Integrated Learning Map
Lesson Plan

Career Cluster: For students who have already selected a career in Health Services & Human Services

Title: Observational Writing Lesson 3: SOAP

What Academic Skills will the student know and be able to do?

Learning Target: I can write informative text to examine a topic and convey information clearly to an appropriate audience.

Learning Steps:
DOK 3: View a video of an in-take session & take notes on SOAP form

Methodology
Circle/quick write; video viewing & note taking; café; whole class discussion

Resources: Video of in-take session; equipment to view video/computer access; SOAP form (attached); pen or pencil; paper
Possible videos to use:
https://www.youtube.com/watch?v=kaF5ADxgBgg
https://www.youtube.com/watch?v=4YhpWZCdI2c
https://www.youtube.com/watch?v=RD4i3te8bK8
https://www.youtube.com/watch?v=aiURx2HrSRg

Work Readiness Skills and Social Capital Skills will the student practice?

Learning Target: I can utilize information and follow directions. I can listen and compose information on what I heard. I can participate in a group. I can compare formats.

Learning Steps:
DOK 1: Read and Study SOAP format for Observational Writing in Health & Human Services
DOK 2: Analyze similarities and differences between Social Worker Observation Report and SOAP format
DOK 3: View a video of an in-take session & take notes on SOAP form
DOK 4: Share results with group/Share discussion questions with group and class

Methodology
Reading handout; applying information; group participation; class participation; comparing formats

Resources: SOAP handout (attached); pen or pencil; paper for group work

Demonstration of Mastery
How will student demonstrate mastery or proficiency of topic content?

SOAP form filled out; café & class discussion

SOAP form filled out; group & class discussion

Next Steps:
HOMEWORK: BRING NOTES OF OBSERVATION TO CLASS FOR LESSON 4.
VIEW VIDEO OF PRESCHOOL CHILD IF UNABLE TO ARRANGE A ‘REAL LIFE’ SUBJECT
Lesson Description

Unit Name: Observational Writing
Lesson Title: Lesson 3: SOAP

CCR (College and Career Readiness) Standards (include full wording):

| CCR W.3.2 | Write informative/explanatory texts to examine a topic and convey ideas and information clearly.  
|           | a. Introduce a topic and group related information together 
|           | b. Develop the topic with facts, definitions, and details.  
|           | c. Use linking words and phrases (e.g., also, another, and, more, but) to connect ideas within categories of information.  
|           | d. Provide a concluding statement or section |
| CCR W.5.4 | Produce clear and coherent writing in which the development and organization are appropriate to task, purpose, and audience. |
| CCR RI.3.9| Compare and contrast the most important points and key details presented in two texts on the same topic. |

Learning Targets (Goals and Objectives)

Academic Target(s): The student can
- write informative text (SOAP NOTES) to examine a topic and convey information clearly to an appropriate audience.

Work Readiness Target(s): The student can
- utilize information and follow directions in an Observational Writing assignment  
- listen and compose information based on what he/she heard in a SOAP format  
- participate in a group/be a team member  
- compare and contrast 2 different formats of Observational Writing

Materials and Tools (Resources)

1. SOAP handout (attached)
2. Computer access
3. Video of in-take session: links
   - https://www.youtube.com/watch?v=kaF5ADxqBgg  
   - https://www.youtube.com/watch?v=4YhpWZCdZc  
   - https://www.youtube.com/watch?v=RD4i3tebK8  
   - https://www.youtube.com/watch?v=aIURx2HrSRq  
4. SOAP form (attached)
5. Paper for note taking and cafe  
6. Pens/Pencils
<table>
<thead>
<tr>
<th>Time</th>
<th>Procedure</th>
<th>DOK</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 min</td>
<td><strong>Motivation/Anticipatory Set:</strong> Quick Write (because of privacy issues)-Have you ever been a patient or a client in an in-take session? (Visit the doctor, trip to the E.R., etc.) If so, how did you feel during the questions? If not, imagine how you would feel. How would you feel being the one who ASKED the questions?</td>
<td>2</td>
</tr>
<tr>
<td>1 min</td>
<td><strong>Transition:</strong> Hand out SOAP notes and samples to class</td>
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| 10-15 minutes | **Activity 1:** Whole Class  
- Read and Study SOAP notes and handouts for Observational Writing in Health and Human Services (attached)  
- Ask and answer questions | 1   |
| 3 min   | **Transition:** Tell students to move closer to the computer screen/Hand out blank SOAP note worksheet |     |
| 20 min  | **Activity 2:** In-Take Session  
- View a video of an in-take session  
- Take notes on SOAP form (attached)  
- Whole class  
Teacher option: Have different groups view different videos in different rooms | 3   |
| 2 min   | **Transition:** Get students into cafes of 3-4 people  
Teacher’s option: number off/self-selection |     |
| 10-15 minutes | **Activity 3:** Café. Set Smart Phone Timer.  
- Share results with group  
- Cover discussion questions with group | 4   |
| 1 min   | **Transition:** After timer alarm beeps, pull back as whole class         |     |
| 10 min  | **Activity 4:** Whole Class  
- Review discussion questions  
- Whole class: similarities and differences between Social Worker Observation Report and SOAP format | 2   |
| 5 min   | **End with Reflection:** Exit Ticket. One thing you learned about SOAP    | 1   |

