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CSSR-TCC Summer 2013 Internship
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Collagen and Conscience: Improving End of Life Care

Introduction:

I participated in the 2013 CSSR summer internship at the Terence Cardinal Cooke (TCC) Healthcare Center along with three other undergraduates from Columbia University. TCC is unique in that it is a continuing care facility that provides services to a wide spectrum of patients. A massive 600-bed institution with nine floors, TCC contains four service lines: a skilled nursing facility (SNF) unit that houses geratrics, Alzheimer's/dementia, and end stage renal disease (ESRD) residents; a special services line that houses sub-acute/transitional care and Huntington's Disease patients; a Discrete unit housing HIV/AIDS patients; and a Specialty Hospital for severely disabled children. In short, TCC is an impressive undertaking and a rare place where you can see many different facets of medicine at work.

My internship this summer had several major components, and they all involved mentorship by the extremely courageous and selfless medical director, Dr. Lechich. The primary purpose of the internship has been the development of a research project geared toward the investigation and improvement of palliative care for patients with End of Life/terminal prognoses. While we dedicated the majority of our time and focus for this project, we were also tasked with various institutional tasks that ranged from assisting with a Department of Health survey to assessing quality of medical care through audit reports. Finally, the internship nurtured our educational needs as students. We had the opportunity to adopt a specific floor or service line and observe the day-to-day operation of an interdisciplinary team that involves physicians, nurses, certified nurse assistants

(C.N.A's), recreational/physical therapists, dieticians, pastoral care, psychologists and social workers. Furthermore, we adopted specific patients identified by Dr. Lechich to be in a 'state of decline' and interacted with them throughout the summer. In doing so, we gained a fuller understanding of End-of-Life issues and the responsibilities of a physician in caring for patients in the final chapters of their lives.

The internship has been a very enriching experience and has taught me a great deal about the state of the healthcare system. Through audits and surveys, I have seen how wonderfully the TCC staff accomplishes their gargantuan calling day after day. While I hope the observations, proposals and suggestions in this report can help the facility improve, I believe TCC has generally been doing a great job and has given me far more than I can give back.

Palliative Care:

Palliative care is "…an approach that improves the quality of life of patients and their families, facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual." (Bruera, 2010)

One of the most important concepts in medicine I learned this summer is the concept of palliation. At its surface, the purpose of palliative care is simple. As the excerpt from the Journal of American Oncology article states above, palliative care aims to relieve suffering. From an initial glance, this seems to suggest that all medicine is palliative. After all, isn't it a doctor's job to relieve patients of their pain? However, the primary goal of palliation is neither to extend life, hasten death nor to cure illness. Rather, treatments take a holistic, interdisciplinary approach to improve the overall *quality* of a

patient's life. Treatments focus on alleviating symptoms instead of targeting the underlying disease itself.

The subject of palliation grows more complicated when we introduce the issue of prognosis, advance directives, the End of Life protocol and Hospice. The difference between palliation, End of Life and hospice is an important distinction to make at this point. Whereas palliative care refers to a patient-based medical approach to maximizing comfort for an individual with a chronic illness, End of Life (EOL) refers to a determination by the attending physician that the patient has a terminal prognosis. TCC then initiates a protocol to alert staff to be more attentive to that patient's end-of-life needs, including a daily visit by pastoral care. Nurses track and report the daily status of EOL patients on morning report and place EOL care plans in Sigma. On the other hand, hospice refers to a set of services available to patients who have a terminal prognosis with a specified life expectancy of six months or less. Residents on hospice receive additional staff services, including the attention of an extra hospice specialty nurse.

Challenges & Barriers:

Palliative care aims to relieve patients with a terminal illness of their pain and distress. But this is the simplest definition. I have discovered that palliative care can grow incredibly nuanced and complex, especially when we reach the process in life where palliative care can count the most: the process of dying. In the context of EOL care, there can be enormous challenges and barriers to the delivery of palliative care and efforts to improve quality of life.

