" when it was his time to speak at the meeting.***

# Objective

- **Factual information that can be seen, heard, smelled, counted, or measured**
- **What you personally observe/witness like general appearance, affect, behavior**
- **Key words include seemed, appeared, as evidenced by**
- **Client strengths and challenges**
- **Avoid labels, personal judgments, value-laden language or opinionated statements; record observed behaviors and let others form their own opinion**
- **Can include outside written materials received, i.e., test results, materials from other agencies**

***O = As John shared his feelings about the group, his eyes began to tear up. Affect looked sad and discouraged although he denied that his sadness was about anything but his lack of participation in group. John was more disheveled today than in past visits as evidenced by rough, uncombed hair and clothing that was torn and mismatched.***

# Assessment/Analysis

- A summarization of your "clinical" impressions regarding the client's issues or problems
- A synthesis and analysis of the subjective and objective portion of the notes
- Include your professional opinion in the assessment portion of the SOAP notes. This involves taking the information provided in the first two sections and using it to draw a final conclusion on the problem and the needs of the client. The assessment should also note possible areas of further inquiry or testing to guide proper treatment of the individual or family members.
- Issues that need to be further addressed
- Unhealthy patterns that need to be challenged
- Level of cooperation/insight/motivation
- How you would label the client's behavior and reasons for the behavior
- Effectiveness of treatment strategies
- Client progress and setbacks

**A = *John appeared to more depressed today then in past home visits. The fact that he "passed" at the anger support group meeting causes concern that John may be avoiding dealing with his anger or may be feeling sadness for not responding during group. He denied any difficulties sleeping or eating.***

# Plan

- Identification of the next step that you plan to take regarding the client; treatment direction and treatment interventions to be used
- Describe final recommendations or treatment to be used by the client in the plan section of the SOAP notes. This may include information such as referrals to outside agencies or consultations needed by the social worker with another professional regarding the client. Final decisions regarding the next steps to take, including dismissal from any further proceedings, should be noted in this section
- Identify the action plan
- Document the date and time of the next session
- Identify any other referral activity that you will pursue; is a consultation needed?
- Identify any assigned homework
- Include the anticipated gains from the treatment interventions

P = *John was asked to do three Life Book pages with his foster/treatment parents related to emotions and feelings. Plan is to discuss next week during home visit to try to give John words to describe what he is feeling. Will call mid-week to foster/treatment parents to get their feedback on his behavior and affect. Will also contact the therapist conducting the anger management group for input. Next home visits scheduled for Monday, October 21st at 4:00 PM.*

# Sample Case Note 2:

| Subjective | Objective |
| --- | --- |
| *S - I met with Mrs. Diaz, the birth mom of Sally. Despite her financial and health concerns and her reported sadness, she has followed through with most previously agreed upon tasks. She also reached out to her children this week and was able to have phone conversations with each of her two children in foster care. She said she felt in slightly better spirits because of the phone conversation.* | *O - Mrs. Diaz reported that she went to the food bank and has enough food to last until her next social security checks arrives next week. She completed an application for food stamps. She was unable to make a medical appointment as planned. When I asked why she didn't follow through with this, she said she is uncomfortable with her present doctor and is also fearful of what the doctor might tell her about her health.* |

# Sample Case Note 2 Continued. . .

**Assessment/Analysis**

**A -** ***Mrs. Dias has followed up on all tasks agreed upon with the exception of making a medical appointment and says she is feeling more hopeful.***

**Plan**

**P -** ***Ms. Diaz is will attend intake appointment with financial counselor set for 9.6.13. Mrs. Diaz was given a list of M.D.'s that accept Medicare. She will make appointment this week. This writer will check in with Ms. Diaz via phone every Friday for the next month and will meet again in person one month from today.***

# Sample Case Note 3

**Name(s):** Omni, Victoria - 704489

**Start Date:** 06/19/2014 1:00 AM

**End Date:** 06/19/2014 3:00 AM

**Type of Contact:** Face to Face with youth

**Duration:** 2 Hours, 00 Minutes

**Program:** Therapeutic Foster Care - Level III

**Outcome:** RC spent time alone with child

**Individuals Contacted/Present:** Child, Foster Treatment Parent

**Contact/Event Purposes:** RC Visit in Resource Home

**Was Client Present?** Yes

**Details:**

S: Foster parent stated that Victoria had a verbal outburst and refused to go to her counseling appointment. Victoria stated that she was sick of being in state custody and of people telling her what to do. She stated that she did not intend to follow any rules and wanted to go home. After being de-escalated and talking, Victoria stated she would try to stay calm in spite of being frustrated.

O: When this RC arrived, Victoria was loud and shouting at her foster parent. She was crying and twice hit the wall with her fist. Her foster mother was attempting to calm her down. After an hour, Victoria calmed down and was willing to talk. Upon leaving, Victoria was in her room writing in her journal.

A: Victoria was very frustrated after her visit home. She has difficulty understanding why she cannot just go home. When stressed, Victoria seems to forget about her coping skills and tends to resort to old behaviors.

P: RC developed a plan for Victoria to have quiet time and journal time when upset. Foster parent agreed to allow her to call her parents if she felt she needed to talk. RC reminded parents of on-call number. Victoria verbalized her coping skills and will see her therapist on Monday. RC will transport.

