S.O.A.P. Charting

Actual Medical Charts

- The skin was moist and dry.
- Bleeding started in the rectal area and continued all the way to Los Angeles.
- She is numb from her toes down.
- Occasional, constant, infrequent headaches.
- Patient was alert and unresponsive.
- When she fainted, her eyes rolled around the room.

Actual Medical Charts

- According to patient, accident was caused because he was receiving gratification of an oral manner from female driver of car
- He was admitted to ER complaining of acute constipation. Removed large accidental cucumber from rectum, which relieved condition. He doesn't know how cucumber got into rectum. Advised that it might be good idea to remove all potentially dangerous fruit and vegetables from home environment

Actual Medical Charts

- Both breasts are equal and reactive to light and accommodation.
- The patient was in his usual state of good health until his airplane ran out of gas and crashed.

SOAP Provides

- Data base to plan patient care
- Communication between health care providers
- Written evidence of why patient received the care and the response to that care
- A way to review, study and evaluate patient care
- A detailed legal record

The Acronym

- S – Subjective
- O – Objective
- A – Assessment
- P - Plan

The Requirements

- Agency
  - Sets the standards for documentation and abbreviations
  - Has policy for when and what will be documented
    - Provides protection to the provider and agency

Demographic Information

- Date
- Day of Week
- Location of call
  - City & Zip
- Patient Info
  - Name
  - Date of Birth
  - Address
- Destination Facility
- Narrative
  - S.O.A.P. format
- Attachments
  - AMA
- Complete Copy to be given to destination facility

ALWAYS

- Be Honest
- Be Objective
- Be Accurate
- Be Complete
- Be Legible
- Use standardized abbreviations
- Watch your spelling
- Use Standardized Format

NEVER

- Use wording that can look
  - Biased
  - Prejudiced
  - Judgmental
- Make up abbreviations that don't exist
- Willingly falsify a record

Subjective

Subjective

- Definition:
  - Information that you are told or read in regards to the patient. You have no proof as to the validity of subjective information.
- Everything that you are told.

Subjective

- Informant
- Chief Complaint
  - History of Present Illness/Injury (HPI)
- SAMPLE History
- Special Considerations

Informant

- The Patient
- Relatives
- Witnesses
- Bystanders
- Law Enforcement
- First Responders

- Patient complains of
- Pt wife states…
- Per bystander #1
- Per witness
- First Responder states
- PD states

Chief Complaint

- Why EMS was activated
- What the patient (or bystander) states is the reason for calling 911

History of Present Illness/Injury

- What happened today to cause the caller to activate EMS
- Use OPQRST mnemonic
- Pertinent Negatives

OPQRST

- O – Onset
- P – Provocation, Palliation
- Q – Quality
- R – Radiation, Region, Rate
- S – Severity – 0 – 10 scale
- T – Time since onset, Treatment – self, home or doctor

SAMPLE

- S – Signs and Symptoms
- A – Allergies
- M – Medications
- P – Past Medical History (PMHx)
- L – Last Oral Intake
- E – Events leading up to

Special Considerations

- Document pertinent positives & negatives
- Direct quotes need quotation marks
  - *Dying patient declarations need to be documented verbatim*
- Don't wander, keep to matter at hand
- Document LMP for all women of child-bearing age

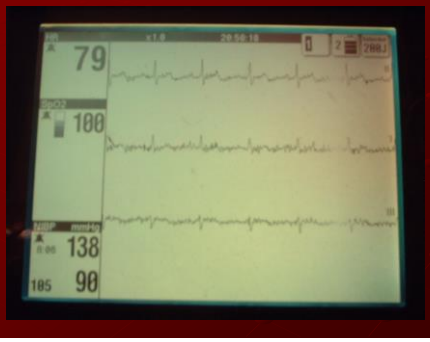
Example

- Dispatched to male with chest pain. Pt c/o substernal chest pain that started suddenly 2 hours ago while working horses in the pasture. Pt states pain gets worse with exertion and is unrelieved by rest. Pt describes the pain as a dull, squeezing sensation that radiates to his neck, left arm and jaw. Pt states pain is 8/10, states took 2 of his friends nitroglycerin pills without relief. Pt also c/o nausea, lightheadedness, diaphoresis, denies vomiting, LOC or previous event like this.