The first key challenge I discovered in providing palliative care to end-of-life patients is an issue of misunderstanding. A common misconception regarding palliative care is that it precludes life-sustaining treatments and that it is provided only after the

exhaustion of conventional medical efforts to cure. In other words, the phrase 'palliative care' carries a stigma for end-of-life patients that medicine has given up on them. Physicians also appear reluctant to order referrals for palliative care. After all, most physicians have been trained to treat and cure; stopping efforts at combating the illness itself may feel like defeat. The truth is that palliation can be administered at any stage of a disease in conjunction with other medical therapies.

To illustrate this point better, I'd like to introduce a case study of one of the patients I have followed this summer. AM is an elderly Hispanic lady with end stage renal failure. She goes to hemodialysis three times a week and is on tube feeding. The dialysis performs the role of filtering her blood that a healthy set of kidneys would do. The treatment sustains her life, but it can wreak havoc with her blood pressure. She has several children. One of her daughters acts as her healthcare proxy (HCP) and visits often. Her advanced directives include a Do Not Resuscitate (DNR) and a Do Not Intubate (DNI) order.

On June 12th, 2013, AM's blood pressure begins spiking with her systolic (or maximum) blood pressure elevating to levels greater than 200. Systolic blood pressure levels lower than 120 are normal whereas levels greater than 180 are considered to be hypertensive crises. In my daily visits to her, I see that her brow is always furrowed, as if in pain. Her medications for hypertension also don't seem to be lowering her blood pressure. If she discontinues the dialysis treatment, toxins will build up in her blood and cause death. If she continues, her blood pressure will elevate to even more fatal levels. Her prognosis looks to be less than six months; the end seems to be in sight.

This understandably causes a very agonizing situation for AM's daughter. The daughter considers sending AM to the hospital. If AM is hospitalized, she could get specialist care to relieve her blood pressure. However, her treatments may be costly,

aggressive and cause undue suffering. In addition, the time spent waiting and being transported in an ambulance often prove hazardous to the frail condition of the sick and elderly. Important questions arise for the daughter regarding goals of care. 'What do you think AM values more?' Would she want to endure aggressive treatments and possibly live longer or would she want to focus more on being comfortable in her last days? Because the other siblings are either distant or not involved enough in the decision-making process, AM's daughter mentions feeling 'alone' and experiences considerable emotional distress in deciding her mother's fate. In the end, AM's daughter decides to hospitalize her mother if the blood pressure cannot be controlled; the idea of switching to 'comfort measures only' sounds too much like a death sentence.

Fortunately, AM's medications do manage to bring her blood pressure down, and her condition stabilizes. Her prognosis improves; she may still be with us in a year. AM's case is an important one. It can be tempting to interpret 'comfort measures only' as an example where palliative care precludes curative medicine. This is not the case. Curative medicine was never excluded as an option for AM; the safety and likelihood of its effectiveness, however, diminishes as the trajectory of her disease advances. On the other hand, palliative care is always an option, which is why the priority of medicine usually shifts toward palliation as the disease progresses. In some cases like AM, a palliative approach with 'comfort measures only' can actually end up prolonging life better than curative medicine can.

The second key barrier I discovered to delivering palliative care at TCC is proper identification and triage of those who should receive it. A major contributing factor to this is the great degree of physician uncertainty in giving prognosis. According to the article 'Uncertainty – the Other Side of Prognosis' by Alexander Smith, 'There has been a resurgence of interest in prognosis…driven by a recognition that prognosis plays a

central role in medical decision making (Smith, 2013)'. Influenced by the emergence of 'big data' in the medical field, I was initially tempted to propose applying population data to help predict disease trajectories. However, I quickly realized that achieving prognostic certainty through the application of population data to an individual case is not generally feasible. As Smith mentions in his article, there is wide variation in survival rates of people with very similar health conditions. The lesson is clear: each patient is an individual case and not a statistic.

Nonetheless, prognosis is an important tool for assessing who is in need of the most palliative care and deciding who should be put on an EOL protocol. To that end, Dr. Lechich has developed a 'RADAR' EOL scoring system. Under this system, a patient receives a RADAR rating of '1' if they are 'critically ill' and physicians estimate a life expectancy of six months or less. A '2' indicates a terminal prognosis where the patients may have more than six months but could easily deteriorate. A '3' is the least urgent score and indicates that the patient is terminal but has a stable condition. The pastoral care department has worked together with Dr. Lechich in utilizing RADAR to compile and maintain a list of EOL patients at TCC.

