OVERVIEW

BIG IDEA
Medical professionals gather and organize data in a SOAP note in order to diagnose and treat medical problems.

OBJECTIVE
1.8 Explain the purpose and organization of the SOAP note method.

AGENDA
1. Injury Response Questions
2. Defining the SOAP Note (reading)
3. SOAP note definitions and example
4. Matching assessment

HOMEWORK
Write effective questions a medical health professional would ask within the Subjective section categories listed.

LESSON 1.8
The SOAP Note

SUMMARY:

This lesson will introduce students to the SOAP note. Students will not be expected to master the use of the SOAP note initially, but rather gain a familiarity with it's parts. The first two patient case studies (PTSD and anorexia) will emphasize the Subjective and Assessment sections and future units will delve more deeply into each of the four sections to guide students toward proficiency with the tool. In this lesson, students will first answer SOAP-related questions for a scenario in which a baseball player breaks a leg. They will then read about the SOAP note and read descriptions of what each section means. After looking at an example SOAP note, students will be assessed and complete homework where they devise effective questions for parts of the Subjective section.

UNIT 1: MENTAL HEALTH LESSON 1.8

SOAP Notes

PH1.8: Explain the purpose and organization of the SOAP method

DO NOW

Medical professionals gather and organize data in order to solve medical mysteries. You are an emergency medical technician attending this baseball game, when the following scene plays out. **Use the following image to answer questions 1-4:**

1) **QUESTIONS:** What questions might you ask about what happened? What might you ask about how the injured person is feeling?

2) **OBSERVATIONS:** What visible clues of injury are present? What auditory (sound) clues of injury might be present? What might you find out if you are able to palpate (feel) the injury?

3) **DIAGNOSIS:** What is the most likely diagnosis for the injury?

4) **TREATMENT:** What are 2-3 treatments you might suggest for the injured person?

DISCUSS

With a partner, share your responses. Then, imagine you are a doctor and the injured patient in the picture is only one of thirty patients you see in a day. Discuss the ways that you think medical professionals handle large amounts of information and data.

DO NOW Possible Answers:

1. **Questions:** How does it feel? How were you moving right before it happened? Have you ever injured anything before? Are you allergic to anything (in order to be able to quickly administer pain medication when paramedics arrive on scene)? Questions to establish that the patient has not had head injury: do you know where you are? What day it is? Who is the president? etc.)
2. **Observations**: Foot is bent at an abnormal angle, patient is holding leg on ground and writhing in pain, patient is yelling and screaming, any movement might be painful; when closer it can be established whether or not a bone is protruding (if not, can palpate to feel the fracture)
3. **Diagnosis:** Broken ankle and possibly torn Achilles tendon
4. **Treatment:** Immediate transportation to hospital, x-rays, casting and rest for several weeks/ months,pain medications to manage pain, mental health counselor to ensure disruption to job and career is being worked through in a healthy way

DISCUSS: Ask students to share responses. They may bring up note-taking or record-keeping, electronic medical records, informal note-taking and mental note-taking, etc....

READ

Medical professionals use a tool called the SOAP method to gather and record information. Read the following description of a SOAP note *(adapted from Wikipedia)*:

The **SOAP note** (an acronym for **subjective**, **objective**, **assessment**, and **plan**) is a method of documentation employed by health care providers to write out notes in a patient's chart. Documenting patient encounters in the medical record is an essential procedure. Prehospital care providers such as EMTs may use the same format to communicate patient information to emergency department clinicians. Podiatrists, Chiropractors, Physical Therapists, Massage Therapists, among other providers use this format for the patient's initial visit and to monitor progress during follow-up care.

Subjective component

Initially is the patient's **Chief Complaint, or CC.** This is a very brief statement of the patient (quoted) as to the purpose of the office visit or hospitalization. If this is the first time a physician is seeing a patient, the physician will take a **History of Present Illness, or HPI.** This describes the patient's current condition in narrative form. The history or state of experienced symptoms are recorded in the patient's own words. It will include all pertinent and negative symptoms under **review of body systems. Pertinent medical history, surgical history, family history, and social history, along with current medications and allergies,** are also recorded.

Objective component

The *objective* component includes:

- Vital signs (pulse, respiration, blood pressure) and measurements, such as weight and height
- Findings from physical examinations, including basic systems of cardiac and respiratory, the affected systems, possible involvement of other systems, pertinent normal findings and abnormalities.
- Results from laboratory and other diagnostic tests already completed.

Assessment

A medical diagnosis for the purpose of the medical visit on the given date of the note written is a quick summary of the patient with main symptoms/diagnosis including a differential diagnosis, a list of other possible diagnoses usually in order of most likely to least likely. It is the patient's progress since the last visit, and overall progress towards the patient's goal from the physician's perspective.

Plan

This is what the health care provider will do to treat the patient's concerns - such as ordering further labs, radiological work up, referrals given, procedures performed, medications given and education provided. This should address each item of the differential diagnosis. A note of what was discussed or advised with the patient as well as timings for further review or follow-up are generally included.

READ: Stop after each section to review. Type short definitions in students own words, if possible, on the slide or write on the board. Use this opportunity to correct any misunderstandings or confusions. The trickiest part may be differentiating S & O. S = information from the patient; O = data and FACTS collected by the medical care team

THINK

Post-Reading Questions: Answer the following questions based on the reading:

1. What are SOAP notes and why are they used?

2. What are the differences between the **Subjective** and **Objective** sections?

3. What are the main components of the **Assessment** section?

4. What do you think differentiates a successful and effective **Plan** from an unsuccessful or ineffective one?

Post-Reading Check: Fill in the appropriate section for each description below.

❶ _____ These are things the patient tells you. These **observations** include the patient's descriptions of pain or discomfort, the presence of nausea or dizziness, when the problem first started, and any other descriptions of dysfunction, discomfort, or illness the patient describes.

❷ _____ These observations include symptoms that can actually be measured, seen, heard, touched, felt, or smelled. Included in objective observations are vital signs such as temperature, pulse, respiration, skin color, swelling and the results of diagnostic tests.

❸ _____ This is the diagnosis of the patient's condition. In some cases the diagnosis may be clear, such as a contusion. However, an assessment may not be clear and could include several diagnosis possibilities.

❹ _____ This may include laboratory tests ordered for the patient, medications ordered, treatments performed (e.g., minor surgery procedure), patient referrals (sending patient to a specialist), patient disposition (e.g., home care, bed rest, short-term, long-term disability, days excused from work, admission to hospital), patient directions (e.g. elevate foot, RTO 1 week), and follow-up directions for the patient.

Adapted from: http://www.physiciansoapnotes.com/

POST-READING QUESTIONS: Review using the reading. For question 4, look ahead to the description in the Plan box to help students elaborate on their answers if they are stuck.

POST-READING CHECK: Students should accurately label all four sections. This is not intended to be an assessment, hence all four appear in order. (Answers: Subjective, Objective, Assessment, Plan) If any students are still struggling, ensure that their misunderstandings are corrected.

NEW INFO

A SOAP note may be organized in many different ways. Below is a guided template to organize the information that we will use to begin our first patient case study. Review each category and the information that fits within each heading.

SOAP Notes - Definitions

Subjective:	
Signs & Symptoms	Patient's chief (primary) complaint (CC); major evidence of the problem
Allergies	Any improper reaction of the body to food/medicine/plants/animals
Medications	Any medicines the patient is currently taking.
Past medical history (Social, Family)	Relationship status, family history of illnesses/disorders, any significant social or behavioral patterns or events, past history of the problem, etc.
Last oral intake	Food last eaten, with time and description.
Events leading to injury or illness	What was happening at the time of the injury/illness/problem.
Frequency	How often the symptoms occur.
Associated Symptoms	Not the major complaint, but any other signs or symptoms of the disorder.
Radiation	Places the pain/symptoms travel or spread to.
Character	Description of the pain. Rating on a scale of 1-10.
Onset	When the symptoms or episode(s) first began.
Location	Place(s) of symptoms in the body.
Duration	How long the symptoms last.
Exacerbating Factors	Things that make the symptoms worse.
Relieving Factors	Things that make the symptoms better.
Objective:	
Measurements	Weight, Height, Age, Gender
Vital Signs	Blood Pressure, Body Temperature, Respiratory rate, Heart rate (pulse)
Physical Exam Results	Findings of visual and physical exam; record any findings using sight, touch, listening, smell
Lab Results	Can test any body fluid (blood, saliva, semen, urine, stool) for many things: (ex: cholesterol, bacteria, blood sugar, etc.); Can also do visual imaging (ex: ultrasound, MRI, echocardiogram, etc.)

SUBJECTIVE Note:
The acronyms SAMPLE and FARCOLDER summarize the questions in the Subjective section. They are listed in this order, but it is important to remind students that real health care providers often do not follow this order. In addition, there will be times when certain questions do not apply. The FARCOLDER questions are designed to get a patient to elaborate on a symptom (usually pain somewhere in the body), but they can often be applied to different type of situations. Sometimes a question like, "Where does the pain/symptom move to?" (Radiation) just won't make sense and can be skipped.

OBJECTIVE Note: Over time, students will be introduced to the different types of physical exam components and lab tests that medical professionals use. For now, they don't need to have background information here but do give them an opportunity to share examples of different tests/exams/labs that they are familiar with. Once a few students get going, chances are all of them will get on a roll and be able to contribute an example.

Assessment:	
Summary	Short summary of patient and chief complaint
Diagnosis	Final conclusion about what the problem is (including a brief summary of supporting evidence)
Differential Diagnosis List	Other possible diagnoses (usually listed in order from most likely to least likely)

Plan:	
Plan steps:	Any care (treatment or preventative) that addresses the problem. Should be comprehensive, including both short- and long-term plans and addressing all relevant components of health (mental, social, and physical). Also includes any prescriptions or over-the-counter medications, procedures to be performed, referrals, or advice and directions given to the patient. States when a follow-up visit will be required.

In order to understand how to record subjective and objective data, assessment information, and the treatment plan, review the example on the following page. As you read through each section, list any questions you have or helpful tips to remember in the spaces below:

Subjective	
Objective	
Assessment	
Plan	

ASSESSMENT Note: The assessment is designed to contain the evidence-based SOLUTION/ANSWER to the patient's problem, but it is important for students to understand that medicine is an IMPERFECT science and that the body and disease process sometimes deviate from what is known or expected. Therefore, even in cases where it "seems" certain that a diagnosis is the only thing it could be, doctors are always asking, "What else MIGHT it be?" and doing tests to rule other things out. This is a VERY important big idea for students to internalize!

PLAN Note: For the Plan, a good rule of thumb is often, "the more detailed the better." Obviously, the patient cannot be expected to comprehend or effectively enact a treatment plan that is TOO complicated. But in order to cover the bases of all aspects of health (mental, social, physical), it is best to encourage students to be very detailed and thorough in this section. LATER on in future modules, they will have a chance to delve into the problems of poor health literacy, impact of poverty on health, and poor adherence to treatment plans, but for now they should just be as comprehensive as they can be.

