College of Pharmacy
Standardized SOAP Note, Rubric, & Expected Components

The following document outlines the Oregon State University College of Pharmacy SOAP note framework and outlines the guiding philosophy and principles of a standardized, educationally-oriented SOAP Note for use throughout the Oregon State University Doctor of Pharmacy curriculum.

Assumptions:

Over the course of the curriculum the following elements would evolve:

- Prioritized Problem List may add in a requirement for a Drug Related Problem List, when applicable.
- The weighting of each element will adjust based on the focus of the case and the related expectations of students.
- Formatting requirements may adjust based on faculty discretion.
- Point deductions based on not following directions may adjust based on faculty discretion.
- Grading scale or key created may adjust based on faculty discretion and the focus of the case and the related expectations of students.
- An educationally-oriented SOAP note is designed for faculty to assess student thought processes in addition to the general SOAP note components. This SOAP note is not designed to mimic what students would necessarily include during rotations. Students should work with preceptors to understand site-specific expectations.

	Points	Not Acceptable (0 points)	Need Improvement (1 point)	Competent (2 points)	Score	Weight	Value	Comments
S	Subjective Information	Limited or no summary of pertinent information, is organized poorly, contains inaccurate information, and/or is difficult to understand.	Provides most of the pertinent information, but is not well organized and/or is slightly challenging to understand. May be missing pertinent negative information (e.g., patient denies…).	Provides complete, concise, and accurate information which is well organized and easy to understand.				
O	Objective Information	Limited or no summary of pertinent information, is organized poorly, contains inaccurate information, and/or is difficult to understand.	Provides most of the pertinent information, but is not well organized and/or is slightly challenging to understand. May be missing pertinent negative information (e.g., patient denies…).	Provides complete, concise, and accurate information which is well organized and easy to understand.				
A	Prioritized Problem List	Identifies no or few problems. Main problem and drug-related problems are missing.	Identifies the main problem and drug-related problems; however, problems are not prioritized appropriately. Includes nonexistent problems and/or list is not complete.	Identifies the main problem and prioritizes problems correctly. Drug-related problems for each problem are identified and all active problems are listed.				
A	Initial Assessment	Does not include pertinent subjective and objective information to assess the problem(s). Introduces significant new information not mentioned in S or O. Assessment is incorrect.	Includes some pertinent subjective and objective information to assess the problem(s). May introduce some new information not mentioned in S or O or include components in the assessment that are incorrect.	Includes all pertinent subjective and objective information to assess the problem(s). Assessment is correct.				
A	Treatment Goals	Missing appropriate therapeutic goals for the main problem and other active problems.	Some appropriate therapeutic goals for the main problem. May be missing goals for other active problems.	All therapeutic goals for the main problem and other active problems are appropriate.				
A	Treatment Options	Does not identify appropriate potential treatment options for the primary problem based on patient-specific data.	Identifies potential treatment options for the primary problem based on patient-specific data; however, one or more options are unreasonable.	Identifies 2 optimal and reasonable treatment options for the primary problem based on patient-specific data.				
A	Justification	Missing justification for treatment choice(s).	Provides some appropriate justification for treatment choice(s).	Provides an evidence-based and appropriate justification for treatment choice(s).				
P	Treatment Plan	Missing or inappropriate treatment plan for the main problem and other active problems.	Mostly complete and appropriate plan for the main problem and other active problems. May be missing appropriate non-pharmacologic treatments and/or sig components.	Complete and appropriate plan for the main problem and other active problems. Includes pharmacologic and/or non-pharmacologic and/or complete sig components.				
P	Education & Counseling	Missing education and key counseling points. May be missing pertinent lifestyle recommendations.	Provides mostly complete education and key counseling points. Lifestyle recommendations may not be complete or pertinent.	Complete education and counseling points for all pertinent treatments, including pharmacologic and/or non-pharmacologic recommendations.				
P	Monitoring, Follow-up, & Referrals	Missing monitoring parameters for the main problem and other active problems, or did not provide specific follow-up timeframe. Missing applicable referrals.	Provides some monitoring parameters for the main problem and other active problems. Specific follow-up timeframe and applicable referrals are included.	Provides all appropriate monitoring parameters for the main problem and other active problems with specific follow-up timeframe, and includes applicable referrals.				
Overall	References	References missing or very limited. References listed are inappropriate (i.e. tertiary) and/or not relevant.	References listed are appropriate (i.e. guidelines or primary), but not complete and some may be missing. Not AMA formatted.	Provides a complete and appropriate list of references that are in AMA format.				
Overall	Clarity	Substantial language, spelling, grammar, or abbreviation mistakes. Significant use of inappropriate, nonstandard, or unexplained abbreviations.	A few noticeable language, spelling, grammar, or abbreviation mistakes. May have a few instances of inappropriate, nonstandard, or unexplained abbreviations.	No noticeable language, spelling, grammar, or abbreviation mistakes. No use of inappropriate, non-standard, or unexplained abbreviations.				
Overall	Format	Missing essential patient or clinician information. Noncompliance with font and page limit.	A few missing or inaccurate components. Incorrect font or exceeded page limit.	Student name in upper right of page header. Patient name, age, date of birth, identifying gender, and allergies in upper left. Student signed at end, including title and date. Font and page limit parameters met.				
				A. Total Points - Deductions				
				B. Total Possible Points				
				Score (A/B)				