**Homework:** Come to class with your observational notes on a preschool child AND A USB DRIVE
Demonstration of Mastery: How will I know that I have met my objectives? What will students DO to show they have met the objectives?
- Students will read and ask questions about the SOAP handout
- Students will view an in-take video and take notes on SOAP form
- Students will share results in groups and then whole class
- Students will compare and contrast the 2 forms of Observational Writing
- Students will ask questions about the homework

- Does this assessment really match with my objectives? YES
- Does this assessment match what I TAUGHT? YES

Trouble shooting: Some students may
- have trouble transferring what they heard into written notes
- not want to work in groups
- not be able to see the differences and similarities in the 2 Observational Writing formats

Reflection for Instructor:
- What went well?
- What could I change?
- Would I do this lesson again?
Handout on the SOAP Method for Taking Notes in Health and Human Service Careers

What: SOAP stands for "subjective, objective, assessment, plan."

S = Subjective

O = Objective

A = Assessment

P = Plan

SOAP is a standardized method of taking notes used by many professionals including social workers, doctors, nurses, EMTs, physical therapists, psychiatrists

Why: The SOAP Method is a way to document a situation from several points of view.

How: Instructions

Part I Subjective: Tell the story from the patient's or client's perspective.

- Who is he or she?
- Detail the way the patient describes himself as feeling.
- List the patient's specific complaint.
- Did it come on suddenly or were there warning signs?
- Was he injured? If so, how and when?
- Where was he when it happened?
- Find out if there was anything done at the time of the injury or incident to improve or change his symptoms.
- Include the patient's past medical history.
- List any medications he is currently taking or has just stopped taking.
Part II Objective: Give your factual perspective

- What was your first impression of the patient? Was he alert? Talking?
- Did his story make sense to you?
- If you were on the scene, what was your impression of the incident?
- Post his vital signs.
- List anything discovered during the physical exam.
- Note the patient’s mental condition.
- Post any general observations: the patient’s behavior, the behavior and condition of anyone who is with him, how he's dressed, drugs or alcohol?

Part III Assessment: Determine your conclusions based upon your initial meeting.

**NOTE:** You will receive training to assess a patient once you are further in your studies.

- List your probable diagnosis and any alternatives.
- Briefly summarize the objective and subjective information in writing.

Part IV Plan: Develop a plan of action.

**NOTE:** You will receive training to devise a plan once you are further in your training.

- What do you believe needs to be the next step?
- Assist in the next step. Refer a specialist or schedule an appointment.
Sample SOAP note for a Doctor’s Visit/Health & Human Services

**Reason for visit**: Mother and baby here for a sick visit because baby has “pneumonia”

**Subjective**: This is a 4-month old infant last seen 2 weeks ago for a routine protocol visit. Mother reports that, about 1 week after the last study visit, the baby started “coughing constantly.” Mother reports that the coughing has not interfered with the baby’s eating (baby is bottle fed); she denies that the baby has felt hot to touch during this period; she states that baby’s activity is the same as before the coughing began. Per the mother, everyone in the family started coughing around the same time as the baby although no one seems ill. She does note that all of the coughing seems related to the excess of dust in the air since the construction of the new road in front of her house began.

