



Towards the Development of the Case Notes Assessment Scale

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Abstract This study initially developed an instrument that measures the counseling professionals' current case documentation process and outcome with reference to a prescribed way of writing case notes. A 10-step test development method was employed in constructing, analyzing and finalizing the scale using 151 participants. In writing the items, the Subjective, Objective, Assessment and Plan (SOAP) Note Format Standards of Cameron and Turtle-Song (2002) were considered. The instrument was subjected to experts' review and was pilot tested to establish its psychometric properties. Results yielded a Cronbach's Alpha of 0.92, indicating a high level of internal consistency. The factor loadings of 0.40 or higher retained 30 items. The loadings observed ranged from 0.42 to 0.82. The newly derived subscales of the Case Notes Assessment Scale are Record Content (14 items), Brevity of Notes (6 items), and Writing Mechanics (10 items). This newly developed tool serves as guidelines or standards that can be used in evaluating the case documentation process and outcome of counselling professionals.

Keywords: case documentation, assessment, case notes, instrument development

The Guidance and Counseling Act of 2004 (R.A. No. 9258), seeks to professionalize the practice of guidance and counseling in the Philippines. In relation to this, the counseling professionals are expected to provide high quality services to students and other clientele. According to the International Association of Counseling Services, Inc., professional ethical practice forms the cornerstone of the counseling service. In particular, systematic case records, such as intake and assessment information, case notes, termination summary and tests, must be maintained as required by professional standards (Kiracofe et al., 1994).

This calls for accountability from counseling professionals who are expected to accurately document what has transpired during their counseling session or therapeutic hour in the form of case or progress notes (Cameron & Turtle-Song, 2002). Case notes, which are part of the student

records and kept in the Guidance Office, serve as tools in monitoring the clients' progress in counseling and in developing the counselors' case conceptualization and treatment planning skills. These records also serve as reference for other counselors or specialists who may handle the same client in an emergency case through referral procedures (Estanislao, 2010). The need to further improve the quality and continuity of client services in this regard remains to be a pressing concern among counseling professionals. What is and is not important enough to be incorporated in the case notes posed some questions for counselors who desire to be systematic in the delivery of client care.

Prieto and Scheel (2002) presented the STIPS format for organizing case notes that could increase the counselor trainees' case conceptualization skills. It consists of five major sections, such as, documenting clients' current Signs and Symptoms, Topics discussed in Counseling, Counseling Interventions used, Clients' Progress and Counselors' Continuing Plan for Treatment, and Special Issues of Importance regarding clients (e.g., suicidality). Such information can be used to enhance the trainees' ability to acquire relevant facts about the clients, to better understand the clients' presenting problems, to better monitor counseling the processes, and to better evaluate and adjust the treatment interventions.

Following this frame of mind, Travers (2002) emphasized the need of writing high-quality case notes, which can be time-consuming. According to him, these notes serve as a record for other counselors who may meet with the same client being handled in an emergency situation or when the client transacts to another counselor. Thus, case notes should be legible, efficient, and detailed. Other important uses of case notes are for supervision and court purposes. "A state or federal court of law can subpoena client files if legal action is taken against you or your client" (Travers, 2002, p. 36).

In the same light, Cameron and Turtle-Song (2002) reported a number of models that enable counselors to identify, prioritize and track client problems so that they can be attended in a timely and systematic manner. They also provided an on-going assessment of both the client's progress and counselor's treatment interventions. Components of these models include the Data, Assessment and Plan (DAP), Individual Educational Programs (IEP), Functional Outcomes Reporting (FOR), and narrative notes, which are all variations of the original Subjective, Objective, Assessment and Plan (SOAP) note format.

From the foregoing review of literature, it was observed that only a few number of research studies were done in relation to assessing existing case records. There seems to be no standard content or procedures in writing what has transpired during the counseling session. It is for these reasons that this study was conceived. It aimed to initially develop an instrument that will measure the counseling professionals' current case documentation process and outcome with reference to a prescribed way of writing case notes. Findings of this study hope to provide valuable information in mapping out gaps and limitations in the existing case records and practices of professionals given the recommended standards. Validated case note writing standards may also serve as guidelines in the conduct of

the profession and in the delivery of better client care services. This initially developed tool can be used by school counselors, educators, supervisors, and other mental health professionals in evaluating their case documentation in terms of content, brevity, and mechanics of writing notes.

