

## GUIDELINES FOR WRITING SOAP NOTES

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SOAP. notes represent an acronym for a standardized charting system which is widely practiced in most clinical settings. The acronym stands for the following components:

S = Subjective Data  
O = Objective Data  
A = Assessment  
P = Plan

### SUBJECTIVE (S)

In this section, the health care provider will record all of the information which the patient has provided. In some cases, this section may contain information provided by the patient's family or other persons participating in the process. Effectively, it represents the "history" portion of the data collection process and would include anything the patient (or others) tells the provider. Examples would include age, description of symptoms, information concerning a patient's past medical history, allergies reported by the patient, family and social information provided by the patient or significant others, etc. Physical and diagnostic data obtained from other health care providers would NOT be included in this section. Such information would be included in the *Objective* section. For example, operative findings from a surgeon's consultation report would be included with the objective data.

As an example, if one were doing a routine GYN exam on a postmenopausal woman with known hypertension, the *subjective* component might include the following information:

Age of menopause, parity, date of last mammogram, date of last pap, family history of osteoporosis, family history of breast cancer, hypertensive medications taken, other medications taken, allergies, alcohol/caffeine intake, smoking history, etc.

### OBJECTIVE (O)

This section includes any information directly gathered by the health care provider or other health care providers. It could include exam findings, laboratory reports, radiology reports, or information from the physical exam done by other health care providers. Anything the patient "tells" the health care provider should NOT be included in the *subjective* section. Information in this section is limited to that which can be "objectively" documented. For example, if a patient is experiencing pain from suspected cholecystitis, the patient's statement that "It is the worst pain I've ever experienced in my life." would be included in the *subjective* section. One cannot *objectively* evaluate pain which a patient is experiencing. One could, however, certainly document a positive Murphy's sign or other findings on abdominal exam which would point to a diagnosis of cholecystitis.

Accordingly information from the physical exam is included in the *Objective* section as would be data concerning the patient's white blood count, abdominal ultrasound, etc. It is important to note that information in the objective section is no more or less important than the subjective data. Sometimes a particular condition has no objective findings and a diagnosis is made solely on the basis of historical data. In writing SOAP notes, however, it is important to place information in the proper section

To continue the example of the routine gyn exam of the hypertensive postmenopausal woman, the following information might be included in the *subjective* section of the SOAP note.

The patient's BP, the patient's height, DEXA scan report, whether any skeletal changes ("Dowager's Hump) were noted, mammogram reports, the appearance of her cervix, her vulva, findings of breast exam, etc.

#### ASSESSMENT (A)

This section is the actual diagnosis (es) made after the health care provider has analyzed the subjective and objective data. An example of an assessment would be "cholecystitis" when the provider is certain of the diagnosis or "R/O cholecystitis" (R/O = "rule out") where there is some room for doubt. The assessment section can include multiple diagnoses and often does. Diagnoses need not necessarily reflect pathology or illness. A diagnoses might be "normal exam" and "immunizations current" for a child who presents for a routine camp physical. They can include E.U. (etiology unknown) where the cause is not known. As an example, one could write "Dermatitis E.U." where a patient presents with skin rash for which the cause has not been identified.

As a general rule, diagnosis should reflect medical diagnoses and not nursing diagnoses. Nursing diagnoses are appropriate for preparation at an undergraduate level and practice as a registered nurse. Advanced practice nurses are held to a somewhat different standard and incorporate medical diagnoses into their clinical practice. Accordingly, the advanced practice nurse WOULD diagnose "dehydration" or "congestive heart failure" where clinically appropriate versus the analogous nursing diagnoses of "alteration in fluid and electrolyte imbalance" or "alteration in hemodynamic status." As an notable exception, many "nursing" diagnoses in the psychosocial arena remain very useful and are appropriately included e.g. "alteration in body image," "grieving," or "dysfunctional family dynamics," etc.