**Objective**: Vitals: Temperature: 98.6 (rectal); Blood Pressure: 110/60; Pulse: 72;
Weight: 17 pounds; length: 24.4 inches.
Well-developed, well-nourished female infant in no obvious distress. Blankets are noted to be quite dusty.

- Throat: pink, moist; no redness
- Lymph nodes: No swelling
- Heart: Rhythm regular; no murmurs
- Breathing: No effort with respiration. No wheezing
- Abdominal: Not done

**Assessment**: 4-month old infant with coughing secondary to airborne dust

**Plan**: Mother advised to cover the windows (closing the curtains might be sufficient), particularly those windows facing the construction. Also recommended that mother keep the baby in the room farthest from the construction. If the problem persists or worsens, she should return to the clinic immediately. Mother reminded of baby’s next appointment on September 17.
Sample Soap Note Worksheet in Counseling/Health & Human Services

S.O.A.P. stands for **Subjective**, **Objective**, **Assessment**, and **Plan**.

Date of Session________________________         Name of Counselor ____________________

Client’s Name _________________________
Client’s Date of Birth ___________________
Client’s Age __________________________
Client is Male Female   Other

**Subjective:**
- Record experience of the client as related/reported by the client.
- Often direct quotes from the client of his/her problems or complaints.
- Examples: “I had an awful week;” “I’m feeling really depressed;” “I hate my mother;” “I can’t seem to stop worrying about my grades;” “I haven’t slept in two days,” etc.
- Also can be statements made by client that you summarize without using quotes.

**Objective:**
- Record an objective account of the client’s appearance and behaviors.
- May include client dress/clothing, posturing, eye contact, timeliness to session, affect, activity, speech, etc.
- All the information in this section should be objective in the sense that it could be verified by observers and contains no analysis/judgment on your part.
- The Objective section should provide a behavioral picture of the client.

**Assessment: You will learn more about this as you progress in your studies**
- **Record a theory-specific** analysis or interpretation of the client’s issues and the session.
- Examples include, “The client seemed to accept his anger” or “The client’s thinking was irrational in the following ways …. .”
- This is your chance to hypothesize and define your conceptualization of your client’s issues.

**Plan: You will learn more about this as you progress in your studies**
- Record what you plan to do in the next session.
- Includes homework assignments, planned exercises or techniques, etc.
- When writing this section, ask yourself, “Following this theory, what is it I want to remember to do with this client?” or “What do I want to cover with them next week?”
- A plan should always be theory-specific.
Date of Session: July 23, 2014       Name of Counselor: Jane Doe, MSW

Client’s Name: John Smith
Client’s Date of Birth: 9/20/96
Client’s Age: 18
Client is:
✓ Male  Female  Other

Subjective:
- John Smith came in to his monthly scheduled appoint.
- When asked how he felt, John responded: “I can’t seem to stop worrying about my grades, so I haven’t slept in two days.”
- John also complained of head-aches and stomach aches
- John reported that he has been taking his medication

Objective:
- The client came dressed in a dirty tee shirt and dirty jeans.
- He came to the appointment on time.
- He was nervously wringing his hands
- He would not make eye contact; he kept looking down at the ground
- The behavior picture of the client: anxiety is high, poor attention to personal grooming and hygiene, signs of depression due to looking down at the ground, speech was normal

Assessment: You will learn more about assessment as you progress in your studies
- Record a theory-specific analysis or interpretation of the client’s issues and the session.
- This is your chance to hypothesize and define your conceptualization of your client’s issues.

Plan: You will learn more about counseling plans as you progress in your program
SOAP Form for Observational Writing

**Directions:** While viewing a video of an in-take session, take notes and fill in at least the Objective and Subjective Information.

Name of client__________________________________  Name of In-Take person________________________

Date of in-take _____________________  Client is Male/Female/Other (circle one)

1. Subjective Information from video

2. Objective Information from video

3. Assessment:

   **NOTE:** You will receive training to assess a patient once you are further in your studies

4. Plan:

   **NOTE:** You will receive training to devise a plan once you are further in your course work

Reflection:

a. What was the easiest part of this assignment?
b. What was the most difficult part of this assignment?
c. How is the SOAP format different from the Social Worker’s Report?
d. How is the SOAP format similar to the Social Worker’s Report?