From observing the work of several physicians at TCC as well as Dr. Lechich, it appears that prognosis often relies on quick clinical approximation and the judgment of the physician. When I asked one physician how precise prognostication techniques are, he succinctly answered 'not very'. Referring back to Smith's article, uncertainty is inherent in the nature of prognosis. After all, disease trajectories change. AM is a clear example of this. This raises an important point. If trajectories change, then maintenance of the EOL list becomes a much more sophisticated issue. Ideally, the EOL identification list would be in constant flux and reflect the changes in each patient's disease trajectory.

The EOL list compiled by the pastoral care department is not a comprehensive list of the whole facility as they are limited by the availability of a physician to give a medical opinion on each patient. But my time here has shown me that such a comprehensive and evolving EOL triage/identification list would be a powerful and much-needed tool. Evidence for its need includes the fact that we have often referred to the pastoral care EOL list in deciding which residents we should 'adopt' and the affirmation by several nurses I have interviewed. To overcome the lack of completeness in the current EOL list, we have also accompanied Dr. Lechich on 'run-throughs' of the whole house, where each patient on the roster is personally assigned a RADAR rating by Dr. Lechich after consultation with the attending physician. While this is an important exercise, it places the burden of responsibility almost entirely on Dr. Lechich. This lends itself to the possibility of not recognizing every patient who should be on an EOL care plan. (See 'Project/Solutions' Section for possible improvements and suggestions)

The final key barrier I discovered to providing good palliative care is communication and proper alignment regarding goals of care between the physician, the patient, and the patient's friends or family. Too often, I have seen doctors properly identify patients as needing EOL care but then find themselves unable to place a patient on an EOL care plan because the patient's family or proxies refuse to give the directives that prevent resuscitation interventions. When I asked one doctor why they don't press the family harder to reconsider, he noted that he felt like it was not his place to tell the family what to do. There is a delicate balance that exists between not encroaching on the wishes of the patient/patient's family and offering the best possible medical advice.

But Dr. Lechich pointed out that there is more to it. Aside from being trained primarily to cure, physicians are not compensated for taking the time to have a conversation educating the patient's family on the implications of aggressive

resuscitation procedures. Physicians are themselves sometimes emotionally unprepared to initiate these types of discussions, which can often bring very difficult emotions to the fore. As a result, physicians do not prioritize these discussions. And without a physician to explain, a patient's family may have no idea that certain interventions must continue once started in order for a patient to survive. Unfortunately, if the physician doesn't take the time to discuss and offer guidance on a course of action, who will? It has to be the physician. This problem is being addressed by greater attention paid to palliative care in medical school. But for now, it seems that basic attitudes toward the true responsibilities of a physician must change. Physicians must view compassion and love as a part of their role in caring for a patient and their family.

The Principle of the 'Good Death':

What, then, is the ultimate objective of palliative care in an EOL context? The simplest definition of palliative care states that the primary goal is to relieve suffering. But in an EOL context where the patient is clearly nearing the end, the primary goal encompasses more and arguably includes the chance for a 'good death'. Here are two case studies to illustrate what I mean by that.

It was February when I first met EF as a volunteer. He looked frail, elderly, but his bright blue eyes still sparkled with intelligence and awareness. After introducing myself, I learned that he was once a judge and that he was in the hospital to recover from a bad fall. As I continued to get to know him on a weekly and then daily basis, I saw that he was still quick-witted and had a warm handshake.

But as the summer started, I noticed that his condition had declined, slowly but surely. He recognized me less and less often, and a wound on his legs opened up. On his bad days, he became verbally unresponsive; his mouth would just hang open due to the

appearance of a growth at the back of the mouth. He would stare blankly into the distance. His skin also glistened with sweat even when it was cool.

