Documentation Skills for Community Health Workers

OBJECTIVES

At the end of this unit, participants will be able to:

- Create documentation using the SOAP note format
- Identify the purpose and common elements of good case notes
- Identify the challenges associated with completing case notes in an effective manner
- Identify best practices and what you as a CHW bring to the process
- Practice writing a progress note based on a case study

INSTRUCTIONS

1. Before the session, review the PowerPoint slides and handouts. This section is divided into two parts:
   - Learning how to write effective case notes, including the SOAP note approach for documentation
   - Critiquing case notes and practicing writing a SOAP note
2. Review the objectives and introduce the topic (slide 2).
3. Review the slides on why documentation is important, challenges of documenting work, observational skills, what CHWs bring to the process, and important points about case notes. Facilitate discussion throughout as indicated in slide notes (slides 3–12).
4. How to write effective case notes and SOAP note format
   - Explain that a helpful method for documenting our work is the SOAP note format.
   - Distribute the handouts on SOAP notes. Ask a volunteer to read what each letter stands for and the examples.
   - Review the slides about the content that should be included in the notes and facilitate discussion (slides 13–18).
   - Refer to the "Do's and Don'ts" section on the SOAP Note Definitions and Examples handout.
   - Review slides about other considerations when writing case notes, time management, and charting goals (slides 19–24).

(continued)

Related C3 Roles

Care coordination, case management, and systems; providing direct service; implementing individual and community assessments

Related C3 Skills

Communication skills, service coordination and navigation skills, capacity building skills, individual and community assessment skills

Method(s) of Instruction

Lecture, group discussion

Facilitator's note: Both CHWs and supervisors should attend this session. Participants could be trained together or separately.

This session can also be conducted virtually as a webinar. It can easily be adapted if you have a platform such as Zoom or Skype and participants have access to a computer. If conducting as a webinar, allow 10 minutes to test the technology and aid participants in connecting.

Estimated time

60 minutes

Key Concepts

Documentation, SOAP notes, case notes

Materials

- Computer with internet access and projector
- PowerPoint slides
- Flip chart
- Markers

Handouts

- SOAP Notes
- SOAP Definitions and Examples
- Example of a Better Case Note
- Blank SOAP Note

Documentation Skills for Community Health Workers

INSTRUCTIONS (continued)

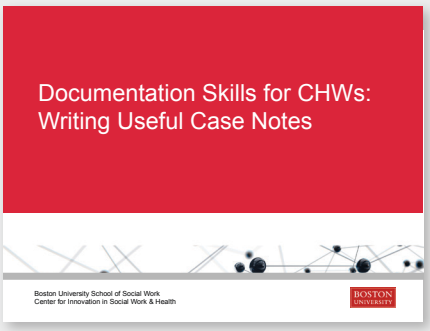
5. Practice writing case notes
   - Explain that we are now going to practice reviewing and writing case notes.
   - Review examples of a substandard case note and discuss how it could be better (slides 26–27).
   - Review example of a better case note (slide 28).
   - Facilitate the activity for Sheila's visit (slide 29). Participants can be placed into pairs. Distribute blank SOAP notes. Allow participants 15 minutes to complete.
   - Bring the group back together to discuss their SOAP notes and care plans for Sheila.
6. Wrap up. Summarize documentation content (slide 30) and ask participants to think about how they currently write notes (slide 31). Ask, "What one thing are you taking away from today's session to use in your work?" Be sure to solicit responses from both supervisors and CHWs if they are in the session together.

Resources

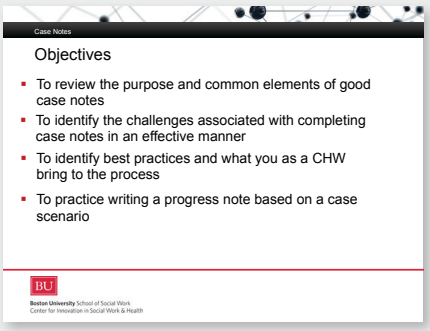
National Career Development Association Tips for writing case notes available at: *https://www.ncda.org/aws/NCDA/pt/sd/news_article/5443/_PARENT/CC_layout_details/false*

Learning to Write Case Notes article available at: *https://onlinelibrary.wiley.com/doi/abs/10.1002/j.1556-6678.2002.tb00193.x*

Additional sample forms for documenting work can be found in the Building Blocks to Peer Program Success resources in Section 7 at *https://ciswh.org/resources/HIV-peer-training-toolkit*