Standard Components of & Guide to Writing SOAP Notes

I. Identifying information:
   a. Student name should be in the upper right of the header.
   b. Patient identifiers come before the subjective information and should be located in the upper left corner. Includes the patient name, age, date of birth (DOB), identifying gender, and allergies.

Disclaimer: Sections given below are not always included depending on the type of visit, and depending on whether or not the information obtained is pertinent to the problem(s) and documentation of the visit.

II. Subjective information (S): Defined as the information that is provided by the patient and obtained in an interview.

   a. **Chief Complaint (CC):** summary statement of reason for visit, often in patient's own words. E.g., "CC: 'I have a headache.'" NOTE: this section may be removed or replaced with statement for why the pharmacist is seeing this patient. E.g., "AL has been referred to (insert name of pharmacy service) as requested by (insert name of doctor) for medication management of her diabetes."

   b. **History of Present Illness (HPI):** Summary of recent history contributing to the CC that is obtained during an interview with the patient and by utilizing open-ended questioning and/or the eight attributes of a symptom. This section is written in a narrative format with full sentences. The eight attributes include:

   - Location
   - Quality
   - Severity
   - Onset/Setting
   - Timing/History
   - Modifying Factors (Provoking and Palliating)
   - Associated Symptoms
   - Meaning to Patient

   c. **Past Medical History (PMH):** Contains a complete listing of childhood and adult illnesses (both active and resolved), immunization history, and surgical history. If available, each problem should include dates, how long the patient has had it for, and/or if it is resolved. If female, may include information on pregnancies and births. This section is written in a bulleted format.

   d. **Social History (SH):** Usually written in a narrative format with full sentences, but could also be in bulleted format.
      i. Information pertaining to the patient's health and lifestyle: diet, exercise, substance use (tobacco, alcohol, recreational drugs, and sometimes caffeine). Information on positive or negative use should be included for substance abuse along with quantifying how much is used if positive (e.g., how many cigarettes/day).
      ii. Personal circumstances and living situation: occupation, residence, mention of family members and/or others who live with the patient and what their role is, sexual orientation and gender identification, and sexual activity.

   e. **Family History (FH):** Health history of immediate family members, and especially pertinent to any similar problems identified with the patient.

   f. **Review of Systems (ROS):** Set questions asked that pertain to symptoms associated with each body system. This section is written in a narrative format and will indicate the body system, symptom asked, and which are positive vs. those that the patient denies. The type of questions that should be asked and what is reported will depend on the type of visit. Knowing that a patient denied a certain symptom can be relevant and would also need to be included within the documentation.

   E.g. "General: patient denies fevers, weight changes, dizziness, weakness, headaches, and night sweats. Heart: patient denies chest pain, palpitations, SOB, syncope, and swelling." **NOTE:** not all systems are listed.

