Written Communication & SOAP Notes

Objectives

- Discuss the importance of written communication in the healthcare setting
- Identify the benefits of using a standard format for written communications
- Define the parts of a SOAP note
- Provide tips on how to write a good SOAP note

Written Communication

- Useful tool to pass along information when transitioning patient care from one person to another:
  - Shift changes
  - From one healthcare field to another
  - Guidance for future encounters

What should you include in your written note?

- NEVER include patient identifiable information:
  - Name
  - Birth date
  - Ids
  - Phone #
  - Hospital ID #
  - Address

- A 78 year old African American female with Type II diabetes is being discharged today after being admitted for heart failure exacerbation. She was admitted several days ago, and has been treated with insulin while in-house. The medical team is now deciding which diabetes medications to restart upon her discharge. The drugs she was on before she came here were: Metformin 850mg PO TID, pioglitazone 45mg PO daily, Losartan 50mg PO daily, Furosemide 40mg PO daily, carvedilol 25mg PO BID, simvastatin 20mg PO qhs, aspirin 81mg PO daily, and Tylenol Arthritis 650mg caps PRN joint pain. She has had diabetes for 6 years, as well as hypertension for about 30 years, and high cholesterol for about 10 years. She has also had osteoarthritis for 20 years. There is a history of diabetes in her mom and siblings, and her dad died of an myocardial infarction at age 42. She doesn't smoke, drink or use illicit drugs. She lives alone but spends time with friends and family several times a week. Her diet before she was admitted included drinks sweetened with Splenda, about 4 carbs per meal, and low sodium intake. She takes daily walks and does tai-chi classes. Her serum creatinine is 1.2 and her weight it 64 kilograms. She also is noted to have edema, cough, jugular venous distention which has resolved since being admitted. Her blood glucose is close to her goal on glargine insulin 26 units nightly at bedtime, and lispro insulin 6 units TID before meals.

I think that the patient should be restarted on metformin. However, the maximum dose she should take is 1500mg per day cuz she has some real issues with her kidneys. She should not restart pioglitazone, cuz she has heart failure and that's just not right. It can also increase fluid retention and edema. She should take glipizide for prandial glucose regulation. I think her lantus dose should be lowered when she goes home because basal glucose levels will be controlled with metformin, and her glucose may go down once this acute illness has passed. She does not need prandial insulin any longer, since her prandial glucose levels will be controlled with glipizide.

She should restart Metformin at 500mg PO BID for one week, then increase to 500mg 2 tabs every morning with one tablet at night. She should start glipizide 2.5mg PO BID in the morning and at dinnertime. She should decrease her glargine insulin dose to 10 units nightly at bedtime. The technique for self-injection should be provided before discharge. The patient should watch for symptoms of hypoglucemia, eat 15 grams of sugar if her blood glucose measures less than 70. She should monitor her blood glucose 5 times a day (AMF, P-B/L/D and B) She should return to the clinic in one week and bring her blood glucose log with her. She should continue to check her weight every day to watch for edema. She should aim for no more than 3 carbs with every meal, and 1 carb for snacks. She should continue exercising as tolerated. Then she should follow up in 3 months, 6 months and 12 months to monitor her renal function, gllucose control. She should also have her eyes and extremities checked or complications of diabetes every 6 months in addition to her self monitoring

SOAP Format

Subjective

Objective

Assessment

Plan

EXAMPLE #1 **03/11/2009 1645 Pharmacy Note: Pt w/ Diabetes**

(S): 78 yo AAF w/ DM T2 being discharged post-heart failure exacerbation. Admitted several days ago, DM T2 tx w/ insulin while inpt, med team deciding which oral antihyperglycemics to restart upon discharge (other meds to remain the same). DH prior to admission:

Metformin 850mg PO TID	Carvedilol 25mg PO BID
Pioglitazone 45mg PO qday	Simvastatin 20mg PO qpm
Losartan 50mg PO qday	Aspirin 81mg PO qday
Furosemide 40mg PO qday	Tylenol Arthritis 650mg 2 caps BID prn joint pain

PMH: DM T2 x 6 years, HTN x ~30 yrs, hypercholesterolemia x ~10 yrs, osteoarthritis x ~20 yrs.
FH: hx of DM in mom & siblings, dad died of MI at 42.
SH: Pt denies tobacco, EtOH, illicit drug use. Pt lives alone, sees friends/family several times/wk. Diet before hospital admission: drinks sweetened w/ Splenda, ~4 carbs per meal, <2400mg Na near goal. Exercise includes daily walks w/ daughter & dog, tai chi classes.

(O): SCr 1.2 (down from 1.5 on admission) wt 64 kg (down from 67 kg on admission), edema, cough, JVD on admission have resolved. BG is close to goal on glargine 26 units qhs, lispro 6 units TID ac.

(A): 1. Restart Metformin. Max dose 1500mg qday since pt has renal dysfunction (CrCl 46).
2. D/C pioglitazone. Pioglitazone contraindicated in this pt due to CHF. Pio ↑ fluid retention/edema.
3. D/C prandial insulin. Switch to oral sulfonylurea to decrease number of daily injections.
4. Decrease lantus dose - lower dose expected for adequate control: basal glucose levels will be controlled with metformin, glucose levels may decrease when acute illness has passed.
5. D/C prandial insulin (Prandial glucose levels to be controlled by sulfonylurea)

(P): 1. Restart Metformin 500mg PO BID x 1 week, then increase to 500 mg 2 tabs qAM, 1 tab qPM.
2. D/C pioglitazone.
3. Start glipizide 2.5mg PO BID (morning & dinnertime).
4. Decrease lantus to 10 units subQ qhs. Injection technique provided at discharge.
Pt to watch for sx of hypoglycemia, eat 15g sugar if BG measures <70. Monitor BG 5x daily: AM fasting, pre-breakfast, lunch, dinner, & bedtime. F/U in 1 wk, bring BG log. Check wt daily. Aim for 3 carbs each meal w/ 1 carb snacks. Continue exercise as tolerated. F/U in 3 mos, 6 mos, 12 mos to monitor renal function, glucose control. Check eyes, extremities for DM complications q6mo in addition to pt self-monitoring for complications.

