How to write brief practice notes using the S O A P format

To support your Community Pharmacy LTC Service medicines management planning & documentation

S *ubjective*

O *bjective*

A *ssessment*

P *lanning*

What are SOAP notes & how can they help you?

Note taking should not be a onerous time commitment and should supports rather than detract from professional interactions.

The SOAP format is used by clinicians to structure notes to succinctly articulate their professional activity and for recording and communicating to others in the team. They can support you to articulate and record your cognitive processes.

SOAP can help you briefly capture pertinent details and document what you do. The key is - **only record information pertinent to the issue.**

Subjective information is what the person (or the caregiver) reports directly to you. It is their experience of the complaint, issue or treatment.

Objective information is data that you have or another health care professional have directly measured or observed. It could include:

- A description of the physical signs you observe or measure
- Reports from health care professionals eg lab & test results
- Current medicines therapy observations, returned medicines, measurements of responses to medicines eg lung function or blood glucose measurements
- Drug allergies or adverse reactions.

Assessment information communicates your critical thinking. It is your assessment and will most likely be medicine or treatment related. It is your assessment of the problem from your professional perspective.

Planning records the specific actions you will take related to the medicines use issues relevant to the person.
This could include:

- Medicines therapy changes (medicines name, dose, route, frequency, duration and how this is communicated to the prescriber)
- Communications to other multi-disciplinary team members
- Medication management interventions eg reconciliation, synchronisation, adherence aids
- Exercise & lifestyle suggestions
- OTC suggestions - eg vitamins or paracetamol
- Therapy recommendations eg influenza vaccine or referral - "go and see your GP"
- Education interventions eg inhaler technique training
- Monitoring and follow up - if no action is required record that too.

Where do you enter & keep these notes?

Use your Pharmacy Management Software (PMS) to securely store notes that other pharmacists can access to see a person's progress and their history of care with your pharmacy. Your PMS vendors have advice on the best way to store a continuous collection of notes so you can quickly see the information you need.

What to note down - SOAP examples

Person 1

S*ubjective*

"I don't know when and how I am supposed to take all these medicines."

O*bjective*

Medicines collection is out of alignment and some medicines are frequently returned.

A*ssessment*

A poor adherence due to complex medicines.

P*lanning*

Synchronise and counsel on adherence ; provide education and a patient held medication record.
Informed GP of adherence issue & plans.
Assess at next visit.

Person 2

S*ubjective*

Just discharged from hospital & medicine looks different. Not sure what to do.

O*bjective*

New prescription for cilazapril.
Metoprolol not on prescription.

A*ssessment*

History obtained from person.
Reconciliation required.

P*lanning*

Checking with prescriber.
Communicate outcome to GP and person this afternoon.
MMP updated (date).

Remember!

SOAP notes can be brief or detailed depending on the context & intended audience.

Only include information relating directly to the identified issues and the related plan.

Write notes keeping in mind that the person you're writing about has a right to see them.

Try to write notes that won't leave other readers with questions about the suggested course of action eg other pharmacists and GPs.

If you don't need to make changes to your MMP plan or if you notice something working well - write it down!