DOCUMENTATION WITH S.O.A.P.

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Today's Objectives

- Discuss the essential components of SOAP documentation
- Identify the requirements for completing SOAP documentation in compliance with standards

SOAP Notes

How do you figure out what's important in the pile of information received from the patient?

Components of S-O-A-P Notes

- Subjective
- Objective
- Assessment
- Plan

Subjective

- What does the patient “say” about their situation. A narrative of the patient’s current condition.
- Onset(when)
- Chronology (how long, how frequent)
- Modifying factors(what makes it better or worse)
- Complaints, Sensations, or Concerns
- Treatment (what has been tried)
- The reason the patient came to see the doctor/clinic

Objective

- What the clinician observes in the patient
- Includes facial expressions, body language or results of tests.
- Physical exam, vital signs
- Laboratory results (Ferritin level, cholesterol levels)
- Physical examination findings (scalloped tongue, leg swelling)

Assessment

- Analysis of what's going on with the client
- These are not medical diagnosis, they can identify important problems or issues that need to be addressed.

Plan

- Caregivers make decisions about how they will provide care that is based on specific needs and abilities of the patients.
- Need to be realistic and measurable so that their effectiveness can be evaluated.
- Include treatments, medications, education and consults to other members of the team.

SAMPLE PATIENT

54 Year Old Man Brought to Sleep Center by His Wife

Subjective

- The patient complains of morning headaches, and sleepiness.
  - Onset has been gradual over the last few years, however for the past year he complains of daily, morning headaches and reports that recently he has nearly fallen asleep in afternoon meetings at work on occasions.
  - He reports that sleeping in a recliner reduces the severity of his headaches and sleepiness.
  - He reports frequent awakenings at night to use the bathroom and his wife complains that he kicks his legs frequently while asleep.
  - He has increased his intake of caffeine in an effort to stay awake in afternoon meetings, but this has not helped much. He has not had any treatment for these complaints.

Objective

- The patient is 54y/o male, 5’4” tall weighing 225lbs. His BMI is 43.
- Blood pressure 165/100, HR 92, pulse oximetry on rm air at rest 97%.
- There is no laboratory results available to review for this visit.
- Physical examination findings included a crowded airway and scalloped tongue, as well as minimal leg swelling.

Assessment

- Based on the patient's complaints, physical examination that shows a crowded airway and scalloped tongue, obesity, uncontrolled high blood pressure, a high Epworth score and his wife's report of snoring there is a high probability of obstructive sleep apnea.

Plan

- The patient will be scheduled for overnight polysomnography for suspected obstructive sleep apnea.
- In addition the patient has been referred for ENT evaluation to exclude nasal or adenoidal obstruction.
- He will be returning for review of the PSG results in 2 wks.

Sample Patient: Mr A

- Mr A is a 43 y/o male with complaints of insomnia. He has witnessed occasional snoring, but described apnea. He states he frequently lies down at the appropriate time and cannot fall asleep. Other times, after having fallen asleep, he awakens and cannot go back to sleep. He c/o being sleepy at inappropriate times, which is interfering with his work-out regime. He is a former accountant by degree.
- Past Medical History: He is a former US Marine who was injured in combat while serving in Iraq. Most significant injury was a total loss of vision by means of ocular nerve damage, having occurred when struck by explosive fragments. He received various superficial flesh wounds on the face and arms, all of which were successfully treated. He has no other significant history.

Mr A (Cont)

- Physical Findings: He is 75” and weighs 198lbs. He has a Mallampati II of IV. He is currently on no medications. Heart rate and Blood pressure are within normal , limits. He has gained weight (approx 15-18lbs) since discharge 5 yrs ago. He reports moderate drinking, consuming 2-3 12oz beers per night.
- Prior to the sleep study, he reports twitching in his lower limbs at various times of the day. This sensation began approximately 1 yr ago.

SOAP Mr A:

- S: c/o Insomnia; states frequently lies down but cannot all asleep. Awakens and cannot go back to sleep. witnessed occ snoring but described apnea; c/o being sleepy at inappropriate times and interferes w his work out regime. c/o twitching in lower limbs at various times of the day that started approx 1yr ago. Mod drinker, 2-3 12oz beers per night. Gained wt (15-18lbs) since discharge 5yrs ago.
- O: 75” tall & 198lbs. Mallampati II of IV. No meds, HR & BP are normal. Combat inj total loss of vision to ocular nerve from explosive fragments.
- A: Could be having nightmares/flashbacks. Compensating w alcohol Suggest no alcohol prior to bed. May have increased wt d/to sleep issues or dietary habits.
- P: Sleep study; Poss referral for CBT or counseling; Labwork to r/o Iron deficiency, standard lab work to r/o other health issues.