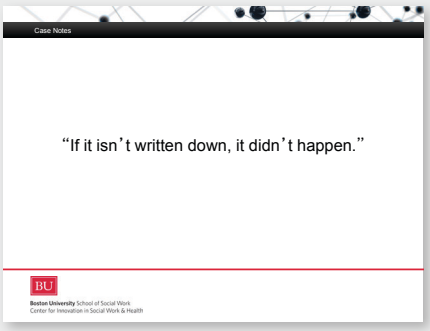
SLIDE 1



SLIDE 2

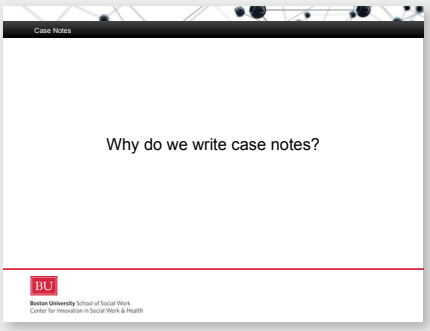
Review the slide.

Explain that in this session we will learn how to document our work with clients using the SOAP note approach, so we can share updates with the care team. Different organizations use different database systems and other forms of health information technology to record participant information. For our purposes today, we are going to focus on how to appropriately document our work as CHWs, knowing that each agency may use different technology to record information.



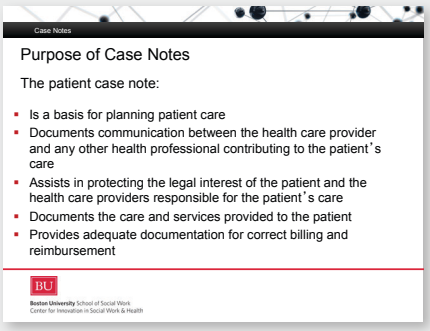
SLIDE 3

Ask, "Have you heard this phrase from supervisors or other people? What is your reaction to this statement?" Hold a brief discussion.



SLIDE 4

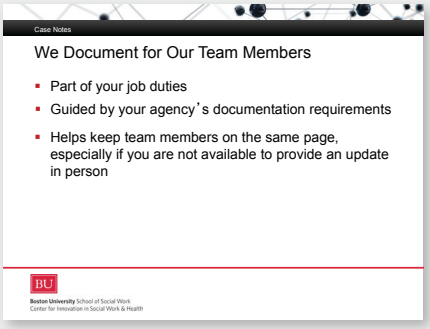
Ask, "Why do we write case notes?" Write responses on a flip chart sheet.



SLIDE 5

After the brainstorm, thank everyone for sharing.

The next few slides summarize some of the common reasons for documentation. Review the next slides quickly; the facilitator can ask for volunteers to read them if desired.



SLIDE 6

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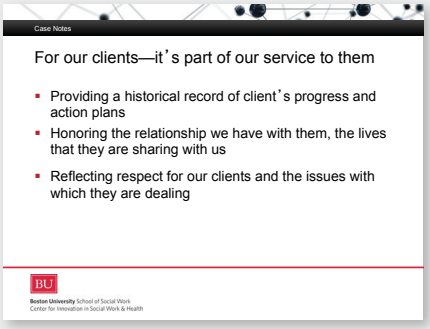

SLIDE 7

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SLIDE 8

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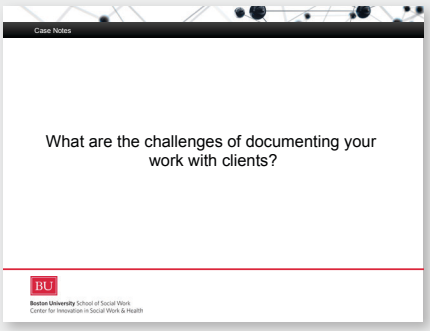
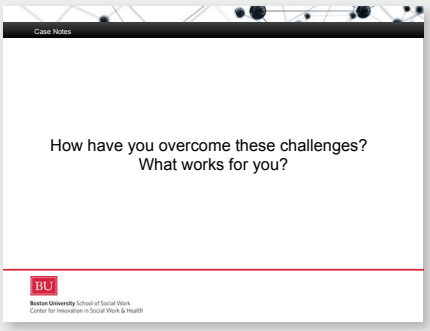


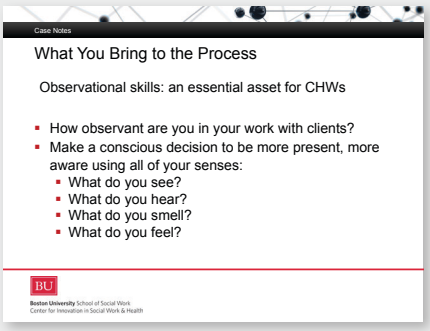
SLIDE 9

Brainstorm with participants to identify challenges. Write responses on flip chart.



