WHY USE S.O.A.P.?

SUCCESSFUL DOCUMENTATION IS A KEY COMPONENT TO HEALTH CARE IN THE CORRECTIONAL SETTING

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The mission of the Department of Juvenile Justice is to increase public safety by reducing juvenile delinquency through effective prevention, intervention, and treatment services that strengthen families and turn around the lives of troubled youth.
Why is documentation so important?

- It is a permanent and crucial legal document
- It is the evidence of your skills and ability to follow practice guidelines
- It is the documentation of quality of care provided
- It may validate your treatment for years to come

Remember: If it’s not documented... it was not done!
Using SOAP notes helps wash your hands of litigation.
The accurate recording of contact with the patient/youth.

- Documentation should include all phone contacts.
- Documentation should include all verbal contacts with staff, mental health and case management regarding the youth.
- These are often identified as “incidental notes”, as it does not involve physical contact with the patient/youth.
Physical examinations or encounters should paint

An accurate picture of the complaint or reason for evaluation
Paint your picture

- Be professional at all times
- Answer questions in simple language—understand your audience
- Document care when it happens, not later!
- Remember it is a legal document—be careful how you say it!
What should I include in my document?

- Date and time for each entry
- Identify the reason for the encounter (first aid/episodic care, follow-up sick call, post restraint)
- Be precise when using nursing protocols
- Document vital signs if indicated in the protocol
- Print your name (or stamp your name) and credentials then sign your name (HSM 15–12)
What not to include in my documentation!

Do not add your personal feelings /comments on the actions or lack of action of the youth:

- “If youth would stop arguing he would see we are just trying to help him”
- “The youth appears to be faking to seek attention”
- “The youth is a frequent flyer to medical when not wanting to go to school”
- “The youth is drug seeking and not really having pain”
Don’t get caught up in emotions or judgements!

Note the facts and Just the Facts!

- Don’t try to explain why you did not want to evaluate the youth… “I tried to tell him to keep the wound clean and dry but he didn’t listen and it’s now oozing, red and warm to touch, but it’s his own fault”
- Don’t pass judgment… “the youth was seen laying on the floor moaning and when I told him to get up he got right up so he obviously was faking it and not in pain.”
The youth cursed and yelled at me to not touch him, then said I’m straight. So I did not need to evaluate youth.

The youth was combative and cursing so he was obviously not in pain.

The staff stated the youth put his finger down his throat to vomit so he would not have to go to school.
Every Patient Has Rights: Florida States Patient’s Bill of Rights and Responsibilities (381.026)

States: Each health care facility or provider shall observe the following standards:

- Financial dignity
- Information
- Financial information and disclosure
- Access to health care;
  1. A patient has the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, handicap or source of payment.
  2. A patient has the right to treatment for emergency medical condition that will deteriorate from failure to provide such treatment.
A Duty To The Patient Exists

- Duty is established when you accept care of a patient under your scope of practice, licensure and employment.
- It requires you to provide the standard of care that a reasonable prudent nurse would provide for a similar patient in a similar circumstance.
- Factors that define standard of care include:
  - Scope of practice under the state Nurse Practice Act
  - Applicable policy and procedure of the facility
  - Nursing certification,
  - Acceptable treatment standards, and in our case DJJ policy and procedures.
Third Party Review

When using SOAP note format the reviewer will be able to:

- See what you saw
- Feel what you felt
- See no reason for doubt
- Be able to follow the plan of care
- See the rationale of your treatment
- Know the facts
Breaking down the SOAP note
Subjective

- What is the patient complaining of?
- When did it occur/start?
- Where is the problem (what body part)?
- How did it occur?
- Has the patient experienced this before (check the history)?
- Have they done anything that improves the problem?
Objective

Examination and documentation of findings

- What you see; vital signs, visible injury
- What you physically feel by palpating
- What you observe; this may include how the patient reacts to evaluation, grimacing, flinching, range of motion
- Document what corresponds with the complaint or subjective report
- Remember to document in descriptive form and avoid using words like “small, large”, instead use measurements like 1 inch by 1/16 inch.
The “A” in SOAP noting

Generally this is the “Assessment”…Under the Nurse Practice Act Chapter 464 Florida Statute it must be defined:

- **LPN**: Nursing diagnosis or “Alteration in”

- **RN**: Assessment or diagnosis of findings
Plan

- Movement to treatment
- Including frequency and duration of care
- Protocol used to provide care or recommendations
- Include education or instructions provided to patient/youth
- Follow up
- Be sure to take credit for education provided
  (this is often referred to a SOAPE noting)
Errors to Avoid

- Never white out or scratch through all or a even a portion of your note
- Make one line through it and initial and date it, then make another entry to clarify the correction.
- Never, never doctor up an existing note!
- Do not go back and add information to a previous note.
- Complete your note at the time you see the patient/youth to avoid errors and confusion of patients.
- Avoid gaps in the medical record
Documenting indifference or anger only makes you the guilty one!
Let the patient/youth speak
Do not use threatening or intimidating language
Be precise and professional
Explain options and choices
Don’t get sucked into a debate
Be empathetic and caring
When it is above your expertise– refer the patient to a higher level for evaluation
Good communication helps the patient to comply with instructions.

Good communication helps develop the patient/nurse/practitioner’s relationship.
Reason for Litigation

- Civil Rights violation
- Delay of treatment
- Inadequate care
- Practicing outside the scope of practice
- A breach of duty occurred
- The patient was injured— the injury was directly caused by the breach of the standard of care.
Not Documented

Not Done!!!!!!!!!!!!!