Despite his decline, I saw that he was very well cared for. The nursing staff was very loving and attentive to his needs; they thought of him as 'their baby'. Pastoral care also saw him on a daily basis, and he was on their EOL list. Dr. Lechich was in constant communication with the loving, astrophysicist daughter to offer compassionate medical advice and establish goals of care. Before he passed, I noticed that his daughter had put pictures of him from just a year ago by his bedside. A man of great stature dressed impressively in judge's robes stood smiling with his arm around his daughter in the picture. It seemed impossible that the frail-looking man with the blank stare in the bed was the same person as the photo. And yet I began to see EF in a different way, as if finally getting to know him for the first time. The picture was a reminder for people to see beyond his condition to the wonderful judge, father and grandfather EF's daughter knew him to be. When EF passed away in the summer, he expired peacefully.

I then had a chance to meet with EF's daughter. And though she was understandably grief-stricken, a part of her seemed to be at peace as well. She had received counsel from Dr. Lechich; she had time to plan and prepare for her father's passing. She knew that her father had died surrounded by people who loved him and who acknowledged his dignity as a man. This was an example of a 'good death'. There was no failure to acknowledge the humanity of the patient. There was no failure to offer medical advice or establish goals of care with the family. There was no failure to minimize distress for the patient or the patient's family. Every component of the interdisciplinary team (IDT) was on point.

In the second case, KS was an AIDS patient who passed away in early June. He was a relatively new admission and expired unexpectedly. After speaking with Dr.

Komal, I learned that she considered him a candidate for the EOL care plan. But he was full code, and having the advanced directives for DNR, DNI, and DNH are prerequisites for EOL care. His niece was the HCP. Although she was uninvolved in her uncle's care, she was reluctant to agree to limit resuscitation procedures. Within the first week of June, KS became unresponsive. He was full code so the paramedics arrived and performed CPR until his pulse stopped, possibly cracking his ribs in the process.

This scenario is an example of a 'bad death'. Without the attention of the EOL care plan, KS died on a floor where most of the nursing staff consisted of 'floats', C.N.A.'s who float between floors. That means he received limited continuity of care – he died alone among strangers. He was new so there was never a chance to truly attune to his needs, to give him the level of love and compassion someone in their dying days deserves to receive.

These two case studies taught me the meaning of a 'good death'. A 'good death' happens when the patient, the family and the caregivers are in agreement regarding the goals of care. There is a clear understanding of the patient's values and priorities. Bereavement and counseling services by social workers, pastoral care and the physicians are available to the family afterward. Nobody is simply left in the dust.

Volunteer Project/Solutions:

Through this internship, I have been fortunate enough to observe comprehensive care plan (CCP) meetings, staff meetings and the day-to-day operations of a multi-disciplinary care team at a very unique medical center. As a corollary to this, I have also been given the opportunity to observe some of the greatest challenges that the team faces in delivering the best care possible. I have already discussed several of these key

challenges, and I would like to now present my proposed solutions to address possible ways to overcome these obstacles.

Names and Labels: 'The picture I had of hospice was of a morphine drip' (Gawande, 2010). Although better education regarding palliative care will hopefully change the current state, the fact is that the terms 'End-of-Life care' and 'hospice' still have a stigma attached to them. For many, hospice means giving up and just numbing a patient-as well as ourselves-to their pain while passively waiting for nature to take its course. Suggesting to a family member that a patient be placed on 'End-of-Life' or 'Hospice' may sound like a death sentence. It's a small tweak, but maybe even changing the name of the 'End-of-Life' care program to, as Dr. Lechich suggested, something like the 'Advanced Palliative' care program could alleviate this problem. We could go even further. Drs. Bruera and Hui noted in their article from the Journal of Clinical Oncology that they renamed their 'Palliative Care' unit as the 'Supportive Care' unit in order to facilitate earlier referrals.

Volunteer Program – 'Roll Call' Shift: Having Dr. Lechich as a mentor has been an unforgettable privilege. He is a great physician and a leading expert on palliative care. He has devoted decades of thought to identifying the most serious obstacles in palliative care and finding ways to solve them. As someone who has thought about these issues very deeply, his insight has been of great benefit and value to us as students.