EXAMPLE #2 01/15/2009 1430 **Pharmacy Note: Hypertension Follow-Up**

(S): 47 y.o. A.A. F presents to clinic for f/u of physical exam findings. Found to be hypertensive during physical exam 1 week ago. PCP ordered blood work + renal "XRAY" to assess kidney function.
PMH: hypertension x 20 yrs. Hyperlipidemia x 10 yrs. h/o sinus headaches (self-medicates).
SH: accountant, works 50-60 hrs/week, lives alone, poor diet: lots of fast food. Caffeine 2-3 /day, occasional EtOH, smokes 1 pack/day (27 pack-year hx) Would like to exercise more, but is often too tired.
FH: father has HTN, is on dialysis for renal failure. Mother has DM Type II.
DH: NKDA
HCTZ 25 mg daily (non-compliant, refills off schedule by 2 weeks)
Atorvastatin 10 mg daily (non-compliant, refills off schedule by 2.5 weeks)
Sudafed 30 mg PRN stuffy nose (takes BID-TID)
Motrin PRN headaches, takes 600mg 3-4x weekly

(O) 1/8/09: BP: 180/104; HR: 62
Today: ROS: non-contributory, no indication of 2° HTN. Vitals: BP: 184/104 HR: 68 RR: 18 Wt: 168 lb Ht: 65"
BUN 35, SCr 1.8, 24-hr urine: >1 g /day proteinuria, glucose: 99mg/dL. Lipid panel: TC: 240mg/dL, TG: 170mg/dL, HDL: 34mg/dL LDL:144 mg/dL Renal ultrasound: no evidence of obstruction. Kidney size reduced bilaterally.

(A): 1. Pt has uncontrolled HTN (Stage II) due to medication non-compliance and existing risk factors. Evidence of end-organ kidney damage warrants combination therapy w/ thiazide diuretic & ACE inhibitor or ARB (per JNC-7 guidelines). Start combo product to reduce pill burden & non-compliance
2. Pt non-compliance limits tx success, is contributing to high lipids. Continue atorvastatin, discuss compliance with pt.
3. Smoking, caffeine, stress and poor diet increase BP and risk of CV disease. Lifestyle modifications and smoking cessation will help to reduce BP. Use of OTC NSAIDs, decongestants contribute to HTN, pt should d/c or limit these medications.

(P): 1. D/C HCTZ 25 mg. Start enalapril/HCTZ 10/25 1 tab PO daily for BP control. F/U in 7-14 d. Contact clinic if cough or facial swelling occurs.
2. Continue atorvastatin 10 mg with proper adherence to lower lipids. Discuss & ensure compliance by using medi-set or other convenient method.
3. Encourage smoking cessation for CV & other health benefits. Counsel pt to eat a balanced low-fat, high-fiber diet. Decrease stress with breaks from work, walks, yoga. Limit caffeine intake. D/C OTC Motrin or other NSAIDs, take APAP 325mg PRN HA. D/C PRN use of Sudafed.

Subjective

Information the pt tells you about him/herself

Includes:

- ID & Chief Complaint (CC) *…46yo M presents to pharmacy for hypertension*
- History of Present Illness (HPI) *…pt reports elevated readings for 2 weeks*
- Past Medical History (PMH) *…has had DM II for 6 years, HTN for 10 years*
- Drug History (DH) *…currently taking metformin 1000mg BID, HCTZ 25mg daily*
- Family History (FH) *…DMII in both siblings, father died of MI at 52yo*
- Social History (SH) *…denies alcohol, illicit drugs. Smokes 1 ppd. Adheres to diet ~50% of the time*

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SH: **accountant, works 50-60 hrs/week, lives alone, poor diet: lots of fast food. Caffeine 2-3 /day, occasional EtOH, smokes 1 pack/day (27 pack-year hx) Would like to exercise more, but is often too tired.**

FH: **father has HTN, is on dialysis for renal failure. Mother has DM Type II.**

DH: **NKDA**
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Objective

Observable/factual information obtained from or verified by a healthcare provider

- Vital signs (BP, HR, RR, temp, wt, ht)
- Physical Exam
- Labs (blood tests, urine tests, microbiology, etc)
- Diagnostic tests (x-rays, CT/MRI, EKG, EEG)
- Medications (from profile or chart)

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Assessment

Your clinical judgment of the patient's drug-related problems

- Problem list (numbered)
- Each item should include
  - problem, solution, evidence/reason for your solution
- Prioritize problems
  - start with most urgent (usually relates to CC)
  - end with least urgent

…Hypertension is currently uncontrolled on HCTZ alone. Pt should be on combo therapy with an ACE-Inhibitor per JNC-7 guidelines.

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Plan

Specific solution for each problem outlined in the assessment

- Numbered list to match the *Assessment*
- Recommendations for drug dose, frequency, duration
- Monitoring
- Follow-up

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