SLIDE 10

Invite participants to share their experiences and best practices. Write responses on flip chart.



SLIDE 11

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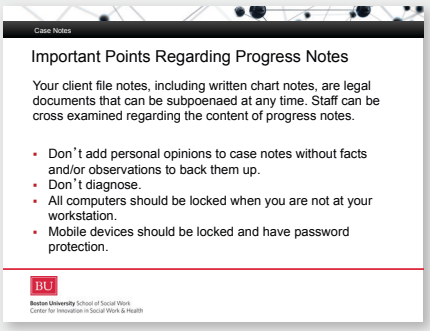
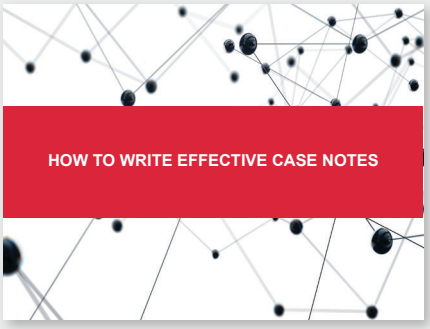


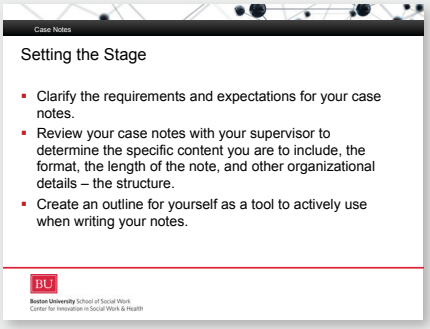
SLIDE 12

Read the slide.



SLIDE 13

Next we are going review how to write effective case notes.



SLIDE 14

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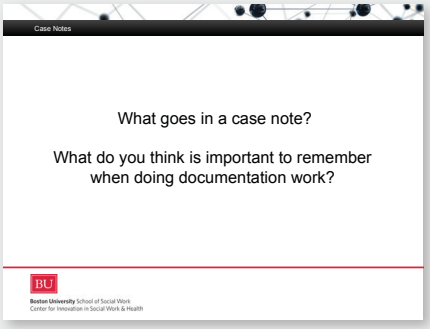
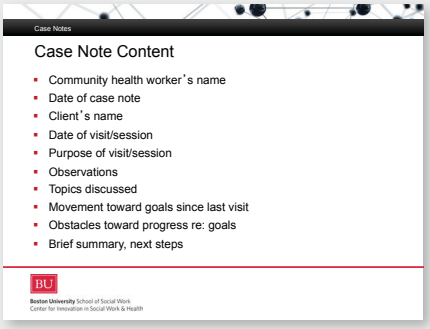


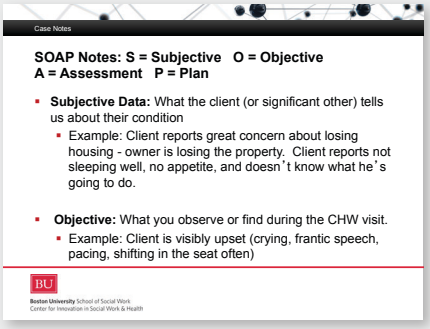
SLIDE 15

Briefly invite participants to share ideas. Write responses on flipchart.



SLIDE 16

This slide lists the core elements of a good case notes. . . . Ask a volunteer to read the slide.

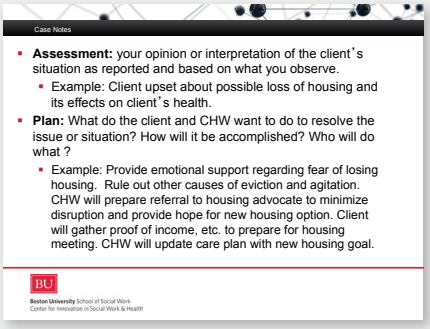


SLIDE 17

Distribute and refer to the SOAP note handout.

Emphasize that the Subjective section should include what the client tells us.

