Chapter 6 - SOAP Note Writing
Pharmacists are the only health care professionals who do not routinely document their patient care activities.

Most pharmacy records are administrative or billing records, not patient care records.
Organize the data

<table>
<thead>
<tr>
<th>Subjective data:</th>
<th>Objective data:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cannot be measured directly</td>
<td>• Can be measured</td>
</tr>
<tr>
<td>• May not be accurate or reproducible</td>
<td>• Are observable or reproducible</td>
</tr>
<tr>
<td>• Usually supplied by the patient</td>
<td>• Are often numerical</td>
</tr>
<tr>
<td>• E.g., “I have high blood pressure.”</td>
<td>• E.g., Taking a patient’s blood pressure and learning it is 126/82</td>
</tr>
</tbody>
</table>
Medication history consisting only of the information in the pharmacy computer does not include:

- Samples
- OTC’s
- Rx filled elsewhere
- Borrowed medications
- Herbals, nutritionals
Finally

- Pharmacists frequently do not have any objective information to report. Not every SOAP note will have objective information in it.
- Only relevant data need be documented.
- Verify with your faculty to see how they want you to consider and document data - especially drug history (S or O?)
The SOAP note

- Subjective - includes only relevant subjective data
- Objective - includes only relevant objective data
- Assessment - describes conclusions about the patient (what’s his DTP?)
- Plan - who needs to do what next, when and how they will do it, monitoring plan
Common problems with SOAP notes

- Subjective contains information that’s not subjective (same with objective)
- Not enough information in the S/O to support A - it should be obvious to the reader why you concluded what you did
- DTP not included in A and re-phrased as patient problem (e.g., dose of Norvasc too high - patient at risk for fall)
Common problems with SOAP notes

- Too much or irrelevant information in S/O that slows down the reader
- New information being introduced in the assessment or plan
- No follow-up or monitoring plan included
- Monitoring plan is included, but is vague or non-specific (e.g., ‘follow up in 1 week’)
Documentation checklist

- See pp. 145, 148, and 150-1 of the textbook (3rd edition) for more detail on documentation checklist.
Subjective section

- Date
- Patient identifier
- Patient DOB
- CC
- HPI
- PMH

- SH
- FH
- Allergies
- Previous ADRs
- ROS
- Medication history and how patient is taking (if not in O)
Objective section

- Objective measures such as
  - Vitals, lab tests, physical exams, screening tests

- Include the source of the measure
  - E.g., “BP as per Dr. Cowan 136/92” or “blood sugar in pharmacy 210 mg/dl”

- Medication history and how patient is taking (if not in S)
Assessment section

- Describes the DTP and the patient’s problem. (If not in the note’s title)
- If a follow up note, includes the status of the problem (stable, improved, worsening, resolved)
- May need some explanation of the DTP
- Goal for therapy can be documented here
Plan section

- How will the DTP be resolved? Who will do what to resolve it? When? How?
- MUST include a follow-up or monitoring section
- Goal for therapy can be documented here if not in A
Some tips

- Keep your note SHORT and TO THE POINT
- Most initial notes usually ≤ 1 page
- Follow-up notes usually shorter than initial notes
- Don’t include information that does not assist in decision making
What’s wrong with the following?

- S: Mrs. RG is a 76-yr-old woman with 5 grandchildren. She comes into the pharmacy requesting OTC treatment for a history of osteo-arthritis x 2yrs. She claims a history of aspirin allergy (GI upset). PMH includes OA, GERD, HBP and elevated TC
  - (includes irrelevant information - 5 grandchildren)
What’s wrong with the following?

- O: Medication history includes Norvasc 10 mg qd for BP, Nexium 20 mg qhs for GERD and Pravachol 20 mg qd for elevated TC. Cholesterol 165 mg/dl as per physician office
  - (history is incomplete - includes only prescription medications filled in this pharmacy)
What’s wrong with the following?

- A: Dose of APAP too low for OA. Patient requires symptomatic pain relief for OA pain. Has tried Tylenol 500 mg tid in past with little relief.
  - (introduces new information in the Assessment that should be in S or O - use of Tylenol)
What’s wrong with the following?

- P: Recommended pt increase APAP to 1 g po qid scheduled dose.
  Patient agrees
  • (missing follow-up and monitoring plan)