

Patient notes - SOAP approach

New Template **TQ SOAP Note** - use if you wish the SOAP approach for patient notes.
 SOAP notes are organised into 4 sections

- **Subjective** = *what the patient reports;*
- **Objective** = *what the pharmacist observes/measures;*
- **Assessment** = *the pharmacist's clinical conclusions;*
- **Plan** = *specific actions to be taken.*

Edit Item F2		Add Int'vent F4	Add Note F5	Add Incid'nt F6	Use Tmplate F7	Add Task F8	
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Patient diary: Active items for patient Susan Pearson

Active items log

Date	Description	Importance	Status	Staff
23/10/14 15:00	TQ SOAP note	Normal	In progress	G G
16/09/14 09:53	Safe Dispensing Alert	Moderate/serio...	In progress	R A
13/09/14 15:40	TQ LTC4 Med Mngmnt Actio	Normal	In progress	R A
12/09/14 09:27	Intervention	Save patient m...	In progress	R A
12/09/14 09:26	Incident	Normal	In progress	R A
09/09/14 10:46	TQ Yellow Card Landscape	Normal	Review	R A
24/02/14 15:42	TQ LTC3 Medicines manage	Normal	In progress	R A

Note

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Pharmacy Patient notes	
Tel: [redacted] Fax: [redacted] Email: [redacted]	
Susan Pearson, RM [redacted]	
Date of interaction	23/10/14 10:40
Pharmacist <i>contact for further information</i>	Susan Pearson
Subjective: <i>What the patient reports</i>	Increasing problems with sore abdomen and constipation. Wants to reduce dose of verapamil. Takes blood pressure daily. Stable and low.
Objective: <i>What the pharmacist observes/measures</i>	Checked blood pressure. Problem has been reported before and laxatives do not seem to be satisfactory solution.
Assessment: <i>The pharmacist's clinical conclusion</i>	Potential to reduce dose.
Plan:	Ask patient to make appt with prescriber and discuss reducing dose.

How to consolidate your Soap notes

The TQ SOAP Note template has two SOAP grid frameworks. This allows a historical SOAP note to be copied forward to current date. If the blank grid is then copied and pasted to the TOP of the note, a current note detail can be filled in and saved.

Result = A comprehensive patient history note, always with the most current note at the top AND accurate dated notes tied to patient history for a perfect audit trail.

Detailed instructions of how this is done are ON THE TEMPLATE.

Edit Note F3 **Change Date F4** **Copy Note F5** **Save to PDF F6** **Email Note F8** **Print F9** **Other F10** **Accept Details F12**

Note
 Description: TQ SOAP note
 Importance: Normal
 Status: In progress
 Patient: Susan Pearson

Pharmacy Patient notes
 Tel: 03-228 2288 Fax: 03-228 2287 Email: susanpharmacy@yohos.com.au
 Susan Pearson, RML5277, 14 The Crescent, Milsherrough,
 Date of interaction: 23/10/14 10:40
 Pharmacist contact for further information: Susan Pearson
 Subjective: What the patient reports: Increasing problems with sore abdomen and constipation. Wants to reduce dose of verapamil. Takes blood pressure daily. Stable and low.
 Objective: What the pharmacist observes/measures: Checked blood pressure. Problem has been reported before and laxatives do not seem to be satisfactory solution.
 Assessment: The pharmacist's clinical conclusion: Potential to reduce dose.
 Plan: Specific actions to be taken: Ask patient to make appt with prescriber and discuss reducing dose.

Instructions:
 1) To keep a running consolidated SOAP note across an entire patient history. Copy the last SOAP note in a patient history.
 2) Then Edit the note to select, and copy the empty grid at the bottom of the SOAP note. Paste it at the top of the note and fill in with today's notes.
 3) To use this template to create a consolidated patient note that spans patient history, containing all SOAP notes.
 4) F2 Edit, F5 Copy Note. When prompted to copy to today - Y
 5) Edit Note. Using the mouse select the empty SOAP note below including the asterisk F11 Edit/paste. Copy
 6) Click TOP left of the document where the asterisk is, and F11 Edit/paste. Paste

Empty SOAP note grid.
 Select this from the asterisk and use F11 Edit/paste to copy it.
 Then go to top of the document click (before asterisk) and use F11 Edit/paste paste it to add a new empty grid to fill in current notes.

Follow instructions to create this consolidated comprehensive note...

Note
 Description: TQ SOAP note
 Importance: Normal
 Status: In progress
 Patient: Susan Pearson

Pharmacy Patient notes
 Tel: 03-228 2288 Fax: 03-228 2287 Email: susanpharmacy@yohos.com.au
 Susan Pearson, RML5277, 14 The Crescent, Milsherrough,
 Date of interaction: 01/11/14
 Pharmacist contact for further information: Susan Pearson
 Subjective: What the patient reports: Doctor was happy with reduction in dose of verapamil.
 Objective: What the pharmacist observes/measures: New prescription has halved the dosage
 Assessment: The pharmacist's clinical conclusion: Lower dose appropriate in this case
 Plan: Specific actions to be taken: None

Pharmacy Patient notes
 Tel: 03-228 2288 Fax: 03-228 2287 Email: susanpharmacy@yohos.com.au
 Susan Pearson, RML5277, 14 The Crescent, Milsherrough,
 Date of interaction: 23/10/14 10:40
 Pharmacist contact for further information: Susan Pearson
 Subjective: What the patient reports: Increasing problems with sore abdomen and constipation. Wants to reduce dose of verapamil. Takes blood pressure daily. Stable and low.
 Objective: What the pharmacist observes/measures: Checked blood pressure. Problem has been reported before and laxatives do not seem to be satisfactory solution.
 Assessment: The pharmacist's clinical conclusion: Potential to reduce dose.
 Plan: Specific actions to be taken: Ask patient to make appt with prescriber and discuss reducing dose.

Instructions:
 To use this template to create a consolidated patient note that spans patient history, containing all SOAP notes:
 1) Open patient diary. Find last SOAP note (description contains SOAP)
 2) F2 Edit, F5 Copy Note. When prompted to copy to today - Y
 3) Edit Note. Using the mouse select the empty SOAP note below including the asterisk - F7 Edit/paste. Copy
 4) Click TOP left of the document where the asterisk is, and F7 Edit/paste. Paste
 Once you are familiar with the process these hints can be deleted.

Callouts:
 For illustration a new soap note is created using the method proposed. Now there is a consolidated note for the patient showing the original interaction and the follow up.
 This can be continually copied forward and added to - for comprehensive consolidated patient notes.
 Empty SOAP grid - to be copied to the top of the document when the next soap note is required.
 The copying to the top of the document ensures that the most current note is always at the top of the document.