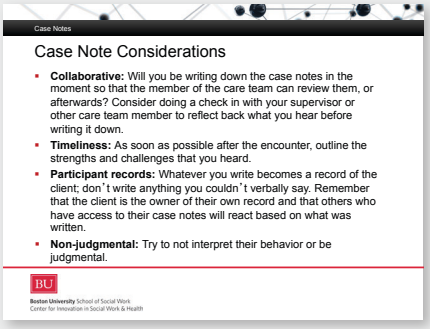
Objective data includes what we can observe that is measurable and describable—what did we see, count, hear, smell or measure?



SLIDE 18

The Assessment section should include what is happening and/or needed with the client.

The Plan is the joint plan of action for the CHW and the client.



SLIDE 19

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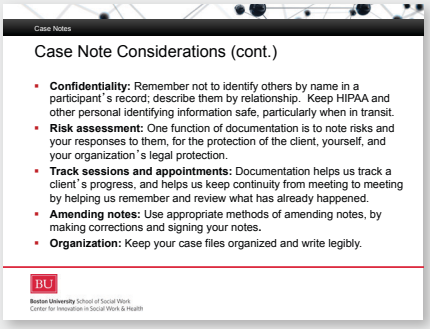

SLIDE 20

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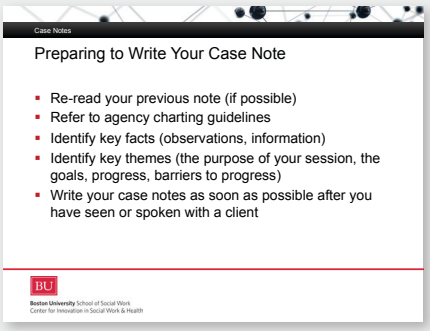

SLIDE 21

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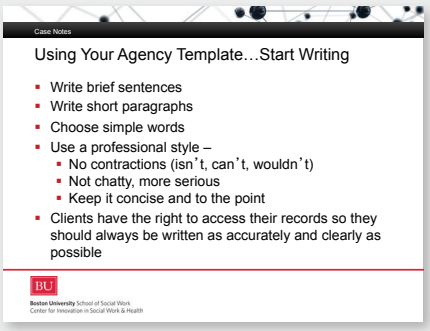

SLIDE 22

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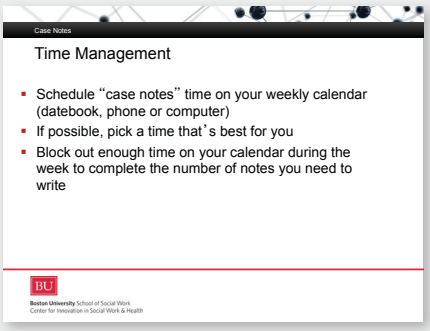

SLIDE 23

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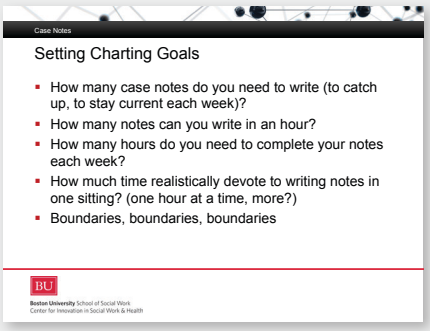

SLIDE 24

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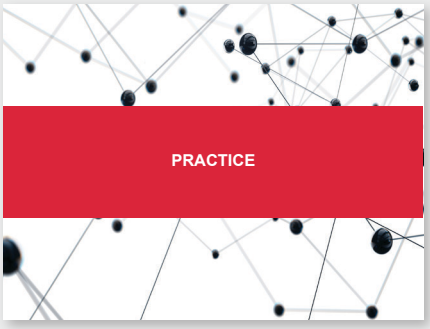
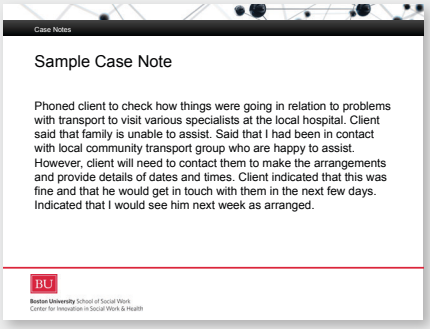


SLIDE 25

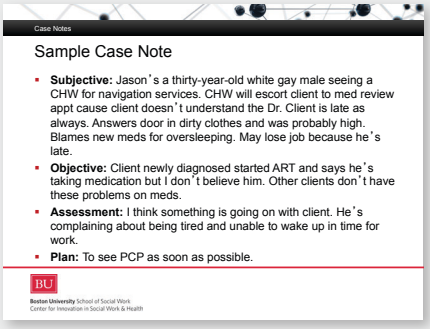
We are now going to critique sample chart notes to identify weaknesses and ways to improve the note.



