SOAP Note 11.0

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Introduction

Please find attached SOAP (Subjective, Objective, Assessment, and Plan) note 11.0.

This SOAP note is provided as is. It is up to the user to confirm the accuracy of the information and to determine the appropriate usage, patient treatment, training required and documentation. The provider of this note assumes no responsibility for patient, legal or other outcomes as a result of the use of this document.

A SOAP note may be considered a medical document and may be subject to privacy regulations. Compliance with appropriate regulations is the user's responsibility.

To insure you have the latest version or to download a printable copy:
http://www.scottenjones.com/other.html

Usage of the SOAP note 11.0:

Front side:

Header: Check either the original or copy box to indicate this is the original note or a copy of the note. A copy is often required to send with a patient.

Section 1), 2), 3), 4) – lists the steps to approach a patient and perform the Primary Survey looking for immediate life threats. The primary survey is in the order in which it should be performed and in order of treatment priority. For example clearing an airway takes precedence over a possible spinal injury. Check the consent box to indicate consent was received or unconscious if the patient is unconscious. Do not proceed without consent, consent is assumed if the patient is unconscious.

5) General – basic information on the responders and patient.

6) Subjective – information the patient tells you about the NOI (Nature Of Injury) and MOI (Mechanism Of Injury). What happened, how it happened and where it hurts? The pain description on the right side should be used to get as much detailed information about the injury as possible.

Mechanism for Spinal Injuries – the specific criteria for a traumatic incident to possibly cause a spinal injury. If a traumatic incident does not have one or more of these elements present a spinal injury is unlikely and you should check no in the MOI for spine in the subjective session. If the patient is unconscious you should assume a spinal injury until the clear spine procedure at the bottom of the page is performed (clear spine is a Wilderness Only protocol). Spinal injuries require immobilization of the spine and neck.

7) Objective – information that you observe as a caregiver doing your primary and secondary survey. A secondary survey should include; vital signs, head to toe exam and AMPLE patient history. The table at the top of the section provides space for time and the five main wilderness vital signs (level of consciousness with scale, Respiration Rate (RR) and effort with normal and help values, Heart Rate (HR) and effort with normal values, skin color temperature and moisture with abbreviations and eyes with abbreviation). There is additional space for vital signs on the back of the form. There is also space for general exam observations. The right side of the area provides a list of the head to toe exam areas to check in order and front and back patient diagrams for marking injury sites. The patient diagram includes the rule of nines values for estimating burn area. Boxes are also provided on the diagram for initial CSM results and a burn area total. The bottom left hand section has space for the AMPLE patient history (Allergies, Medications, Pertinent medical history, Last ins and outs and Events).

8) Clear Spine – in the event that there is an MOI for a spinal injury or the patient was initially unconscious, the clear spine section has room for the clear spine assessment. This section is not required if there is no MOI for a spinal injury. Clear spine is a wilderness only protocol.

Back side:

Assessment Criteria – this section presents information that may be useful in assessing the patient. This information is believed to be correct but is provided as is. It is up to the user to confirm the accuracy of the information.

9) Assessment – lists the patient's injuries in order of priority.

10) Plan – lists your plan to address the patient's illnesses in the same order as the assessment.

Additional Information – space for additional information that does not fit in the other sections. There is a table at the bottom of this section for additional vital signs, CSMs (Circulation Sensation Motions) or any other time series patient monitoring data.

Bottom Section – a section is provided in case a patient at any point refuses additional care, also prepared by, witnessed by and date. A witness is optional but may be helpful if available particularly for unconscious or very young patients or if the patient is of the opposite sex.

Printing notes
It is recommended that the SOAP note be printed double sided.

Write in the rain makes waterproof paper that can be printed on with a laser printer and would be helpful for wilderness usage.

This note printed on 8-1/2" x 11" paper should have a ¾" margin on the front side for three-hole punching and a ½" margin on the top, bottom and right side. Many laser printers will shrink the document during printing because by default they add a small margin (1/4" is typical). In the box that pops open when you go to print the document, look for a page scaling drop-down box and select none to print the note with the correct scaling.

Suggestions questions or comments
Emails of suggestions, questions or comments may be sent to scotten@scottenjones.com

Rev 11.0 - provided as is, proper usage, treatment, and training is the responsibility of the user.

S O A P N O T E 11 . 0

Check one ☐ Original, or ☐ Copy

1) Scene Safety - you, then other rescuers and bystanders, then patient ☐ Consent ☐ Unconscious

2) Introduction & consent - if conscious you must get consent, if unconscious consent is assumed

3) Body substance isolation - gloves minimum, liquid proof clothing, mask and goggles as needed

4) A - airway, **B** - breathing, **C** - circulation and chunk check, **D** - deformity and da spine, **E** - environment

5) General

Responder(s): _____ Date: _____

Location: _____ Patient: _____ Sex: M F Age: _____

Height: _____ Weight: _____ Emerg Contact: _____

6) Subjective

What the patient tells you, Mechanism of Injury (MOI), Nature of Injury (NOI)

_____

_____

_____

_____

_____

Pain Description
O - onset, what started it?
P - pain better or worse with movement or other?
Q - quality of pain, dull, sharp, burning, tearing, etc.?
R - region and does it radiate?
S - severity on a 1 - 10 scale?
T - time, same, comes and goes, worse or better?