Example cont'd

- PMHx – HTN, hypothyroid, hypercholesterolemia, appendectomy
- Meds – HCTZ, Synthroid, Zocor, Baby ASA
- Allergies - PCN

Objective



Objective

- Information that is gathered from the primary and secondary exam
- Everything the examiner can see, hear, touch and smell

Objective

- Primary Survey
- Secondary Survey
- Trauma Documentation
- Vital Signs

Primary Survey

- Location and position found
- Approximate age, weight, sex, race
- Level of Consciousness
  - AVPU – alert, verbal, painful, unconscious
  - CAO X 4 or PPTE– conscious, alert and oriented to person, place, time and event
  - GCS
- Skin Color, Temperature, Turgor, Moisture
- Patient Condition
  - i.e. tripod position, pursed lip breathing, accessory muscle usage

Secondary Survey

- HEENT: Head, Eyes, Ears, Nose, Throat
  - DCAPBTLS
  - Pupils, Facial Symmetry, Slurred Speech, # word dyspnea, odor EtOH
- Neck:
  - DCAPBTLS
  - JVD, Tracheal Deviation, c-spine tenderness, nuchal rigidity, accessory muscle usage

Secondary Survey cont'd

- Chest:
  - DCAPBTLS
  - Symmetry, barrel chest, flail segments
  - Retractions
  - Lung sounds
    - Rales, wheezes, stridor, rhonchi
  - Respiratory rate and/or pattern
    - Cheyne-Stokes, Kussmaul, Ataxic, etc

Secondary Survey cont'd

- Back:
  - DCAPBTLS
  - Be sure to visualize, or document why you could not
- Abdomen (ABD):
  - DCAPBTLS
  - Tenderness, rebound tenderness, guarding, rigidity, pulsatile mass
  - Palpate all quadrants

Secondary Survey cont'd

- Pelvis
  - DCAPBTLS, Urinary or Bowel Incontinence
- Genitals – if necessary
  - Presence/absence of priapism
- Lower Extremities
  - DCAPBTLS
  - CNS (PMS) – central nervous system or pulse, movement and sensation
  - Pedal Edema

Trauma Documentation

- MVC
  - Patient location in vehicle, seatbelt, airbag
  - Vehicular damage, pt compartment intrusion
- Falls
  - Approximate distance
- GSW
  - If known, caliber and proximity

Trauma Documentation

- Stabbing
  - If known, length of knife
- Burns
  - Percentage and severity using Rule of 9's
- Other types of trauma
  - Mechanism, weapons, etc

Vital Signs

- At least 2 full sets documented on all transports.
  - Full set = Pulse, Resp Rate, BP, SaO_2, pain scale
- Repeat – q 5 unstable, q 15 for stable
- Repeat after admin of any medication
- At least one blood pressure should be auscultated to verify accuracy of NIBP preferably before NIBP is placed

Example

- Upon arrival found male, 55 y/o, approx 120 kg supine on front porch. Pt AAOX4, skin ashen, cool, diaphoretic with perioral cyanosis. Pt in obvious distress clutching his chest. HEENT: no trauma noted, perioral cyanosis, PEARL; NECK: no trauma noted, no tracheal deviation, + JVD; CHEST: no trauma noted, symmetrical resps, (= excursion), LS: bilateral basilar rales, clear bilateral upper fields; BACK: no trauma noted; ABD: soft, non-tender, no pulsatile mass, no ascites; PELVIS: stable, no trauma noted, no incontinence noted; LOWER EXTREMITIES: no trauma noted, + pedal edema bilateral ankles, distal neuros = and intact; UPPER EXTREMITIES: no trauma noted, + peripheral cyanosis & delayed cap refill. EKG: 3HB with multiple multifocal PVC's. VS: BP: 60/40, P: 32, irreg, RR: 28, SaO2: 79%