III. **Objective Information (O): Defined as the information obtained by the clinician, EMR, any lab work, and diagnostics.**

    a. **Medication List:** Complete list of the current medications the patient is taking. All medications should include the drug name, dose, route, frequency, date started, and (if applicable) the duration of treatment. Compliance to medications and any adverse effects should also be listed here, if obtained. This section is written in a bulleted format. **NOTE:** Medication lists can be found in either the Subjective or Objective sections depending on the source. If the clinician is starting from scratch in obtaining a medication list, then it is generally found in the Subjective section. If there is an existing medication list that is verified with the patient, then it is generally found in the Objective section.

    b. **Vital Signs:** BP, HR, RR, Wt, Ht, BMI, Temp, and O2. May also see relevant values from previous visits listed.

    c. **Physical Exam:** Includes the observations and results of any exams done. Will be broken down by body system and is formatted as a list.

    d. **Laboratory Values:** This includes all lab work done recently and is often compared to previous values. Normal and abnormal values will usually be given and is in a list or bulleted format.

    e. **Diagnostics:** There is a broad spectrum of diagnostic tests that could be done and an equally broad range of costs associated with each. Some will provide images that are not shown but will have interpretation of what was seen (many health systems employ physicians who will look at the image and give the interpretation). Because of the high cost associated with diagnostics, only those tests that are needed for diagnosing or monitoring the patient's problem should/will be done, and in general all should be included in this section.

IV. **Assessment (A): This section is where the clinician assimilates all the information they have obtained from the Subjective and Objective areas and applies it to standard practice as defined by evidence-based medicine.**

    a. **Prioritized problem list and drug related problems:** This list should be complete for all *ACTIVE* problems for this patient and numerically prioritized according to severity. Generally, the problem associated with the chief complaint will be the highest acuity; however, this is not always the case.

    NOTES for Problem Lists:
- Problem titles should be very short and ARE NOT the same thing as symptoms. *E.g., "Seasonal Allergies" (NOT itchy eyes, rhinorrhea, sneezing, etc.).*
- Some problems may be controlled, but if the patient is actively doing something (e.g., taking medication) then it should still be listed. These problems are listed lower in priority, and later on when assessing the problems the documentation can state whether the current regimen is sufficiently controlling the problem.
- **Drug-Related Problems (DRPs):** These problems are associated with and given as sub-bullets to each problem, when applicable. They are short statements that identify areas where drug therapy is contributing to the problem or interfering with desired outcomes. Examples include adverse reactions, drug-drug interactions, drug-disease interactions, sub-optimal therapy, or dosing, etc.

      E.g., "Prioritized Problem List:
        1. Uncontrolled Hypertension
          DRP: Combination of ACEi, thiazide, and NSAID can adversely affect renal function
        2. Back Pain
          DRP: Use of scheduled naproxen can increase BP
        3. Pre-Diabetes
          DRP: Elevated A1c requires lifestyle modifications and the possible use of metformin"

b. **Assessment and therapy justification for each problem:** Should be numbered and titled according to the problem list in order to connect the assessment with the problem being discussed. The format is generally put into a narrative. Only pertinent information needs to be included, and attempts should be made to be complete yet concise. The assessment for each problem should include:

  i. **Initial Assessment:** Analysis of the Subjective and Objective information as it pertains to each problem. Utilize the signs, symptoms, vitals, physical assessment, labs, diagnostics, medication list, and/or any other pertinent information that is contributing to why this patient has each of the active problems. It is possible that some of the active problems are being appropriately controlled either by lifestyle modifications or by medications. If this is the case, indicating that it's controlled, and how, is all that needs to be communicated.

     NOTES on Problem Analysis:
     - All the Subjective and Objective information found in this section should also be listed within their respective categories (S and O) in the beginning of the SOAP note.
     - References to clinical practice guidelines should be utilized and referenced here in order to indicate why the medical community would consider this set of information as contributing to the problem.

  ii. **Treatment Goals:** This may include short and long-term goals for therapy as it pertains to each problem. Clinical guidelines should be utilized and referenced.

  iii. **Treatment Options and Justification:** Each problem should mention 2-4 different treatment options (pharmacologic and non-pharmacologic) that could be used. This should then be followed up with an explanation for why 1 option is preferable to the others. Examples for justification include clinical guideline recommendations, patient-specific factors, cost, and resolution of DRPs.