Sample Patient #2 Mrs L

- Mrs L comes to the Sleep Center with a c/o falling asleep during the day. She complains that she falls asleep during the day on most days, and she has trouble functioning without a 30min afternoon nap. Her usual bedtime is 10pm and she falls asleep quickly. She is out of bed at 7:30a. Her husband says that she is a loud snorer on occasion and makes gurgling sounds from time to time. She denies symptoms of restless legs syndrome or narcolepsy.
- Approximately 8yrs ago, she had a sleep study in a different city. She was told that she had sleep apnea and needed a f/up test but she moved and did not follow up with the doctor.

Mrs L (cont)

- Past Medical Hx: She has hypertension which is mostly controlled with Lisinopril. She has had elevated hemoglobin A1C but has not been given a diagnosis of or takes no medication for diabetes. Her PCP has noted premature beats but no other cardiac abnormalities. She has not had an ECG or other cardiac work up. She is a livelong smoker and currently smokes 10 cigarettes per day.
- Physical Exam: Blood pressure in the office was 132/95, pulse 82 and regular. She is 59 y/o, 65” tall and weighs 317lbs (BMI 52.8). Airway is Mallampati III. Heart sounds are normal. Neurological exam is normal.

SOAP: Mrs L

- S: C/o falling asleep during the day. Has trouble functioning without a 30min nap ea afternoon. Routine bedtime (10p), up 2-3x's to use bathroom but falls back to sleep quickly. Out of bed by 7:30a. Witness loud snorer on occasion, makes gurgling sounds from time to time. Denies sx of Restless legs and Narcolepsy. . Has had Elevated Hemoglobin A1C, no diagnosis of diabetes and takes no meds. Currently smokes 10 cigs/day, lifelong smoker.
- O: 8yrs ago, sleep study w Dx Sleep apnea- no fup.
- Hypertension controlled by Lisinopril. PCP noted Premature beats but no cardiac abnormalities. No EKG or cardiac workup. BP in office 132/95, HR 82/regular. 59y/o female; 65" and 317lbs (BMI 52.8). Airway Mallampati III. Heart sounds normal. Neuro eval normal.

Mrs L (cont)

- A: High probability of sleep apnea especially given she had a prior study that suggested the problem and she didn’t follow through for tx.
- P: Sleep study; labwork to determine Hemoglobin A1C level to r/o diabetes. Referral for cardiac follow up.

Sample Patient #3 Mr W

- 52 y/o man with a c/o daytime sleepiness. He is a loud snorer with episodes of witnessed apnea that has worsened recently. He is an active sleep, often tossing the bedclothes on the floor and sweating during the night. He typically takes more than half an hour to fall asleep and has frequent awakenings during the night to urinate. He has no symptoms of narcolepsy or restless legs syndrome. Spouse does not sleep in the same room but confirmed as a witness. He is referred by his PCP for a sleep study with a split night approved based on suspected sleep apnea.

Mr W (cont)

- Past Medical Hx: He has type II diabetes with onset at age 47. Bedtime blood glucose has been around 95 and hemoglobin A1C is 5.8 indicating that he has reasonable control with insulin, in recent hx. Patient reported taking several years to stabilize the diabetes. He has mild hypertension and takes losartan. He is a moderate drinker, reporting 2 beers per night.
- Physical Exam: He is 72” tall and weighs 285lbs, resulting in a BMI of 41.1. Mallampati III of IV. Blood pressure in the clinic was 125/88 and pulse 77 and regular. Lungs are clear and an abbreviated neuro exam was normal.

Mr W (cont)

- Prior to the sleep study: He has reported gaining about 15lbs over the Christmas holiday and has made a New Years resolutions to change his diet and begin an exercise program. Today was his first day on a physician supervised calorie restricted diet and his first at the gym. After leaving the gym, he felt anxious about the sleep study and stopped at a bar on the way to the center. He stated he limited himself to two beers, but the technologist noted he was a bit unsteady and was slurring his speech.

SOAP: Mr W

- S: C/o daytime sleepiness. Loud snorer w episodes of witnessed apnea that has worsened recently. Active sleep, incl tossing bedclothes and sweating during the night. Takes 30min to fall asleep, w frequent awakenings
- to urinate. No sx of narcolepsy or restless legs syndrome.
- Reported several yrs to stabilize his diabetes. Mild hypertension, takes Losartan. Mod drinker, 2beers/night
- Reported wt gain of 15lbs over the holidays. Beginning an exercise and MD supervised calorie restricted diet. Today 1st day at the gym. States was anxious over study so had 2 beers on the way to the study.
- O: Type 2 Diabetes onset age 47; Bedtime bl glucose 95 and hg A1C 5.8. Ht 72”; wt 285lbs (BMI 41.1) Mallampati III of IV. BP today 128/88 and HR 77 and reg. Lungs clear and abbreviated neuro normal. Tech notes he’s a bit unsteady and slurring his speech.

SOAP: Mr W

- A: Client could be inebriated or having a blood sugar issue d/to exercise and diet changes. May recommend the client test his BS prior to study. Follow protocol for results or for inebriated clients.
- P: Perform sleep study if appropriate based on assessment decision. If unable to perform study, then call family member to take the client home and reschedule.

QUESTIONS?

Thank you, Kathy Ohlmann, RN, MSN, COHN-S

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