The Problem-Oriented Medical Records Model

This study adapted Cameron and Turtle-Song's (2002) Subjective, Objective, Assessment and Plan (SOAP) Note Format Standards, as described in the Problem-Oriented Medical Records (POMR) Model. This model considers four areas: (a) Clinical Assessment includes intake interview information, tests, reason for help-seeking behaviors, reason for seeking treatment, secondary complaint, presenting concern, personal, family, and social histories; (b) Problem List covers active and inactive resolved list of the client's presenting and underlying problems derived from the clients history, numbered, dated, and entered into the list-attached in clients file, when resolved, dated, and made inactive; (c) Treatment Plan contains statement of possible therapeutic strategies and interventions to be used in dealing with each noted problem, stated as goals and objectives, and written in behavioral terms in order to keep track the client's therapeutic progress, or lack thereof; and (d) Progress Case Notes, using the SOAP Standards, serve to bridge the gap between the onset of counseling services and final session to clearly document and support, through subjective and objective sessions, decisions to modify or to bridge the gap between the onset of counseling services and final session or closure.

Cameron and Turtle-Song (2002) discussed the first component in terms of its contents such as information gathered during the intake interview/s. These generally include the reason the client is seeking treatment, secondary complaints considering the client's personal, family and social histories, psychological test results, if any, diagnosis and recommendations for treatment. They continue that from the Clinical Assessment, the second component emphasized on a Problem Checklist, which includes an index of all the problems, active or inactive, generated from the client's history. The third component of the POMR is a statement of the possible therapeutic strategies and interventions to be used in dealing with each noted problem. Treatment Plans are stated as goals and objectives are written in behavioral terms in order to track the client's therapeutic progress, or lack thereof.

Finally, the fourth component, progress case notes are generally written using the SOAP format and serve to bridge the gap between the onset of counseling services and the final session. In writing case notes, clear and concise document serves as references in order to organize the counseling professional's thinking about the client and to aid in planning of quality client care. An example of case notes based on the objective and subjective data reads: "Death of a loved one or diagnosed with a potentially life-threatening health problem..." By recording this information in the progress notes, it provides justification and documentation for sudden shift in therapeutic decision and is immediately able to address what is now the more pressing issue for the client. The next step, which should be recorded, may state: "Refer client to a domestic violence group for perpetrators". The subjective and objective sections of the SOAP notes would chronicle the

client's history of physical aggression and violent behaviors. Other benefits of case notes include improving the quality of continuity of client services, enhancing communication among mental health professionals, facilitating the counselor in recalling the details of each client's case, and generating an ongoing assessment of both the client's progress and treatment success (Cameron & Turtle-Song, 2002).

The SOAP Note Format

The Subjective, Objective, Assessment and Plan (SOAP) are described with examples and rules in writing case notes. These descriptions are: Subjective (S) - includes what the client tells you and what the significant others tell you about the client. Basically, it is how the client experiences the world. Client's feelings, concerns, plans, goals and thoughts, intensity of problems and impact on relationships, pertinent comments by the family, case managers, behavioral therapist, etc., client's orientation to time, place, and person and client's verbalized changes toward helping are recorded in this section. Objective (O) or Factual -contains what the counselor personally observes and witnessed. These are quantifiable, such as what was seen, counted, smelled, heard or measured outside written materials received. The client's general appearance, affect, behavior, nature of the helping relationship, client's demonstrated strengths and weaknesses, test results and materials from other agencies, etc., are to be noted and attached here. Assessment (A) - summarizes the counselor's clinical thinking, a synthesis and analysis of the subjective and objective portion of the notes. For counselors, inclusion of clinical diagnosis and clinical impressions (if any), are considered in this portion. For care providers, they look into how would you label the client's behavior and the reasons (if any) for this behavior? Plan (P) - describes the parameters of treatment, consists of an action plan and progress format and standards. This section also includes interventions used, treatment progress, and direction. Counselors should include the date of next appointment. In addition, prognosis is determined, whether there can be anticipated gains from the interventions.

The rules in Case Note Writing using the SOAP Note Format consider the following: keep notes brief and concise; maintain quotes to a minimum; use an active voice and in precise and descriptive terms; record notes 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 inks if notes are hand written and sign-off using signature, plus your title. Moreover, what to avoid in writing case notes are the following: using names of other clients, family members, or other names mentioned by the client, terms like "seems, appears" (uses senses), value-laden language, common labels, opinionated statements, the use of terminology unless trained to do so, erasing, obliterating, using correction fluid or in any way in attempting to obscure mistakes. Finally, blank spaces between entries and squeezing of additional commentary between lines or in margins should not be done.

The abovementioned SOAP descriptions, examples, and rules in case note writing was considered in the construction of the Case Notes Assessment Scale, which went through content and factor analyses.

The Present Study

This study aimed to initially develop an instrument that assesses the current case documentation process and outcome of counseling professionals in accordance to prescribed note format and standards. Specifically, it sought to answer the following questions: (1) What are the factors or subscales that will measure the counseling professionals' current case documentation process and outcome with reference to a prescribed way of writing case notes? (2) Is the Case Notes Assessment Scale (CNAS) a reliable instrument in measuring the counseling professionals' current case documentation process and outcome?; and (3) Is the CNAS a valid instrument?