For my project, I chose to focus on improving EOL identification and triage. After learning from Dr. Lechich, I reflected on its importance. Having a watertight EOL identification and triage method will allow us to make sure that people don't fall through the cracks. If we can identify the people in a state of decline in real time, then we can allocate the appropriate palliative care resources in time to prevent unexpected and disastrous situations like a 'bad death' in KS's case. Dr. Lechich often spoke to us about

the need for a 'conscience' and for 'collagen', a connective tissue to support and catch us

when we aren't being as attentive to the needs of each patient as we could be.

The 'At Your Service Program' piloted by Ashley Shaw has made significant

headway as far as providing that 'collagen'. Drawing from my own experiences as an 'At

Your Service' volunteer, I have developed some ideas for improvement to strengthen this

collagen. The first is the implementation of a 'Roll Call' Shift for the program. For this

shift, participating volunteers would receive an assigned floor along with a roster of all of

that unit's patients. The volunteer would go to each patient of their assigned floor and

record their observations on a questionnaire sheet (Appendix-2). More details and

guidelines describing this shift are in the following section.

Roll Call Assessment Guidelines

In the past, TCC utilized a 'Palliative Care Symptom Assessment' tool (See
Appendix-1) to track patients in real time. However, the tool relied solely on a numeric
rating system for each symptom and thus primarily captured information on symptom
severity at the exclusion of other information. Each symptom's score had to be self-
assessed by the patient, which left out the possibility of an objective perspective. The tool
also required that each of the chart's 16 symptoms be tracked on a daily basis. This made
the tool inefficient to use, as it was not customized to each patient's individual needs.
Ultimately, this tool fell out of use, but has inspired my own proposals.

Identification: There are at least ten common symptoms frequently associated with
palliative/EOL patients: 'pain, dyspnea, nausea/vomiting, weakness/fatigue, insomnia,
weight loss, confusion, constipation, anxiety, and depression.'(EPEC) Volunteers will
conduct brief (<10 minutes) interviews with each patient to assess their condition. While
volunteers will probably not ask each and every patient about each of these symptoms
due to time limitations, they can use these identifiers as a reference point to guide their
investigation and interviews. Education on these symptoms will be part of the volunteer's
training.

Subjective: This will be the first component of every interview. The volunteers will ask
each patient for their personal input on chief complaints. The volunteer can use either the
template I designed (Appendix-2) or some variation of it to record the patient's direct
concerns, observations, quotes, and thoughts.

Objective: In the second component of the interview, the volunteer can record physically observable data. They will base their observations on patient feedback in the subjective component. For example, if the patient reported feeling pain around the lower leg, the volunteer should check for wounds, swelling or lesions in the area and record their findings.

Assessment: The third component of the assessment tool will allow an opportunity for quick reflection by the volunteer. They should ask themselves the following questions: Did my observations confirm the patient's feedback? What do I think is the patient's primary problem? How can we improve the patient's quality of life?

Purpose: This method will help volunteers be mindful of which patients appear to be in a state of decline. My intent is to use this shift to catch people who might otherwise fall through the cracks. For example, if a volunteer notices that a patient has become breathless, lost weight, or experienced more pain lately, then we can put that patient on the RADAR. Additionally, the act of going to each patient on a floor can help facilitate and guide increased patient interaction for the volunteers.

Optimally, I would also suggest that each week, physicians call together an IDT meeting to conduct their own roll call for the unit. The volunteers can submit their reports to the doctors as a supplement. In turn, the volunteers can use their own observations and the IDT meeting to compile an evolving triage list for their floor.

I developed this method of assessment based on an existing model called the 'S.O.A.P. Progress Note Checklist' (See Appendix-3), which is used to assess clients in Alcoholics Anonymous (AA) meetings. It stands for 'Subjective, Objective, Assessment, and Plan'.

There are limitations to this proposal. First of all, an additional training component would be needed for volunteers who choose to participate in this shift. They would require education on how to assess a patient's symptoms. For instance, to assess physical pain, there should be guidelines on asking for location, severity, duration, and nature of the pain. Northwestern University's Education for Physicians on End –of-Life Care (EPEC) identifies nine common symptoms for EOL patients and offers ways of asking the patient for information on each one. Secondly, I anticipate from personal experience that volunteers may be overly cautious at first about putting people on alert due to lack of familiarity with each patient's baseline and limited medical knowledge.