**Worker:** Faehl, MS, Lisa

# Sample Case Note 4

**Name(s):** Omni, Victoria – 704489

**Start Date:** 06/20/2014 10:00 AM

**End Date:** 06/20/2014 11:00 AM

**Type of Contact:** Face to Face with youth

**Duration:** 1 Hours, 00 Minutes

**Program:** Therapeutic Foster Care - Level III

**Outcome:** RC spent time alone with child

I**ndividuals Contacted/Present:** Foster Treatment Parent

**Contact/Event Purposes:** RC Visit in Resource Home

**Was Client Present?** Yes

**Details:**

S: Victoria said she has had a good week and was excitedly showed this RC some art work she has been working on during the past week. She stated that she was looking forward to a visit with her mother and father on Saturday of this week. Victoria stated that she felt safe in her foster home and stated that she feels she can talk to her foster mother any time she is upset or needs to talk. She stated she and her foster mother have a ten minute meeting every day just to talk about what is going on, appointments, or anything that upsets her. Victoria stated that she is sleeping better now that she is on medication and also has a night light in her room. Foster mother stated that Victoria has attended counseling this week and that the therapist talked to her also for about ten minutes.

O: This RC did a walkthrough of the foster home. Victoria's room was clean, with clothing picked up and hung in the closet and her personal items reasonably organized in the room. There did not appear to be any changes in the foster home. Victoria has a daily goal and RC noted the form on the refrigerator, with stickers on the days when Victoria met her goals. Victoria appears to be well groomed and made good eye contact. She became visibly upset when she began talking about her parents and wanting to see them on upcoming pass.

A: Victoria made improvements in her ability to verbalize her feelings from the last home visit, evidenced by her daily goal sheet and participation in the check in. Victoria's parents are participating in counseling and have progressed to the point that she will have a weekend pass with them this weekend. Victoria's foster parents seem aware of her needs and have noted her improvements in daily notes, which indicate she has had only one verbal outburst since the last home visit. Victoria is participating in outpatient therapy

P: Next home visit is July 3, 2014. This RC left 2 life book pages for the foster parent and Victoria to complete between this visit and the next. Victoria will also draw some additional illustrations with this assignment. Victoria has a psychiatric appointment next week to review her medication. Foster parent will be providing transportation. This RC will call psycho RC will speak with her parents about safety plan for upcoming visit this weekend.

**Worker:** Faehl, MS, Lisa

# Sample Case Note 5

## NON-SOAP NOTE

Resource Coordinator (RC) visited with Collin at his respite home. It was reported to this RC that Collin had aggressive behaviors at his resource home and mobile crisis was called. It was not necessary to call mobile crisis because of his behaviors, but the resource parents decided to contact them. Collin attended his therapy session today with Josh Chestnut at Centerstone. He was then taken to the respite home for overnight respite. RC Potts noted Collin was behaving fine while she was in the home and the respite parents were having no problems with him. They had one incident with Collin, but nothing major and he did not escalate. Collin did not want what was being served for lunch and he started to get upset and angry, but respite parent was able to redirect him with another option and he calmed down

## SOAP CASE NOTE

S: Collin was sitting down to lunch at his respite home. He yelled: "I no want that! while pushing back from the table in an angry manner. When asked about his visit to his therapist, Collin said "good"

O: The respite parent calmly offered him another option and he sat back up and began to eat. He appeared calm and happy. The respite parent reported no major problems with Collin and this RC did not observe any behavior issues. A brief walk through at the home revealed toys appropriate for preschoolers scattered about but otherwise the home was neat and clean and free of any safety concerns. It was reported that Collin had had his therapy session with Mr. Chestnut today. The respite parent also said that Collin had been aggressive in his foster home and the treatment foster parents had called mobile crisis.

A: Collin appears to be comfortable at the respite home and the respite parent is able to manage him well. This RC reviewed a behavior management plan to be used in the resource home as well as the respite home to promote consistency. It seems that much of Collin's aggression is environment-specific.

P: This RC will review the incident report and discuss guidelines for contacting mobile crisis with the resource family. Mr. Chestnut will be contacted for a progress report on treatment. RC to schedule visit at resource home next Tuesday morning.

# Case Notes Deliverables

- Each case note entry includes the letter “S” or “O” or “A” or “P” followed by narrative
- “S” portion of case note details what the clients tells you regarding his/her thoughts or feelings about issues, problems, or concerns
- “O” outlines factual information that can be seen or heard and what you personally witness in the client’s behavior, appearance and affect
- “A” is a summary of your “clinical” impressions regarding client’s issues or progress; progress on treatment plan goals
- “P” is identification of the next steps that you plan to take regarding the client; treatment direction and treatment interventions to be used (TFC, Life Book, trauma interventions)

# References…


1. Case Recording Styles, Rehabilitation 413W: Case Management and Case Recording
2. Case Management Standards Toolkit, NYC Department of Youth and Community Development, Mental Health Association of New York City, Inc.
3. "Learning to Write Case Notes Using the SOAP Format," Journal of Counseling and Development, Sumer 2002, Volume 80.