Expanded SOAP Notes

- Members of the Clinical Faculty grade will grade written assignments and submit those grades to Course Faculty for inclusion in the course grade.
- Patients selected for written assignments must reflect pediatric health problems that are appropriate to the didactic coursework in NURS 652/662.
- Students must submit three written assignments to Clinical Faculty by dates posted on course calendar.

This assignment provides the student with an opportunity to think through the diagnostic reasoning process and to improve clinical documentation utilizing an expanded problem-oriented progress note format (SOAP). The focus of mastery for this assignment in NURS 662P is for the student to develop complete, concise, and accurate subjective and objective sections. It is hoped that through this process, problem-oriented charting will improve, will be applied to different patient populations, and will enhance written communication in the clinical setting. An additional focus for the evaluation of this assignment will include the ability to establish a plan of care that reflects the practice of a family nurse practitioner.

Instructions:

Select a pediatric patient whom you have evaluated in your clinical setting, with a problem that relates well to the content of your current clinical course (for example, students in Nursing 662P would select a patient requiring help with an acute, common health care problem in one of the following systems: HEENT, respiratory, genitourinary, dermatologic, musculoskeletal.)
Expectations of Expanded SOAP: SOAP #1 chose a pediatric patient with an HEENT or Respiratory complaint. SOAP #2 chose a pediatric patient with a GU, GI, Derm or MSK complaint.

2. Research the patient’s complaint, the diagnosis selected, and the differential diagnoses that should be considered for the patient’s complaint. Read from a minimum of 3 sources, such as current textbooks, current national guidelines, current journal articles, etc. Be sure to save the bibliographical information, as this will be documented at the end of the assignment.

3. Write an “expanded” SOAP note, clearly delineating the headings and subheadings as directed below. Much of the information to be included in this note should be in the original SOAP that was written by the student in the clinic area for the selected patient. However, the note for this assignment will include some things that may be elsewhere in the patient’s chart and therefore not in the original note, such as medications, allergies, etc. This note will also differ from the original in that information may be reorganized, added, or deleted in order to improve upon the original. If after researching the patient’s problem it becomes clear that additional information should have been solicited during the history and physical, then add it or make it up. Underline the additions or changes made which differ from the original. The note should be succinct but thorough. Avoid use of unnecessary words. Remember, take this opportunity to change the original note in any way that improves it.

EXPANDED SOAP NOTE

Subjective:

Chief complaint: Need not be the patient’s complete statement – may be a brief summary of reason patient wanted to be seen for this visit

HPI: Complete subjective description of problem, including “OLDCARTS” findings or similar, including location, quality severity, duration, timing, context, modifying factors, associated signs/symptoms, relieving and aggravating factors, related systems. Also include “NEEWS” Pertinent PMHX (as appropriate for the patient/chief complaint/presenting problem):
- Illness
- Injuries
- Surgeries
- Hospitalizations
- Allergies
- Current medications, including over-the-counter and herbal preparations
- Pregnancy status, if appropriate
- Immunization status
Pertinent family medical history
Psychosocial:
  Relevant past hx – lifestyle, health, medical care, etc
  Family situation (including assessment of client’s safety in home, relationships, living arrangement)
  Occupation

**ROS:**
Review and document a review of those systems which are pertinent to the patient’s problem, and which have not been addressed in the HPI.

**Objective:**
Vital signs, including temperature, pulse, respirations, BP (document size of cuff used), height and weight.

**General:**
Specific systems as appropriate

**Assessment:**

**Most likely diagnosis:** (if more than one diagnosis, number each in order of priority)

**Differential diagnoses:** List the other diagnoses that should be considered in light of the history and physical findings.

**Rationale:** Articulate a rationale for the most likely diagnosis and for each differential diagnosis. In this discussion, include pertinent positives and pertinent negatives which help to rule out or rule in each diagnosis. This section should clearly illustrate the student’s diagnostic reasoning process for the reader, should be based on current literature/guidelines, etc, and should be organized and succinct.

**Plan:**

Write the plan in a numbered list format, which includes diagnostics (lab, x-ray, etc), treatment, education, follow-up, referrals, and goals.
A mnemonic that can be used to remember what to include in the plan is:

“Do Everything That Feels Right and Good”

Provide a rationale for each item, based on current literature and scientific principals.

Discuss what other treatment options could be considered, if any, and whether or not any of those options would be better choices than the ones actually selected. Explain your rationale.
4. Sign the note as follows:
   Signature
   FNP Student, Gonzaga University

4. Attach a copy of the original SOAP note that you wrote in the clinical setting to this assignment. **MAKE SURE THAT THERE IS ABSOLUTELY NO PATIENT IDENTIFICATION INFORMATION ON ANY OF THE PAGES!** This includes name, social security number, address, etc. Inclusion of patient identification information is a violation of federal HIPAA regulations.

   If your clinical site does not allow a note to be copied or printed – **HAND WRITE or Type A NOTE** prior to leaving clinic that day and use that as your original SOAP.

5. Attach a list of the bibliographic information for the references used for this assignment, using the updated requirements in the APA new 7th Edition Publication Manual. Be sure to include page numbers in your citation.

6. Turn assignment in to your clinical faculty via computer attachment of a Word Document by the posted due dates. These Expanded SOAPS cannot be repeated.