     E.g., Assessment: (only given for 1 of the example problems from above)
     1. Uncontrolled Hypertension: The patient's home BP readings have been ranging from 150-170/96-112 mmHg, with BP of 165/100 mmHg in clinic today. His readings indicate his BP is not at goal per JNC8 guidelines (BP goal of < 140/90 mmHg); despite being at max dose of lisinopril and chlorthalidone, his BP is still elevated. Factors that could be contributing to his elevated BP include the increased use of NSAIDs for back pain and recent diet changes. The short-term goal is to control his BP and resolve associated HAs and dizziness. Long-term goals are to minimize end organ damage and to prevent cardiovascular mortality. Naproxen use should be discontinued and back pain and headaches should be evaluated further to find an alternate analgesic. Exercise and dietary changes that reduce sodium should be recommended. If BP continues to be elevated, the addition of a calcium channel blocker (CCB) or a beta blocker (BB) can be added. For this patient, CCBs would be preferred over a BB because of fewer associated side effects and that BBs can reduce exercise tolerance.

V. **Plan (P): This section is where the final treatment plan is given for each of the active problems as justified in the assessment. It should also be numbered and titled according to the problem list, and the format is both a list and narrative.**

  a. **Treatment Plan:** Contains a list of all the final treatments being chosen. All pharmacologic options should have a complete sig that includes drug name, dose (if weight-based, then dose needs to be calculated), route, frequency, and (when applicable) titrating instructions, the amount, and the duration of treatment. All non-pharmacologic options should include specifics that help to differentiate them from other lifestyle changes.

  b. **Education and Counseling:** Brief mention of the most important key counseling points that should be communicated to the patient for each specific treatment chosen. Information for both pharmacologic and non-pharmacologic therapies should be given.

c. **Monitoring, Follow-Up, and Referrals:** Provides monitoring for both the problem and the treatment plan chosen. Examples include monitoring effectiveness of the plan or needed monitoring for any added medications. Specifics should be given that include what monitoring is being done, time frame for when or if follow-up should happen, and (if applicable) any referrals to other clinicians. **NOTE**: not all problems or plans will need monitoring, follow-up, or referrals. However, if this is the case, it should still be noted in the documentation why monitoring is not needed.

> *E.g., <u>Plan:</u> (only given for 1 of the example problems from above)*
> *1. Uncontrolled Hypertension:*
> > *Discontinue Naproxen*
> > *Encourage a low sodium diet and increased exercise*
> > *Start Amlodipine 5mg PO daily*
>
> *Monitoring and Education: Patient should be encouraged to maintain a home BP/HR log. He should be educated on reducing sodium in his diet to less than 2,300 mg a day as recommended by the Dietary Approaches to Stop Hypertension (DASH) diet. Additionally, a moderate-intensity exercise regimen of at least 150 minutes/week should be recommended and encouraged. Follow-up can be done by phone in 4-5 days to check resolution of high BP and associated symptoms of HA and dizziness. A CHEM-7 should be repeated in 2 weeks in order to reassess renal function and potassium levels.*

VI. References: This section should contain a complete listing of all references used.

- Appropriate Unites States clinical guidelines NEED to be utilized and are considered to be standard of care. If the guidelines are out of date, then other PRIMARY sources can be used. Tertiary sources are NOT appropriate.
- Dynamed, UpToDate, MicroMedex, etc. are tertiary sources and SHOULD NOT BE USED for clinical justifications. They are ok starting points if the student does not know which clinical guidelines or primary sources to use, but are not considered to be standard of care.

VII. Signature: All notes should be signed by the student with credentials and the date written.

Additional Information:
- Common medical abbreviations are ok to use; however, unrecognizable or error-prone abbreviations should be avoided. Here are a few references to use when using medical abbreviations:
  - https://www.ismp.org/Tools/errorproneabbreviations.pdf
  - http://www.medilexicon.com/