SLIDE 26

Ask for a participant to read the slide.

Then ask, "Do you think that these case notes are useful? If not, why not? How would you improve them?"



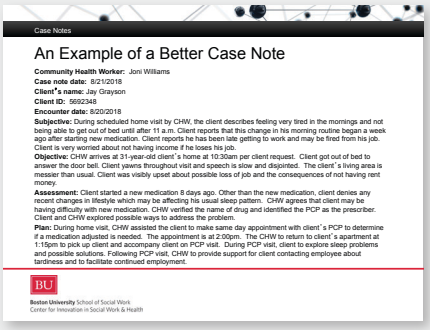
SLIDE 27

Ask for a participant to read this SOAP note.

Ask, "Why is this a substandard case note?"

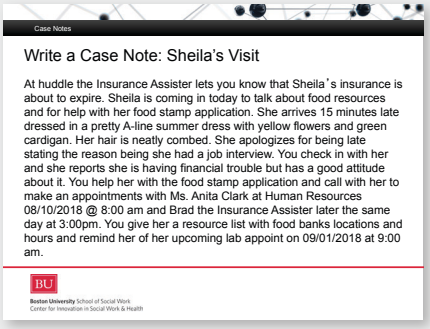
Possible answers:

- No documentation of who wrote note, date, time, place
- Judgmental: Client is late AS always. Client is high.
- Not objective: "I don't believe him…Other clients don't have these problems."
- Risk assessment: Too subjective: "I think something is going on with the client."
- Casual/unprofessional writing style.



SLIDE 28

Review the slide.

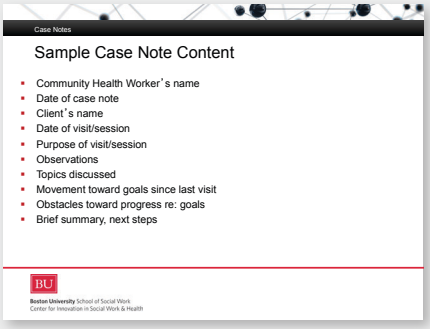


SLIDE 29

Now we will write our own case note and care plan. Here are your rough notes about work you did today with Sheila. How would you turn this into a chart note?

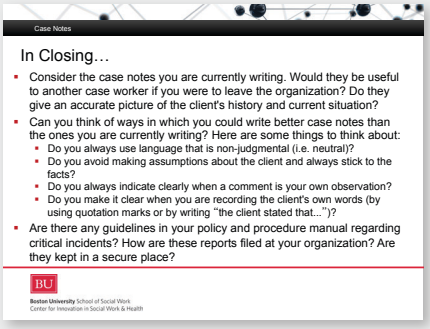
Divide participants into pairs and pass out the blank SOAP note. Have participants write a SOAP note for her visit. Allow 15 minutes for completion.

Bring the group back together to share their notes.



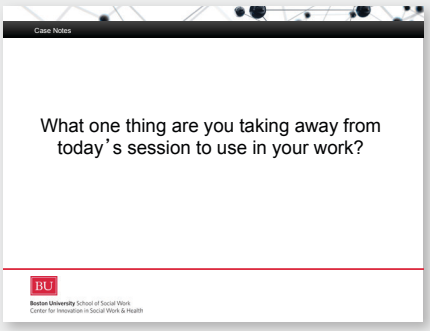
SLIDE 30

As participants discuss their SOAP notes, reference the content that should appear in the case note.



SLIDE 31

Encourage participants to add their thoughts on how they could improve the case notes they write.



SLIDE 32

Ask, "What one thing are you taking away from today's session to use in your work?" Be sure to solicit responses from both supervisors and CHWs if they are in the session together.

SOAP Notes

S=Subjective, O- Objective, A=Assessment, P-Plan

Subjective Data: What the client (or significant other) tells us about their condition. **Example:** Client reports great concern about losing housing - owner is losing the property. Client reports not sleeping well, no appetite, and does not know what he is going to do.

Objective: What you observe or find during the medical case management visit. **Example:** Client is visibly upset (crying, frantic speech, pacing, shifting in the seat often.

Assessment: The CHW's opinion or interpretation of the client's situation as reported and you observe. The conclusions made in the assessment are more than a restatement of the problem as it determines whether or not the situation can be resolved.