However, as volunteers continue to track the same adopted floor on a weekly basis, I

expect this problem will diminish over time. On the other hand, even if 14 out of 15

patients put on alert by the volunteers turn out to be 'false alarms', if we can improve the

quality of life for so much as one patient who would otherwise not be recommended for

an EOL care plan, then I believe this program will be worthwhile.

Volunteer Program-'EOL' Shift: There were two types of shifts in the pilot year of the
'At Your Service' volunteer program. One of these shifts was a one-on-one, long-term
companionship session where we stayed and bonded with one particular resident over the
course of a year. As interns, we enjoyed a similar experience. We each 'adopted' several
EOL residents whom Dr. Lechich identified as hot cases: people who were in a state of
decline and illustrated the challenges of palliative care. We visited them daily and kept
track of their condition through use of variable scorecards.

     By combining these two roles into one EOL volunteer shift, we can accomplish
the following:
  - Provide sustainability to the variable scorecard project to provide in-depth attention
    to the needs of residents who are on our RADAR
  - Educate volunteers on palliative care principles
  - Consolidate important care notes for specific residents onto one sheet that can be
    accessed by staff members, especially during shift changes
  - Adapt care to the evolving trajectories of each resident

Shift Description: The volunteers will divide their time during the 2-hour shift to visit 1-3
EOL patients. Volunteers will receive a customizable scorecard (See Appendix-4 for an
example of a scorecard I constructed over the summer) for each patient. The first four
rows will allow for common EOL symptoms that the patient exhibits. However, the
remaining fields in the scorecard will be variable. The volunteer will identify/track key
symptoms or items of attention as they spend more time with their resident and become
more familiar with their specific needs.
     As an example, EF had a bad leg wound that often gave off a bad odor. In my
visits to him, I would make sure to check on the condition, size and odor of the wound. If
the symptom was not visible to me due to a bandage, I would ask the C.N.A or nurse for
more information. Each scorecard will last for a month before being replaced by a new
one.

Additional Tasks: Aside from the 'Roll Call' and EOL shifts, I would also suggest that
we empower the volunteers to do more. Often, I felt powerless when my residents needed
very simple things and I was unauthorized to do anything about it. Additional tasks that
come to mind for the volunteers include: 1) Helping residents with grooming and hygiene
2) Implementing a 'Musical Therapy' shift to take advantage of the musical talents of the
Columbia student body.

Conclusion:

'You have to love the patient with your heart, show him or her that love, hold the patient, nurture the family and then and only then will you succeed in this endeavor' (Lechich, 2011). I leave TCC with a much deeper understanding of medicine, especially in terms of palliative medicine. It's true that palliative care means to reduce the pain, suffering and discomfort of a patient with a serious illness. But this is the simplest possible definition. In dire circumstances, it also means minimizing the distress of the patient's family; it means speaking with the patient and family about their priorities and to make sure that treatments are aligned with those priorities. In an EOL context, it also means properly educating the patient and their family on the implications of treatments, advising them on an appropriate course of action, and coming to a consensus about how to care for the patient. Dying is a natural process, but there is a very clear difference between a 'good death' and a 'bad death'.

Overall, I have greatly enjoyed my experience at TCC. More so than ever before, my time at TCC has inspired me to pursue medicine so that I can be at the forefront of the fight against disease and suffering. My experiences there have also made me aware of the great need for innovation in healthcare to make medicine more precise, improve efficiency and thus create better physician care. I am very thankful for the time I had to bond with my patients. Many of them have amazing stories and adopted me just as much, if not more so, than I adopted them. I am also especially grateful to Dr. Lechich for being an amazing physician, teacher, role model and mentor. The love and compassion he shows the residents of TCC on a daily basis has set an example for me to follow that will stay in my heart forever.

