#### Daily Progress Notes (The "SOAP" note)

Progress notes are to be written by the resident or intern on each covered medical patient on a daily basis. The daily progress note serves as a written medical-legal document that:

- Serves as a record of a patient's hospitalization
- Must be completed on a Daily basis and includes all "events" that occur during the hospitalization
- Records "events" in terms of subjective and objective findings
- Must include new and active patient health/social issues ("problems")
- Each problem is evaluated/assessed and an appropriate plan is formulated
- Must be legible and well written so to avoid any misunderstanding by the reader
- Must have a time and date and be signed on each page by the author in legible fashion.

The daily progress note is traditionally organized as a "SOAP" Note. Many, however, organize the Progress note as "HSOAP" where the H stands for history and contains one or two sentences summarizing the patient's case.

#### S=Subjective

- Record of subjective findings that occurred during the evening, overnight, and in the morning that patient is being examed.
- Essentially how the patient felt during the evening, night time and morning hours and what happened during those hours.

#### O=Objective (Includes all the following)

- Physical Exam: Vital signs, focus ed physical exam but almost always should include:
  - LUNG
  - CARDIAC
  - ABDOMINAL
  - EXTREMITIES
- Laboratory data
- Diagnostic Imaging
- Microbiology
- Please note that a Medication List which includes a listing of all scheduled and PRN (as needed) medications that are relevant to active problems is always helpful and recommended but is not required.

#### A/P=Assessment and Plan:

# **Home Health Care Daily Progress Notes Examples**

**L Darling-Hammond** 

## **Home Health Care Daily Progress Notes Examples:**

Speech-Language Pathologist's Guide to Home Health Care Roberta Pierce, 1999-12-13 Roberta B Pierce has worked extensively with patients of all ages and all types of communication disorders for over thirty years She has experience in an out patient rehabilitation center a rehabilitation hospital an acute care hospital and private practice Since 1975 she has contracted to provide speech language pathology services to home health agencies She shares this expertise with clinicians just entering the home health field in the Speech Language Pathologist's Guide to Home Health Care This book contains reference materials patient and family counseling and education materials and treatment activities that are invaluable for working with the adult neurogenic population in all healthcare settings Content coverage includes diagnostics documentation counseling the patient and family treatment procedures and therapy activities The Home Health Aide Handbook Jetta Lee Fuzy, 2006 The Home Health Aide Handbook is unlike any other handbook or pocket guide on the market Not only is it inexpensive but it s full color loaded with photos and illustrations. Use it for training and encourage your aides to carry it with them into the field to use as a quick reference tool The second edition contains updated information on all of the federal requirements for home health aides a considerable emphasis on observing and reporting HIPAA and how to protect a client's privacy home care focus boxes nutrition and the USDA's MyPyramid numerous procedures emphasizing how they are performed in the home including a new two step procedure for taking blood pressure care guidelines for specific diseases pain management chart of medical and commonly used abbreviations mercury free thermometers home care specific tips for housekeeping and cooking disaster guidelines comprehensive glossary and easy to use index including a table of where to find procedures The OTA's Guide to Writing SOAP Notes Sherry Borcherding, Marie J. Morreale, 2007 Written specifically for occupational therapy assistants The OTA's Guide to Writing SOAP Notes Second Edition is updated to include new features and information This valuable text contains the step by step instruction needed to learn the documentation required for reimbursement in occupational therapy With the current changes in healthcare proper documentation of client care is essential to meeting legal and ethical standards for reimbursement of services Written in an easy to read format this new edition by Sherry Borcherding and Marie I Morreale will continue to aid occupational therapy assistants in learning to write SOAP notes that will be reimbursable under Medicare Part B and managed care for different areas of clinical practice New Features in the Second Edition Incorporated throughout the text is the Occupational Therapy Practice Framework along with updated AOTA documents More examples of pediatrics hand therapy and mental health Updated and additional worksheets Review of grammar documentation mistakes Worksheets for deciphering physician orders as well as expanded worksheets for medical abbreviations Updated information on billing codes HIPAA management of health information medical records and electronic documentation Expanded information on the OT process for the OTA to fully understand documentation and the OTA s role in all stages of treatment including referral evaluation intervention plan

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