Assessment

Assessment

- Your impression of patient's medical problem
- Precede impression with poss., prob., R/O, or R/I
- Clinical Impression vs Differential Diagnosis
- At least 2 – 3 possible diagnoses

Assessment

- R/O AMI

or

- Prob. AMI, poss. Unstable Angina, poss. Severe GERD

Plan

Plan

- Chronological order of treatment and responses to that treatment.
- Everything you did from the time you arrived on scene to the hand-off at the hospital
- Written in a timeline, with times documented on all treatment.

Plan

1. Arrive on Scene
2. Patient Contact
3. ABC's or Primary Assessment
4. HPI, PMHx, SAMPLE
5. Vital Signs
6. Secondary Assessment – including pertinent positives and negatives

Treatment Documentation Oxygenation

- Liter Flow
- Delivery System
  - Nasal Cannula (NC)
  - Non-rebreather (NRB)
  - Bag-Valve-Mask (BVM)
  - CPAP
- Pt response or lack

Treatment Documentation Supraglottic Airway

- Pre-oxygenation
- Size of Tube
- Number of attempts
- Successful or Unsuccessful
  - By whom
- Time of Completion
- Lung Sounds
- Epigastric Sounds
- EtCO2 change
- Secured by device
- Ventilation rate and oxygen flow
- Documentation of reassessment after every patient move

Treatment Documentation Pharmacology

- 5 Rights
  - Patient, Drug, Dose, Route, Time
- Time and Who administered
- Effects, positive, negative, or none
- Repeat VS after each admin

Treatment Documentation Fractures

- Type of Immobilization
- Sensory, motor and circulatory function before and after immobilization

and

- At completion of patient contact

Transportation

- Document time transport began and ended
- Position in which patient was transported
- Safety devices used

Pearls of Wisdom

- If it wasn't documented it wasn't done!
- DOCUMENT, DOCUMENT, DOCUMENT
- Remember, you may end up in court one day with the chart you write, be sure it is thorough.

Plan

1555 – Arrive, Pt contact, primary & rapid secondary exam, HPI, PMHx
1557 – Pt georgia lifted to gurney, placed in trendelenburg position, secured to gurney and loaded into ambulance
1558 – Enroute, C3 to WVMC, EKG – 3HB, multifocal PVC's
1558 – VS -VS: BP: 60/40, P: 32, irreg, RR: 28, SaO2: 79%
1558 – 15 L O2, via NRB, no change
1559 – Pacer patches applied, pt rhythm change to Sinus Tach, rate 112, 4 mm ST elevation, prior to application of pacer
1600 – IV NS established R AC, 16 ga by JES, WO, fluid bolus
1602 – IV NS established L AC, 16 ga by DS, WO, fluid bolus, VBG 98
1603 – VS – BP 80/40, P – 116, RR 32, SaO2, 88 %, pain 7/10
1605 – ASA – 324 mg, p.o., no change
1607 – Reassess after 500 cc fluid challenge, VS BP 98/60, P 128, RR 30, SaO2: 95%, pain 6/10

Plan cont'd

- 1610 – EKG change – multifocal bigeminy
- 1610 – EKG change – v-fib
- 1610 – pre-cordial thump – no change
- 1612 – Debib – 360 J by JES, conversion to Sinus Tach – multifocal bigeminy
- 1613 – Lidocaine 180 mg IVP, bigeminy resolved
- 1614 – Radio report to WVMC, no questions
- 1614 – VS: BP 90/40, P 120, RR 16
- 1615 – Lidocaine drip, 2 mg/min, no change
- 1616 – Arrive WVMC, to ER Rm TR B, pt care and report to Dr. Pardini