A common area of confusion for nurse practitioner students when they are writing the "assessment" for SOAP notes is that they often include information which they had been previously taught to include as part of their "nursing assessment." For purposes of SOAP notes, information previously gathered as part of a "nursing assessment - subjective and objective data - now belongs in the respective subjective and objective sections of the SOAP note. The assessment section is strictly limited to diagnoses.

Continuing with the previous example of the menopausal woman with hypertension, assume she had a normal BP while taking Vasotec (enalapril) and that there was bone demineralization evidenced with both skeletal changes on physical exam and DEXA scanning. The assessment section for this patient might be as follows:

- A.
  1. Menopause with osteoporosis
  2. Hypertension well controlled on current regimen

## PLAN (P)

This section includes the interventions which are planned for the patient, given the particular diagnoses made. It could include actual drugs ordered (enalapril 2.5 mg qd), further tests needed (“Stat CBC and urinalysis”), additional consultation needed (“refer to GYN”) or psychosocial interventions (“emotional support given”). The possibilities for plans or interventions are virtually limitless but they should always be based on research and/or sound medical/nursing practices.

Patients may always refuse proposed interventions and this decision should be documented on the record. As usual, if it hasn’t been documented, it hasn’t been done. Continuing with the previous example, the health care provider, after diagnosing osteoporosis, may recommend estrogen replacement therapy (ERT) for this particular menopausal woman. The patient, however, may well, refuse this option preferring not to take hormone replacement therapy. During this same visit, she may have had a pap smear done and also given a slip for a mammogram. Since she is taking an antihypertensive agent which can cause hyperkalemia, blood may have been drawn for electrolytes, as well. All of these interventions would be documented in the plan. Additionally, all plans must address the expected time frame for follow-up and revisit. Accordingly, the plan for this particular patient might be as follows:

- P.
1. ERT w rationale explained (pt declines option)
  2. Fosamax 10 mg qd w administration/precautions reviewed
  3. Pap done: if normal will screen annually
  4. Annual mammogram - slip given
  5. Serum electrolytes today
  6. Continue Vasotec 2.5 mg q d
  7. F/U in 3 months for BP check and repeat blood work

## RATIONALE:

Rationale is not normally included in the SOAP note format but is often expected of nurse practitioner students when handing assignments into their instructors. Rationale consists of documenting the reasoning processes employed for developing the diagnosis and treatment plans. Instructors normally require the rationale to be supported by references to include citations from medical and advanced practice nursing journals or texts. Using the above Plan, a rationale might be written as follows:

Pt has obvious evidence of bone demineralization documented both on DEXA and skeletal changes on physical exam. Estrogen would be the first line therapy in this patient who has no contraindications to its use (cite a reference). Since she has refused this option, even with risks versus benefits having been explained, a decision was made to substitute alendronate (Fosamax) which is currently indicated for both treatment and prevention of osteoporosis (cite a reference). Alendronate, as a potent inhibitor of osteoclastic activity, is likely to result in increased bone density (cite a reference) and hopefully will avoid further deterioration of bone mineral density.

The student would include similar rationale for ordering electrolyte testing for this patient who is taking enalapril, an ace-inhibitor which predisposes to hyperkalemia. Rationale might well be included for the proposed time frame for follow-up with respect to frequency of BP monitoring and mammogram and pap screening, particularly since there is some controversy in the literature regarding these issues.

In actual practice, formal rationale is not required, however, it is not unusual for practitioners to include brief rationale in the form of a comment which appends the SOAP note, particularly where the rationale for the plan may not be obvious to another reader or auditor. As an example, a patient might present for treatment of obesity and request a prescription for an anorectic to control appetite. The practitioner may, instead, prescribe Zoloft (sertraline), an SSRI, based on the belief that the patient is overeating as a result of depression. A brief comment may append the SOAP note as follows:

While not indicated for treatment of obesity, Zoloft was prescribed for this patient since it was felt that her weight gain is secondary to a pattern of compulsive over-eating in response to an exacerbation of significant underlying anxiety and depression. Moreover, given her addictive personality, it might be best to avoid controlled substances in this case.