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TERENCE CARDINAL COOKE HEALTH CARE CENTER

Palliative Care Symptom Assessment*

Patient's Name: _____   Med. Rec. Num.: _____   Unit: _____

Directions: Symptom Assessment is to be done once a day. Each sheet is for one (1) week. Each symptom must be reported by the patient. Zero (0) represents the absence of the symptom and 1-9 represents a worsening of the symptom. Ten (10) represents worst.

Symptom	Date							
Pain								
Tired								
Nausea/Vomiting								
Depression								
Anxiety								
Drowsy								
Appetite								
Feeling of Well-being								
Shortness of Breath								
Insomnia								
Constipation								
Diarrhea								
Hiccups								
Pruritis								
Stomatitis								
Other problems								

*d Edmontom Symptom Assessment Scale: Numerical Scale   Rev. 5/02

<u>Template for Roll-Call Shift Volunteers</u>
<u>Unit/Floor:</u>   **<u>Date:</u>**

1.   Patient name/Room #:_____
Subjective: Patient's chief complaints? _____
_____
_____
Objective: Problems/Symptoms observed?_____
_____
_____
Volunteer Assessment_____
_____
_____
Vital Signs-Last week: Blood Pressure:_____ Weight_____
Vital Signs-Current: Blood Pressure:_____ Weight_____

2.   Patient name/Room #:_____
Subjective: Patient's chief complaints? _____
_____
_____
Objective: Problems/Symptoms observed?_____
_____
_____
Volunteer Assessment_____
_____
_____
Vital Signs-Last week: Blood Pressure:_____ Weight_____
Vital Signs-Current: Blood Pressure:_____ Weight_____

3.   Patient name/Room #:_____
Subjective: Patient's chief complaints? _____
_____
_____
Objective: Problems/Symptoms observed?_____
_____
_____
Volunteer Assessment_____
_____
_____
Vital Signs-Last week: Blood Pressure:_____ Weight_____
Vital Signs-Current: Blood Pressure:_____ Weight_____

S.O.A.P. Progress Note Checklist

	Check if Addressed
S *Subjective* *Client statement capturing the theme of the session*	
1. Subjective data about the client—what are the client's observations, thoughts, direct quotes? ɯ	
2. Does the client's direct quote summarize the theme of the session?	
O *Objective* *Objective, often observable data or information supporting the subjective statement*	
3. Objective data about the client—what does the counselor observe during the session (affect, mood, appearance)?	
4. Does objective data or information match the theme expressed in the subjective statement?	
A *Assessment* *Counselor's assessment of the situation, the session, and the client's condition or prognosis* *Client's response to intervention and progress made in achieving tx plan goals / objectives*	
5. What is the counselor's understanding about the problem?	
6. What are the counselors' working hypotheses?	
7. What was the general content and process of the session?	
8. Was homework reviewed (e.g., journal, reading assignments – if any)?	N/A
9. What goals, objectives, interventions were addressed this session?	
10. What is the client's current response to the treatment plan?	
P *Plan* *Document what is going to happen next*	
11. What in the treatment plan needs revision?	
12. What is the counselor going to do next?	
13. When is the next session date?	
General Checklist	
14. Does this note connect to the client's individualized treatment plan?	
15. Are client strengths/limitations in achieving goals noted and considered?	
16. Is this note dated, signed, and legible?	
17. Is the client name and identifier included on each page?	
18. Has referral information been documented?	
19. Does note reflect changes in client status (e.g., GAF Scale, measures of functioning)?	
20. Are any abbreviations used standardized and consistent?	
21. Would someone not familiar with this case be able to read this note and understand exactly what has occurred in treatment?	
22. Are any non-routine calls, missed sessions, or professional consultations regarding this case documented?	
22. Did counselor/supervisor sign note?	

Customized Punchcard for: Patient Name
Month of: October

Date Symptom	Week 1	Week 2	Week 3	Week 4
Pain				
Responsiveness				
Nausea/Vomiting				
Mood				
Patient-Specific Symptom 1 (eg Leg Wound)				
2				
3				
4				
5				

Physician Comments:

C.N.A. Comments:

Nurse Comments:

Additional Assessment Comments: