

Investigation

2.7: Soap Notes

Commonly physicians use **SOAP** Notes to track a patient's progress on subsequent visits to their office. SOAP notes represent an organizational tool for information about the patient's complaints, examination findings and test results, professional opinions on cause, and assessment or treatment plan going forward. SOAP, an acronym, stands for Subjective, Objective, Assessment, and Plan.

You took a complete history and examination during the patient's first visit to your office. You do not need to repeat the process every time you see this patient. Now, when they return to see you, you need only to add new observations and new patient experiences related to the patient's original complaint.

Each SOAP note has a title taken from a list of the patient's problems. Today you are seeing a patient with only one problem on her Problem List, "Trauma to left wrist." If the patient presents with a new problem that you believe has no relationship to the original complaint, you would add that complaint to the patient's problem list and initiate a new series of SOAP notes under that title to track the new problem. Some physicians number their problem list and attach the appropriate number to each SOAP note instead of writing out a title. When treatment gets rid of a problem the physician joyfully strikes that problem off the list usually adding the date on that line to document the triumph.

S - Subjective findings convey the patient's symptoms and experience exactly as they tell you about it. You were not there so you are documenting the patient's description. Subjective information helps you, but patient perceptions may not always prove accurate. You must weigh the subjective information against the objective information that you will record in the next section of the SOAP note.

When writing SOAP notes physicians commonly use abbreviations to save time. They use standardized abbreviations that other health professionals will easily recognize to avoid misunderstanding. Working efficiently benefits more patients, so the use of abbreviations represents a patient benefit when used properly.

O - Objective findings list the results of your examination or laboratory tests. Skin erythema might go on the objective findings list; you see the redness of the skin. Edema constitutes an objective finding; you can measure swelling of the ankle. An elevated white cell count would go on the objective finding list; it reports the outcome of a laboratory test. An X-Ray represents objective information; it shows anatomical findings relevant to the patient's complaint. You may find yourself wanting to add your opinion or a supposition in this part of the note, but save that for the next section.

A - Assessment records your professional opinions on the status of this problem. The assessment is based on the subjective information provided by the patient and your objective findings from your observations and test results. Your assessment may

conclude that the solution to this problem remains unknown; perhaps the answer awaits results from tests not yet performed. Most importantly, you will return to the assessment when this patient returns again to your office. The assessment will remind you where you left off in your quest to solve this investigation.

P - Plan summarizes the treatments or tests you are recommending at this visit. If you prescribe an antibiotic to treat a suspected or documented bacterial infection, write that in the plan. If you recommend a test, such as an X-Ray or blood test, you list that in the plan. A prescription for physical therapy or an ultrasound goes into the plan.

Before the patient's next visit to your office your staff will receive the results of any tests that you have ordered. They will bring any abnormal findings to your attention for immediate consideration, and all results will go into the objective findings of the next SOAP note that you write.

SOAP notes represent a systematic method of keeping you organized on the current issues (or problems) in each patient's care. With so many patients in your medical practice, you cannot reliably remember everything that is going on with each patient. You need a system to avoid mistakes. SOAP provides you that organizational tool that saves you time and avoids missing important cues to the right diagnosis and treatment. Every patient wants to feel confident that you have complete control of their care; SOAP notes allow you to quickly refresh your memory so that when you walk into that examination room you give each patient the level of care they expect and deserve.

Now we will look at a sample of a SOAP note on a hypothetical patient. Below each entry you will find a translation of the abbreviations a physician would use to write efficiently the SOAP notes.

S: 45 Y.O. female C/O pain in L wrist of 3 wks duration, not resolving. Hit wrist kitchen counter, pain hours later. She self Txd c ASA TID x 5 days w/o resolution or improvement.

Translation: A 45 year-old female is complaining of pain in her left wrist of three weeks duration that is not getting better. She recalls hitting her wrist on the kitchen counter, but did not experience pain until several hours later. She self-treated with aspirin three times per day for five days without the pain improving or going away.

O: 2+/4 **edema** L wrist; 0/4 edema R wrist
2+/4 pain L wrist **extension** palmer, 0/4 pain dorsal
1+/4 pain wrist **flexion** on palmer, 0/4 pain dorsal
No erythema or induration

Translation:

Moderate soft tissue swelling of the left wrist; no swelling on the right wrist.

Moderate pain in the left wrist on outwardly extending the wrist felt on the palm side of hand; no pain felt on the wrist of the back side of the hand.

Mild Pain felt on the palm side of the wrist moving the moving wrist into flexion (curled forward); no pain on the back of the wrist.

No redness or thickening of the skin to suggest chronic swelling.

A: Mod Sprain L Wrist
R/O fracture

Translation: Moderate sprain left wrist; rule-out fracture of a bone.

- P:**
1. Wrist splint – remove for bathing only
 2. Rx: X-ray L wrist
 3. Rx: Ibuprofen 800mg/TID 5 days c food
 4. Ret 1 wk eval progress
 5. Call pt c X-ray results

Translation:

1. Patient to wear a wrist splint except when bathing
2. Prescription: X-ray Left wrist
3. Prescription: Ibuprofen 800mg Three Times per Day with food
4. Return in one week to evaluate progress
5. Call patient with X-ray results

When the patient returns you can quickly refer to the assessment and plan to remind yourself where you left off with this patient and to know exactly what you are looking for at this upcoming visit. If you had seen 200 patients during the week, without SOAP notes you probably would not recall all the details of her problem and progress.

Think about the times you have been to the doctor to check on your progress in recovering from a sickness or injury. Did your doctor know why you were there? Please remember that patients want to feel that you care about them personally. Poor organization can destroy your patient's confidence in you in the blink of an eye. SOAP notes keep you organized, save you time, and help you always appear in control and well informed about your patients' problems.

Food for thought. Elsewhere in this workbook you will find comments on the future of medicine requiring new ways to manage the vast amount of information we call medical science. Human memory, long seen as the mainstay of medical practice, can no longer fulfill our expectations for consistent accuracy, day and night, when human lives depend on the right diagnosis and treatment. The hero's and heroin's of modern medicine will increasingly become those individuals who figure out work methods by which every healthcare professional can perform at the level of the best experts in that area. Dr. Lawrence Weed, M.D., had that vision of medical practice even in 1968, when he published an article describing the problem-oriented medical record. The SOAP note came from that publication. Weed lectured often during his career about the fact that patient's commonly die in the hospital on the wrong service, meaning their primary doctor, trained in one specialty, did not recognize and treat a complication much better understood in another specialty. Weed believed strongly that computer technology could bridge this knowledge gap and provide greater patient safety. Most would argue Weed's dream has not yet been fulfilled, but the need for others with his vision has never been greater.