SOAP Notes

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Introduction

The Subjective, Objective, Assessment and Plan (SOAP) note is an acronym representing a widely used method of documentation for healthcare providers. The SOAP note is a way for healthcare workers to document in a structured and organized way.[1][2][3]

This widely adopted structural SOAP note was theorized by Larry Weed almost 50 years ago. It reminds clinicians of specific tasks while providing a framework for evaluating information. It also provides a cognitive framework for clinical reasoning. The SOAP note helps guide healthcare workers use their clinical reasoning to assess, diagnose, and treat a patient based on the information provided by them. SOAP notes are an essential piece of information about the health status of the patient as well as a communication document between health professionals. The structure of documentation is a checklist that serves as a cognitive aid and a potential index to retrieve information for learning from the record.[4][5][6]

Function

Structure

The 4 headings of a SOAP note are Subjective, Objective, Assessment and Plan. Each heading is described below.

Subjective

This is the first heading of the SOAP note. Documentation under this heading comes from the "subjective" experiences, personal views or feelings of a patient or someone close to them. In the inpatient setting, interim information is included here. This section provides context for the Assessment and Plan.

Chief Complaint (CC)

The CC or presenting problem is reported by the patient. This can be a symptom, condition, previous diagnosis or another short statement that describes why the patient is presenting today. The CC is similar to the title of a paper, allowing the reader to get a sense of what the rest of the document will entail.

- Examples: chest pain, decreased appetite, shortness of breath.

However, a patient may have multiple CC's, and their first complaint may not be the most significant one. Thus, physicians should encourage patients to state all of their problems, while paying attention to detail to discover the most compelling problem. Identifying the main problem must occur to perform effective and efficient diagnosis.

History of Present Illness (HPI)

The HPI begins with a simple one line opening statement including the patient's age, sex and reason for the visit.

- Example: 47-year old female presenting with abdominal pain.

This is the section where the patient can elaborate on their chief complaint. An acronym often used to organize the HPI is termed "OLDCARTS":

- Onset: When did the CC begin?

- Location: Where is the CC located?

- Duration: How long has the CC been going on for?

- Characterization: How does the patient describe the CC?

- Alleviating and Aggravating factors: What makes the CC better? Worse?

- Radiation: Does the CC move or stay in one location?

- Temporal factor: Is the CC worse (or better) at a certain time of the day?

- Severity: Using a scale of 1 to 10, 1 being the least, 10 being the worst, how does the patient rate the CC?

It is important for clinicians to focus on the quality and clarity of their patient's notes, rather than include excessive detail.

History

- Medical history: Pertinent current or past medical conditions

- Surgical history: Try to include the year of the surgery and surgeon if possible.

- Family history: Include pertinent family history. Avoid documenting the medical history of every person in the patient's family.

- Social History: An acronym that may be used here is HEADSS which stands for Home and Environment; Education, Employment, Eating; Activities; Drugs; Sexuality; and Suicide/Depression.

Review of Systems (ROS)

This is a system based list of questions that help uncover symptoms not otherwise mentioned by the patient.

- General: Weight loss, decreased appetite

- Gastrointestinal: Abdominal pain, hematochezia

- Musculoskeletal: Toe pain, decreased right shoulder range of motion

Current Medications, Allergies

Current medications and allergies may be listed under the Subjective or Objective sections. However, it is important that with any medication documented, to include the medication name, dose, route, and how often.

- Example: Motrin 600 mg orally every 4 to 6 hours for 5 days

Objective

This section documents the objective data from the patient encounter. This includes:

- Vital signs

- Physical exam findings

- Laboratory data

- Imaging results

- Other diagnostic data

- Recognition and review of the documentation of other clinicians.

A common mistake is distinguishing between symptoms and signs. Symptoms are the patient's subjective description and should be documented under the subjective heading, while a sign is an objective finding related to the associated symptom reported by the patient. An example of this is a patient stating he has "stomach pain," which is a symptom, documented under the subjective heading. Versus "abdominal tenderness to palpation," an objective sign documented under the objective heading.

Assessment

This section documents the synthesis of "subjective" and "objective" evidence to arrive at a diagnosis. This is the assessment of the patient's status through analysis of the problem, possible interaction of the problems, and changes in the status of the problems. Elements include the following.

Problem

List the problem list in order of importance. A problem is often known as a diagnosis.

Differential Diagnosis

This is a list of the different possible diagnosis, from most to least likely, and the thought process behind this list. This is where the decision-making process is explained in depth. Included should be the possibility of other diagnoses that may harm the patient, but are less likely.

- Example: Problem 1, Differential Diagnoses, Discussion, Plan for problem 1 (described in the plan below). Repeat for additional problems

Plan

This section details the need for additional testing and consultation with other clinicians to address the patient's illnesses. It also addresses any additional steps being taken to treat the patient. This section helps future physicians understand what needs to be done next. For each problem:

- State which testing is needed and the rationale for choosing each test to resolve diagnostic ambiguities; ideally what the next step would be if positive or negative

- Therapy needed (medications)

- Specialist referral(s) or consults

- Patient education, counseling

A comprehensive SOAP note has to take into account all subjective and objective information, and accurately assess it to create the patient-specific assessment and plan.

Issues of Concern

The order in which a medical note is written has been a topic of discussion. While a SOAP note follows the order Subjective, Objective, Assessment, and Plan, it is possible, and often beneficial, to rearrange the order. For instance, rearranging the order to form APSO (Assessment, Plan, Subjective, Objective) provides the information most relevant to ongoing care at the beginning of the note, where it can be found quickly, shortening the time required for the clinician to find a colleague's assessment and plan. One study found that the APSO order was better than the typical SOAP note order in terms of speed, task success (accuracy), and usability for physician users acquiring information needed for a typical chronic disease visit in primary care. Re-ordering into the APSO note is only an effort to streamline communication, not eliminate the vital relationship of S to O to A to P.

A weakness of the SOAP note is the inability to document changes over time. In many clinical situations, evidence changes over time, requiring providers to reconsider diagnoses and treatments. An important gap in the SOAP model is that it does not explicitly integrate time into its cognitive framework. Extensions to the SOAP model to include this gap are acronyms such as SOAPE, with the letter E as an explicit reminder to assess how well the plan has worked.[7][8][9][10]

Clinical Significance

Medical documentation now serves multiple needs and, as a result, medical notes have expanded in both length and breadth compared to fifty years ago. Medical notes have evolved into electronic documentation to accommodate these needs. However, an unintended consequence of electronic documentation is the ability to incorporate large volumes of data easily. These data-filled notes risk burdening a busy clinician if the data are not useful. As importantly, the patient may be harmed if the information is inaccurate. It is essential to make the most clinically relevant data in the medical record easier to find and more immediately available. The advantage of a SOAP note is to organize this information such that it is located in easy to find places. The more succinct yet thorough a SOAP note is, the easier it is for clinicians to follow.

Review Questions

- Access free multiple choice questions on this topic.

- Comment on this article.

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