Missouri WIC Documentation Guidelines for Professional Staff

To ensure continuity of care, SOAP notes are required for all participants at certification, mid-certification assessment (MCA) and for high-risk follow-up. This tool may be used to help develop appropriate SOAP notes. See the Health and Nutrition Assessment Handbook (HNAH) for approved abbreviations. Quality nutrition education documentation should always be: 1) consistent with training, policies and resources; 2) clear and precise so the reader easily understands; 3) concise and well organized, following a logical order without duplications and unnecessary information; and 4) complete to create a picture of the participant, the services provided over time and outlines a plan for future services. Refer to policy 8.1.070 Certification and Mid-Certification Assessment (MCA) Data Collection and Risk Factor Assignment.

	Information to be noted	Example of a non-high-risk note	Example of a high-risk note (completed by the nutritionist)
S SUBJECT	**Information given by the participant or caregiver:** • Thoughts, feelings and complaints. • Dietary intake or eating habits. • Health concerns.	Per mom, the doctor diagnosed GERD for her 7-month-old infant. HCP advised that the cereal in the bottle helps with reflux. Mom states that the infant eats well and likes mashed potatoes and some other soft table foods. She offers 6-8 oz bottles of Similac Advance 4-5 times/day.	Mom reports Jessie is a 2-year-old picky eater, especially with meat. She would rather drink milk than eat. Mom allows Jessie to drink as much milk as she wants. She usually has 5-6 cups a day. Mom denies any current illness but notices tooth decay.
O OBJECTIVE	**Observations and measurements taken by WIC or their health care provider (HCP):** • Anthropometric, biochemical and risk factor data.[1] • HCP diagnoses (including self-reported), medications and recommendations. HCP contact information is required with each diagnosis.[2] • Clinical observations (i.e., signs and symptoms).	Dx: GERD Dr. Dave Smith at Northeast Health Center.	Hgb: 9.9. Weight/length: 2.1%. Risk factors: 201.
A ASSESSMENT	**Competent professional authority (CPA) assessment of nutritional status:** • Assessment of **S** and **O** data. • Assessment of participant's comprehension and motivation; vitamin recommendations. • Referral outcome and goal progress. • Justification for resolving high-risk risk factors.	It's possible for the infant's age to consume too much formula per day. The current formula is inappropriate for their diagnosis. The cereal feeding method is inappropriate.	Excessive milk intake is likely interfering with appetite and iron absorption. DGA for milk per age group is 2 cups. Slight tooth decay was noted. Mom will need ongoing support and encouragement to decrease milk intake.
P PLAN	**Plan for intervention and follow-up:** • Intervention to address risk factors or nutritional status. • Discussion, education and resources provided. • Referrals provided. • Plans for follow-up. • Statement for resolving high-risk factors, if appropriate.	Discussed appropriate feeding method; suggested Enfamil A.R. formula, provided WIC-27 and referred to HCP. Mom is receptive. Goal: Offer cereal by spoon two times per day instead of from the bottle for the next two weeks. F/U on referral to HCP for formula change and goal success.	Discussed excessive milk intake and milk recommendations. Provided high iron food handout and encouraged mom to offer these food items at meal and snack. Dental and HCP referrals were given. Goal: Limit milk to 2 cups/day over the next 2 months. F/U in 2 months to check weight, appetite and referral outcome.

[1]Not required to document Management Information System (MIS) Objective data.

[2]A medical diagnosis or self-reported medical diagnosis should prompt the certifying staff to validate the presence of the condition by asking more pointed questions related to that diagnosis. The certifying staff shall document in general/SOAP notes the doctor's name and contact information, whether the condition is being controlled by diet or medication and any follow-up plans with the health care provider.