Pharmacy Skills Laboratory Guide to Writing a SOAP Note

General Comments

- The SOAP format is used by pharmacists primarily to communicate written patient information in the medical record.
    - (S)ubjective, (O)bjective, (A)ssessment, (P)lan

- The (S)ubjective and (O)bjective information in a SOAP note should be limited to only that information which pertains directly to the (A)ssessment or recommended (P)lan.

- (S)ubjective information is obtained verbally from the patient or caregiver and so is not directly observed or measured by the SOAP writer.
    - Information in this section can come from the following sections of the medical record:
        - Chief Complaint (CC)
        - History of Present Illness (HPI)
        - Past Medical History (PMH)
        - Social History (SH)
        - Family History (FH)
        - Medication History (prior to admission)

- (O)bjective information is presented next, and details data directly measured or observed by the SOAP writer or another health care professional.
    - Information for this section includes:
        - A general description of the patient
        - Vital signs
        - Physical exam findings
        - Results of diagnostic testing and imaging (e.g. x-rays, CT/MRI, EKG, EEG)
        - Laboratory results
        - Current drug therapy (from profile or chart)
        - Drug allergies or adverse reactions

- The (A)ssessment section communicates the critical thinking of the writer. A pharmacist's assessment is drug- related.

    - A treatment goal should be specified for each problem and whether the goal has been met.
        - For some diseases (e.g. dyslipidemia) addition information should be included such as risk factors, disease scores (i.e. Framingham score, CHA2DS2–VASc score) or other information that are used to determine a treatment goal.

    - Discuss how the patient's drug therapy conforms to standard, evidence-based drug therapy recommendations.
        - For example, discuss how well a patient's currently therapy matches JNC7 (hypertension), NCEP ATP-III (cholesterol), or NIH (asthma) treatment guidelines.
        - Consider patient factors such as medication adherence and financial considerations

    - It should identify drug-related problems (DRP) and explain why they need correcting.
        - DRPs can be roughly categorized into categories
            - Current drug therapy
                - dose not optimal
                - not receiving optimal drug
                - experiencing adverse drug reaction
                - experiencing unwanted drug interaction
            - Missing drug therapy
                - not receiving a drug needed for optimal therapy

    - It should also include is a short list of therapeutic alternatives with a brief explanation of benefits and potential problems associated with each option, and treatment goals.

    - When written optimally, by the time the reader reaches the end of the assessment section, that reader will know exactly what is going to be recommended, and why.

- The (P)lan communicates to other providers specific recommendations regarding the patient's drug therapy or other actions needed to facility treatment.

    - Recommendations may include
        - Drug Therapy Changes

            - New drug therapy
                - recommend drug name, dose, route, frequency, and duration

            - Altered drug therapy
                - specify which drug to change and the new dose, frequency, and duration and how quickly the change is to occur (e.g. immediately or tapered)

            - Discontinued drug therapy
                - specify which drug(s) are be discontinued and when (e.g. immediately to tapered)

        - Disease Modifying Changes
            - Dietary changes (dietary recommendations such as the DASH or TLC diet)
            - Exercise suggestions (e.g. weight bearing exercise 2-3x week)
            - Lifestyle modifications (e.g. stop smoking, reduce alcohol intake)
            - Vitamin, Herbal or other OTC suggestions (e.g. 1200 mg calcium + 800 IU vitamin D daily)
            - Vaccination recommendations (influenza vaccine annually)
            - Educational interventions (inhaler technique training)

        - Monitoring and follow-up requirements

    - There should be no question in the reader's mind as to the suggested course of action. If no change is needed, then it should be written as such.

- Medication Lists

    - It can be confusing whether to list medications in the S or O section.

    - (S)ubjective section: any information <u>you obtain from the patient or family members</u> about medication names, doses, frequency, adherence, or purpose.
        - Example: a list of patient medications taken prior to hospitalization obtained by questioning the patient.
        - It is reasonable to quote patient remarks about therapy if it helps better communicate a patient's attitude toward or understanding of the therapy or condition.

    - (O)bjective section: any information obtained from a medication administration record or pharmacy database.
        - Examples:
            - A list of current medications obtained from a medication administration record (MAR) for a hospitalized patient.
            - Medication information obtained from a computerized pharmacy database.

Common Documentation Mistakes

1. Information in the wrong place
2. Vague or unclear information
3. Excluding important information (which results in an unsupported (A)ssessment statement)
4. Including extraneous information (including information which doesn't directly support the (A)ssessment makes a note that is too long)
5. Lack of clear reasoning supporting choice of recommendation in (A)ssessment (e.g. no treatment goals, discussion of treatment guidelines, etc.)
6. Inaccurate or incomplete problem assessment, drug therapy recommendations, or monitoring plan.

SOAP Example

Good comments:

- This is a nicely-written SOAP note, there is not a lot of extraneous information provided
- The assessment focuses on the medications rather than diagnosis.
- The plan includes monitoring for toxicity as well as efficacy.

Areas to fix:

- The note is written almost too succinctly.
- Missing is the rationale for choice of agent versus another iron product.
- Missing is the rationale for discontinuing ibuprofen and why APAP was selected.
- Current Drug Tx: clarify how frequently and what type of antacid product she uses.
- The writer also needs to be more careful about the numerous abbreviations used. Fewer would be better.

Problem: Possible GI Bleed/Ulcer

Current Drug Tx:

She takes frequent doses of antacids

Ibuprofen 200mg prn headaches

Subjective:

PMH: peptic ulcer and pre-eclampisa with last pregnancy

Objective:

Vitals: T 38 C, RR 18, BP: sitting 118/75, standing 120/60, HR: Sitting 90, standing 110

Labs: guaiac stools

Assessment & GOALS

Discuss guaiac stool and ibuprofen, f/u with PCP on GI bleed, possible ulcer. Recommend d/c ibuprofen, use APAP prn headache.

Plan:

Make appt with pcp for probable ulcer/GI bleed.

- d/c ibuprofen
- begin APAP 500mg po q 4-6 h prn p, NTE 4000mg/24 h (counsel on liver toxicity)

Problem: Iron Deficient Anemia

Current Drug Tx:

Subjective:

HPI: weakness, dizziness , 2 weeks ago she experienced decreased exercise tolerance.

Objective:

Labs: HgB 8gm/dL, Hct 27%, platelets 300,000/mm3, retics 0.2%, MCV 75, serum iron 40mcg/dL, serum ferritin 9ng/ml, TIBC 450 mcg/dL

PE: Cheilosis at corners of mouth, and koilonychias at nail beds

Assessment & GOALS

Treat anemia with an iron supplement (iron sulfate). Educate and counsel parent on tolerance and SEs.

Plan:

Iron sulfate 325mg TID x 6months – f/u with PCP for retics count after 7 days of therapy.

- counsel/educate pt on a) take on empty stomach if possible, ok with food if cannot tolerate
- separate iron dose from antacid dose,
- iron can cause constipation and darken stool color
- keep iron out of reach from children – toxic.