UNIT 1: MENTAL HEALTH LESSON 1.8

Subjective:	
Signs & Symptoms*	Severe burns to face, abdomen, limbs, with pain; uncounscous for short time, possible circulatory shock risk
Allergies	Unknown
Medications	Unknown, possible past medication use for ear infection
Past medical history **Social:** *alcohol, smoke, drug use, marital status, children, occupation, sexual history, living situation, etc.* **Family:** *conditions & diseases run in the family*	-Pilsen resident -Med history unknown, except possible ear infection -Parents meeting at hospital
Last oral intake	Macaroni & cheese, dinner
Events leading to injury or illness	House fire, cigarette, awoken from sleep & trapped in closet in room, parents not home at time of fire, Pt. was running through house in smoke searching for brother, status of brother unknown
*Frequency	n/a
*Associated Symptoms	Difficulty breathing
*Radiation	n/a
*Character	Painful hands, stomach and legs, lack of feeling in center of burns, stinging on borders, esp. near wrists
*Onset	n/a
*Location	Hands, stomach, legs, wrists
*Duration	n/a
*Exacerbating Factors	n/a
*Relieving Factors	n/a
Objective:	
Measurements	8 yr old, Hispanic female
Vital Signs	BP = 60/40, HR = 165, RR = 35 Regained consciousness during transport, verbally unresponsive, disoriented
Physical Exam Results	Severe burns: lower limbs, hands, abdomen; Flash burns: face Gray-white with red-blistered borders
Lab Results	n/a
Assessment:	
Summary	An 8 year old, Hispanic female with severe burns to the legs, hands, and abdomen and flash burns to the face with vital signs showing risk of circulatory shock, has recently gained consciousness and is disoriented with trouble breathing.
Differential Diagnosis List Diagnosis	Burns covering 33% of body with third-degree burns on legs and hands, second-degree on abdomen and parts of limbs, first degree on face. Vitals show circulatory shock risk with low BP and high HR/RR.
Plan:	
Plan steps	**1 hour (Immediately):** • Aggressive IV fluids until vitals stabalize; keep in pediatric intensive care unit until transfer to burn unit is possible • Broad-spectrum antibiotic **24 hours:** • Debridement of burns • Application of a broad-spectrum, topical antibiotic • Plastic epidermal graft applied over burned areas • Social work and therapist support with visits to Tanya 2x/day for the first few days to help her process the events **1 week:** • Change position in bed every 2 hours to prevent the formation of decubitus ulcers (i.e. bedsores) • Nasogastric tube feeding of 5000 calories ("Kcals") per day • After 9 weeks, graft sheets of cultured epidermal cells to her regenerating dermal layer • By the 15th week of hospitalization, her epidermal graft will be complete, and she should be back on solid foods, her antibiotics were discontinued, and discharged from the hospital with a rehabilitation plan for both physical and occupational therapy at home, as well as twice-weekly visits by a nurse and once-weekly visits with social worker and psychologist.

SAMPLE SOAP: This example is for a young girl who suffered severe burns following a house fire. Before students begin (or after), use the analogy of the SOAP note telling the patient's story. The more we know, the better we understand her entire health picture and can treat her.

ASSESS

Label each of the four parts as Subjective, Objective, Assessment, or Plan:

_____ **1.** WT = 210 lbs, HT = 60, BW = 115 lbs, Chol = 255, BP = 140/95

_____ **2.** Obese at 183% BMI, hypercholesterolemia, hypertension.

_____ **3.** Long Term Goal: Change lifestyle habits to lose at least 70 pounds over a 12 month period. Short Term Goal: Client to begin a 1500 Calorie diet with walking 20 minutes per day. Instructed Pt on lower fat food choices and smaller food portions. Client will keep a daily food and mood record to review next session. Follow-up in one week.

_____ **4.** Pt. states that she has always been overweight. She is very frustrated with trying to diet. Her 20-year class reunion is next year and she would like to begin working toward a weight loss goal that is realistic.

HOME WORK

Fill in the following chart with example questions that an excellent doctor would ask when obtaining a person's Subjective information. The patient has come in because she is experiencing major headaches.

Subjective Category	Example Questions
Signs & Symptoms	
Past Medical History	
Events leading to illness	
Radiation	
Character	
Duration	
Exacerbating Factors	
Relieving Factors	

Assessment Answers:

1. Objective
2. Assessment
3. Plan
4. Subjective

HOMEWORK: The goal of this homework assignment is for students to begin practicing the skill of asking effective questions. Allow students to brainstorm (either before completing the homework or after) what makes an effective question from a physician. Questions should be open-ended (whenever possible), unbiased/fair, clear, simple, and not double-barreled (only asking one thing at a time).