Method

Participants

One hundred fifty one (151) counseling professionals, who are employed in different schools, colleges, and universities in Metro Manila and provinces across educational levels at the time of this investigation were randomly tapped as participants for this study. Majority of them were female (76.16%) and 14.57% were male. More than half of these participants (52.32%) were married; 31.79% were single; and a handful of them (15.89%) did not indicate their marital status. In terms of age, the oldest was noted at 68 years and the youngest, 20 years, with a group mean age of 37.71. The counseling professionals' profile further revealed that the longest number of counseling years of experience was 28 and the shortest was less than a year, with a mean of 10.53 years. Finally, close to half of the participants (44.37%) have obtained their Bachelor's Degree; 50.34% of them have finished or are still working on their Master's Degree when these data were gathered; and the rest 5.29% obtained or were working on their Doctoral Degree.

Measures

The Case Notes Assessment Scale (CNAS) was administered to the participants of this study in order to establish its psychometric properties. The CNAS contains a 30-item, 5-point Likert type self-report scale following Cameron and Turtle-Song's (2002) Subjective, Objective, Assessment and Plan (SOAP) Note Format Standards. It measures the current case documentation process and outcome of counseling professionals based on the said prescribed standards. The participants were asked to rate their degree of agreement or disagreement to each of the statements using a scale from Strongly Agree (5) to Strongly Disagree (1).

Procedures

This study employed the 10-step procedure in test development, as suggested by Sevilla, Ochave, Punsalan, Regala, and Uriarte (1992). The steps include the search of content domain, item writing and review, development of the pre-try-out, main try-out and final forms, first trial and final test administration and evaluation tests validity and reliability, and plan for the development of norms. During the mid-section stage, copies of

the main try-out forms were fielded to the 151 participants. Some of these counseling professionals were requested to respond online and for those working in nearby universities and colleges from my workplace, they responded through the hand-carried forms.

Data Analysis

Factor analysis was primarily used to validate the Case Notes Assessment Scale (CNAS). It is a statistical procedure of reducing a large number of measures to a fewer number called factors. A factor matrix is derived which is comprised of each of the item correlation coefficients and the groupings of items under individual factors. Thus, the components of a construct are discovered. In this study, exploratory factor analysis was done using several factor solutions. In this analysis, the items were simply entered and the resulting factors were described (Gable, 1986).

A Principal Components Analysis with Varimax Rotation (with Kaiser Normalization) was finally performed using a 3-factor solution. Factor loading of 0.40 or greater was adopted for the screening of the items. The reliability of the CNAS was determined using the Cronbach's Alpha.

Results

Validity

Considering the exploratory factor analysis, factor solutions were done before determining the final selection. The three-factor was chosen because of the highest value obtained in the total variance was accounted for by this solution. An initial principal components analysis with Varimax rotation was performed on the entire sample of the 151 respondents but only 140 records were considered valid. They were included to maximize the possible range of item responses that would affect the inter-correlations between items entering factor analysis. The following factors extracted in the Varimax rotation were given these labels in describing the process and outcome of case documentation, namely, Record Content, Brevity of Notes, and Writing Mechanics.

Factor 1: Record Content. The first factor extracted displayed the most number of items ($n = 14$). All of them were observed to solely load on just this aforementioned factor. A factor loading of 0.40 or higher was adapted as a basis for screening these items. Factor loadings range from 0.43 to 0.78. This dimension describes the written information that should be found in case records indicating how the client experiences the world in terms of orientation to time and place, attitude towards counseling, and what significant others tell about the client. Facts or quantifiable observations in terms of the client's general appearance, affect and behavior, nature of the helping relationship, demonstrated strengths and weaknesses, test results and other materials, etc., are noted and attached here. Finally, a summary of the counselor's clinical analysis, prognosis and interventions are portions of these notes. Sample items include no. 9: "I document what I personally observed and witnessed (ex. nature of our relationship)." and no. 15: "I document action plans including interventions, treatment, progress and direction of counseling".

Factor 2: Brevity of Notes. The second factor extracted in the Varimax rotation consisted of the smallest cluster of six (6) items with loadings ranging from 0.42 to 0.82. Five (83%) of these items solely loaded on this factor. It describes the shortness of case notes indicating only general words and minimum quotes, which are documented in precise and descriptive ways. The rules are to be observed in terms of what should be included and how these notes are written. Sample items include no. 2: "I document only key words or a very brief phrase when using quotations." and no. 16: "My case notes are brief and concise."

Factor 3: Writing Mechanics. The third factor yielded 10 items. This factor describes how case notes are written and presented following the rules, format, and standards prescribed by the POMR - SOAP Model discussed earlier. Likewise, this factor identifies a number of standards or rules that should be followed or avoided in writing case notes. Sample items include no. 24: "My case notes are documented using proper spelling, grammar, and punctuation marks." and no. 30: "My case notes are not squeezed with additional commentary between lines and margins."

