CERTIFIED REGISTERED
Massage Therapist Association

CRMTA

SOAP Notes Expectation

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CRMTA SOAP NOTE EXPECTATIONS

SOAP notes are a massage therapist's clinical health records. SOAP stands for Subjective, Objective, Assessment Plan. In keeping with the CRMTA Health Care Records Policy, below are specific comments relating to the keeping of SOAP notes. The CRMTA Health Record Policy governs if there is any confusion or discrepancy between this SOAP policy and the CRMTA Health Care Records Policy.

1. SOAP NOTE POLICY

1.1 CRMTA members are required to:

(a) Make and maintain client records relating to the provision of their massage therapy services.

(b) Maintain these client records for at least 11 years from the date of the last entry or, if the client is less than 18 years old, at least 11 years from the date the client becomes 18 years of age.

(c) The CRMTA member must retain personal possession of the records, or make arrangements for a custodian to assume this responsibility if they move out of the province or quit practicing.

(d) Ensure that the confidentiality of the client information is maintained.

(e) Release the information contained in the client's health record, but only with the client's consent.

2. PRINCIPLES

2.1 The following principles should be adhered to in dealing with the maintenance, access to and/or release of SOAP notes:

(a) All information relating to the services provided to a client are to be treated as confidential.

(b) The health information contained in the file belongs to the client, not the therapist and can only be released with the client's consent or as required by law.

(c) The client has a right to access the information contained in his or her health record.

3. NOTES

3.1 All SOAP notes must include detailed information in the following areas:

(a) ***Subjective:*** The subjective component of clinical notes is required to describe the client's presenting complaint or condition. Subjective data is generally not verified and is often the opinion and statement made by the client to the therapist. Subjective information should include the characteristics and qualities of the primary complaint. This can include mechanism of the injury, location, onset, aggravating factors, relieving factors, medications, treatments, radiation, duration, intensity, character and frequency. Subjective findings should be updated with each treatment visit.

(i) ***Note:*** Subjective information is in addition to the client health history form.

(b) ***Objective:*** Objective data is the descriptive finding that is observed, palpated or assessed at each treatment. Objective data is what is observed by the therapist on examination and includes orthopedic testing, posture, gait, and all palpation for tone, temperature, texture and toxicity.

(c) ***Assessment:*** Must be completed as to the probable cause or condition being treated. As an RMT therapists DO NOT diagnose, they merely determine a probable cause.

(d) ***Plan:*** The expected treatment plan should include specific techniques used for that visit, treatment planning, treatment revisions, the area that treatment was performed, and the specific muscles or joints that were treated. This section will also document the outcomes of the massage treatment and any re-assessment plan. In the plan section, the therapist will also provide adequate home care and outside referrals, if required.

3.2 All SOAP notes must be:

(a) **Well-Organized**

(i) SOAP notes must be well-organized, understandable and accurate.

(ii) Entries must be dated.

(iii) Late entries must include both the date of the item being required and the date the entry was made.

(iv) The person who provided the care and/or made the entry must be identified by name and job title, or by a unique identifier.

(b) **Clear and Concise**

(i) Entries must be legible.

(ii) Specialized terms, short forms and diagrams must be understandable to anyone who may be involved in the care. This can be done by defining the terms, short forms and diagrams in the record, or having a list of definitions available.

(iii) Records must be in either English or French.

(iv) Records must use appropriate, respectful and non-judgmental language.

(b) **Accurate**

(i) Information must be entered within a reasonable time period.

(ii) Entries must be permanent. That means there must be a way to ensure that content is not lost or deleted.

(iii) If there are additions or corrections, the original content must remain legible. The new content must indicate who made the addition or correction, the date and the reason for the addition or correction.

(c) **Record Retention**

(i) Clinical records must be retained for at least 11 years from the later of the following 2 dates:

- The date of the last patient encounter; or
- The date that the patient reached or would have reached 18 years of age.

(ii) It must be possible to retrieve and reproduce a complete clinical record for each patient throughout the retention period.