Example: Client upset about possible loss of housing and its effects on client's health.

Plan: What do the client and case manager want to do to resolve the issue or situation? How will it be accomplished? Who will do what part of the service? This can often be incorporated into the care plan.

Example: Provide emotional support regarding fear of losing housing. Rule out other causes of eviction and agitation. CHW will prepare referral to housing advocate to minimize disruption and provide hope for new housing option. Client will gather proof of income, etc. to prepare for housing meeting. CHW will update care plan with new housing goal.

SOAP Definitions and Examples

Section	Definitions	Examples
Subjective (S)	• What the community member tells you • What pertinent others tell you about the community member • Basically, how the community member experiences the world	• Community member's feelings, concerns, plans, goals, and thoughts • Intensity of problems and impact on relationships • Pertinent comments by family, case managers, behavioral therapists, medical professionals, etc. • Community member's orientation to time, place and person • Community member's verbalized changes toward helping
Objective (O)	• Factual • What the CHW personally observes/witnesses • Quantifiable: what was seen, counted, smelled, heard or measured • Outside written materials received	• The community member's general appearance, affect, behavior • Nature of the helping relationship • Community member's demonstrated strengths and weaknesses • Test results, materials from other agencies, etc. are to be noted and attached
Assessment (A)	• Summarizes CHWs thinking • A synthesis and analysis of the subjective and objective portion of the notes	• How would you describe the community member's behavior and the reasons (if any) for this behavior?
Plan (P)	• Describe the parameters of the intervention • Consists of an action plan and prognosis	• Action plan: Include interventions used, progress towards goals, and direction. CHWs should include the date of the next appointment. • Prognosis: Include the anticipated gains from the interventions

Guidelines for Subjective, Objective, Assessment, Plan (SOAP) Noting

Do

- Be brief and concise
- Keep quotes to a minimum
- Use an active voice
- Use precise and descriptive terms
- Record immediately after each session
- Start each new entry with date and time of session
- Write legibly and neatly
- Use proper spelling, grammar and punctuation
- Document all contacts or attempted contacts
- Use only black ink if notes are handwritten
- Sign-off using legal signature, plus your title

Avoid

- Avoid using names of other clients, family members, or others named by community member
- Avoid terms like “seems, appears,” etc.
- Avoid value-laden language, common labels, opinionated statements
- Do not use terminology unless trained to do so
- Do not erase, obliterate, use correction fluid, or in any way attempt to obscure mistakes
- Do not leave blank spaces between entries
- Do not try to squeeze additional commentary between lines or in margins

Example of a Better Case Note

Community Health Worker: Joni Williams

Case note date: 8/21/2018

Client's name: Jay Grayson

Client ID: 5692348

Encounter date: 8/20/2018

Subjective: During scheduled home visit by CHW, the client describes feeling very tired in the mornings and not being able to get out of bed until after 11 a.m. Client reports that this change in his morning routine began a week ago after starting new medication. Client reports he has been late getting to work and may be fired from his job. Client is very worried about not having income if he loses his job.

Objective: CHW arrives at 31-year-old client's home at 10:30am per client request. Client got out of bed to answer the door bell. Client yawns throughout visit and speech is slow and disjointed. The client's living area is messier than usual. Client was visibly upset about possible loss of job and the consequences of not having rent money.

Assessment: Client started a new medication 8 days ago. Other than the new medication, client denies any recent changes in lifestyle which may be affecting his usual sleep pattern. CHW agrees that client may be having difficulty with new medication. CHW verified the name of drug and identified the PCP as the prescriber. Client and CHW explored possible ways to address the problem.

Plan: During home visit, CHW assisted the client to make same day appointment with client's PCP to determine if a medication adjusted is needed. The appointment is at 2:00pm. The CHW to return to client's apartment at 1:15pm to pick up client and accompany client on PCP visit. During PCP visit, client to explore sleep problems and possible solutions. Following PCP visit, CHW to provide support for client contacting employee about tardiness and to facilitate continued employment.

Blank SOAP Note

Subjective (S)	
Objective (O)	
Assessment (A)	
Plan (P)	

Acknowlegements

This curricula draws from and is adapted from other training curricula for peer educators and community health workers, such as the Building Blocks to Peer Success (https://ciswh.org/resources/HIV-peer-training-toolkit) and the Community Capacitation Center, Multnomah County Health Department (https://multco.us/health/community-health/community-capacitation-center)

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