Is there an MOI for the spine, ☐ yes, or ☐ no, or ☐ unconscious, if yes or unconscious, clear spine below

Mechanism for Spinal Injuries: Falls from 2-3x the victims height or they land on their head. Car accident, head injury, diving into shallow water, direct blows. Any "high energy" event. Assume if unconscious.

7) Objective

What you observe, head to toe exam, vitals and history

Time								
LOC orient x	x1 - who, x2 - where, x3 - when A-alert, V-verbal, P-pain, U-none							
RR & effort	Normal 12-24 Help <10, >30							
HR & effort	Normal 50-100							
Skin C/T/M	Pink/Warm/Moist - p/w/m, Pale/Cool/ Clamy - p/c/c, Red/Hot/Dry - r/h/d							
Eyes	Pupils, equal, round, reactive to light - PERRL							

Unconscious/unstable - vitals every 5mins, Conscious/stable - vitals every 15mins (see over for more space).

Exam: _____

_____

Allergies: _____

Medications: _____

_____

Past, pertinent, history: _____

_____

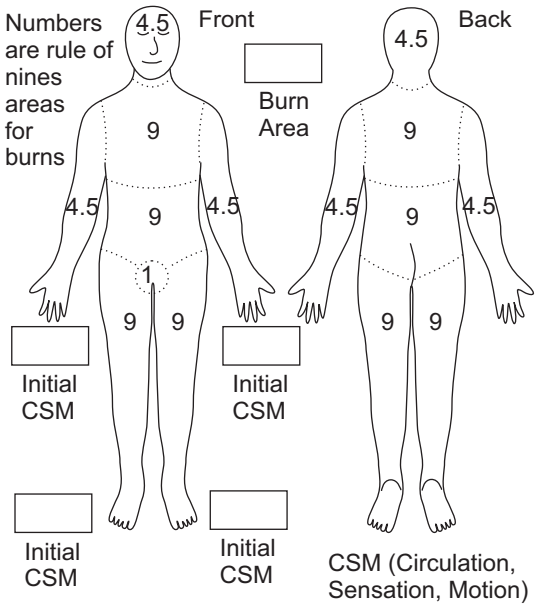
Last ins and outs: _____

_____

Events: _____

_____

Head to Toe Exam
Check, head, cheeks and jaw, trachea and neck, ribs, abdomen (all 4 quadrants), legs and feet, arms and hands, spine and back.



8) Clear Spine - only required if there is a spinal MOI

☐ A+O x3 + sober and reliable + no distracting pain

☐ No pain or point tenderness in spine including exam(s)

☐ CSM in all 4 extremities, no numbness, no radiating pain

☐ Neck range of motion, rotate, look up, look down, no pain

Spine is cleared, Yes ☐ No ☐

Assessment, Plan and Additional Information is on the other side

SOAP NOTE 11.0 - Continued

Assessment Criteria

Information to help with assessment

Shock
Compensatory phase
Pulse increases and becomes weaker
Breathing increases and becomes weaker
Initially normal skin -> pale, cool and clammy
LOC - high anxiety -> disoriented, combative
Decompensatory phase
Pulse drops
Breathing drops
Pale, cool and clammy
LOC - drops through AVPU scale

Burns
Superficial (1st degree)
Red skin, dry, sore to touch, tired, nausea
Partial Thickness (2nd degree)
Superficial symptoms plus blisters
Evac: face, airway, joints, genitals, 5-10% area
Full Thickness (3rd degree)
No pain, wet feel, infection likely
Evac: always

Head injury
LOC: deteriorates -> disoriented, irritable and combative.
HR: slow, bounding
RR: irregular, kussmaul's (heavy) or Cheynne Stokes, pattern of breaths, then pause.
Skin: can be anything
Pupils: uneven (late sign)
BP: widening difference between systolic and diastolic

Blood pressures
Systolic - peak, Diastolic - between beats
Estimating systolic:
Radial pulse (wrist) present: >100, all organs perfused
No radial, femoral present: >80, only critical organs perfused
Only cartoid present: >60, only brain pefused

Changes in LOC
Head injury
Hypovolemia - low blood volume
Hypothermia - cold
Heart/cardiac problems
Hyponeutremia - low electrolytes
Hypoglycemia - low blood sugar
Hyperglycemia - high blood sugar
Hypoxia - lack of oxygen
Seizures
Poisoning
Stroke

Soft Tissue Injury

Normal	*Infection*
S - swelling	**P** - pus
H - heat	**S** - smells
A - ache	**S** - streaking
R - red	

Heart beats/terms
Vtac - really fast
Vfib - quivering/stopping/quivering
Asystole - flat line, none
Myocardial infarction - muscle death

9) Assessment

Problem list in order of priority

1. _____
2. _____
3. _____
4. _____

10) Plan

Plan in order of priority

1. _____
2. _____
3. _____
4. _____

Monitor how: _____ How often: _____

Additional information

Any additional information that doesn't fit on the front

_____
_____
_____
_____
_____
_____

Additional vitals, CSMs or other monitoring data

Time									

☐ Patient refuses further care Patient signature: _____ Date: _____

Prepared by: _____ Witnessed by: _____ Date: _____

Primary and Secondary Survey Information is on the Other Side