Table 1
Accepted Items with Their Factor Loadings

Item Number	Factor 1	Factor 2	Factor 3
3*	0.596		
4*	0.462		
5*	0.558		
7*	0.599		
8*	0.643		
9*	0.636		
10*	0.529		
11*	0.715		
12*	0.783		
13*	0.611		
14*	0.714		
15*	0.652		
19*	0.435		
20*	0.446		
1*		0.422	
2*		0.534	
6*		0.592	
16*		0.740	
17*		0.821	
18		0.506	
22*			0.444
23			0.517
24*			0.728
25*			0.569
26*			0.690
27			0.646
28*			0.519
29*			0.658
30*			0.697
31*			0.441

Note: * items that solely loaded in one factor

Reliability

Measures of internal consistency indicate the extent to which items on a test interrelate and represent similar content. They also provide a check on the content validity of the subscales since items within a subscale should be relatively homogeneous. In determining the reliability coefficient of the Case Notes Assessment Scale based on the 30 items, the Cronbach's Alpha was computed for the total scale. Results yielded a coefficient of 0.92, indicating a very high level of internal consistency.

After these initial procedures, the final form entitled Case Notes Assessment Scale (CNAS) was finalized. This 30-item scale assesses the current case documentation process and outcome of counseling professionals in accordance to prescribed note format and standards.

Scoring Procedures

In scoring the CNAS subscales and overall score, ratings for each item per cluster are added: For Factor 1 (Record Content), items included were nos. 3, 4, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15, 19, and 20; Factor 2 (Brevity of Notes), items included were nos. 1, 2, 6, 16, 17, and 18; Factor 3 (Writing Mechanics), items included were nos. 21, 22, 23, 24, 25, 26, 27, 28, 29, and 30. In interpreting the raw scores per subscale and overall score, the following arbitrary scaling was computed:

4.500 and above	Strongly Agree (Outstanding)
3.500 - 4.499	Agree (Very Satisfactory)
2.500 - 3.499	Neutral (Satisfactory)
1.500 - 2.499	Disagree (Needs Improvement)
1.499 and below	Strongly Disagree (Poor)

Discussion

It is evident from the results of this study that the Case Notes Assessment Scale (CNAS) is a valid and reliable instrument. This scale was constructed using Cameron and Turtle-Song's (2002) Subjective, Objective, Assessment and Plan (SOAP) Note Format Standards, as described in the Problem-Oriented Medical Records (POMR) Model. The derived factors are Record Content, Brevity of Notes, and Writing Mechanics. Findings suggest that counseling professionals have to consider these three components in assessing their case notes to ensure the appropriate process and outcome of written proceedings of the counseling session. Findings also provide valuable information in mapping out gaps and limitations in the existing case records and practices of professionals given the recommended standards.

In particular, Factor 1, Record Content enumerates all the essential elements covered by the SOAP model in terms of inclusions or substance of case records. The next two Factors 2 and 3, Brevity of Notes and Writing Mechanics, focused on the rules prescribed in writing progress notes - what to do and avoid in documenting what has transpired during the therapeutic hour. This validated the applicability of Cameron and Turtle-Song's (2002) note format standards in the Philippine milieu. Moreover, in terms of the number of items left after the factor analysis procedures, unequal numbers were observed for each factor. Factors 1, 2, and 3 have items that consist of

14, 6, and 10, respectively. However, all of the factors describe the different dimensions or characteristics required from a well documented case notes that are considered precise and brief. This observation also lends support to a study of Hansen (2009), suggesting a simple one-page anecdotal notes or summary of the time spent to a particular student for referral and/or reporting purposes.

The foregoing three factors of the CNAS, which were constructed empirically through factor analysis, maybe used by the counselor educators, supervisors, and counselors as an objective checklist on certain characteristics and standards necessary to help write well-documented case notes. Such information will also be helpful in reviewing the counselor's case records during supervision, in designing continuing education programs, and coming up with a support system for professionals' enhancement in the area of case documentation.

Finally, in the process of establishing the psychometric properties of the CNAS, this study undertook the initial stages of testing its validity (item review and factor analysis) and reliability. Thus, a validation study is hereby recommended to give more detailed properties of the test. Additional test items are also needed for inclusion in the item bank and larger sample size for its norming and interpretation of test scores may be considered. Furthermore, a review of the individual item or item analysis may be done for future research studies. Other helping professional populations in the different settings aside from schools (e.g., community, industrial, and clinical sites) may likewise be tapped as added norm groups since the test items cover case documentation processes and outcomes that are applicable to all those who are engaged in mental health and client care services.

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