Faculty Guidance for
Developing Instructional Patient Cases and Assessing Student's SOAP Notes

UNC Eshelman School of Pharmacy

In the fall of 2009, a subcommittee of the school's Curriculum Committee met to discuss issues related to the use patient cases (recitations, IPPE /APPE case write-ups) for students in the professional program. The group agreed that students' professional development would clearly benefit from routine use and assessment of patient cases throughout the curriculum. The inconsistencies of current recitation experiences, SOAP note preparation, and student assessment were noted by the subcommittee, especially with regard to faculty and preceptor variations in the expected format of and depth of detail provided in student SOAP notes.

The group agreed on the need for a consistent approach to teaching pharmacotherapy workup / clinical problem-solving and SOAP notes writing skills, and assessing student work in this area. The following principles, guidelines and tools were developed, piloted in selected pharmacotherapy and pharmaceutical care lab (PCL) courses and in the non-prescription and self-care course, and refined based on these experiences. It is now the committee's intention and strong recommendation that these be implemented in throughout the professional curriculum (pharmacotherapy and PCL sequences, non-prescription and self-care course, IPPEs and APPEs).

- Core pharmacotherapy courses (PHCY 442, 443, 444, 445, 446, 447, and 449) will include recitation discussion sessions coordinated with the PCL sequence throughout the PY1-PY3 years.
- In general, 1 recitation session will be conducted for every 1 credit hour of pharmacotherapy instruction. Preference should be given to content / therapeutic areas commonly encountered in and central to a generalist's pharmacy practice.
- Recitation cases will be developed by relevant pharmacotherapy course faculty, in a manner consistent with the attached *Process of Care and SOAP rubric* documents. These will be reviewed and approved by the relevant pharmacotherapy and PCL course directors prior to the start of the semester. The case author also will provide guidance for recitation session facilitators as well as a detailed answer key / scoring rubric and sample SOAP note for the case.
- The final student product for each recitation session will be the student's SOAP note.
- SOAP notes will be scored and graded, using the answer key and standard rubric, usually by teaching assistants in the PCL courses.
- SOAP note grades will be included in the overall grade for the Pharmacotherapy module. It is recommended that each SOAP note assignment represent approximately 5% of the overall course grade.
- In addition to use during the didactic curriculum, the *Process of Care and SOAP rubric* documents will be provided to faculty and preceptors who participate in IPPEs and APPEs with the intention that mentoring for and assessment of students' patient workup and documentation skills will be consistent across all elements of the curriculum.

The attached ***Process of Care*** **document** articulates an approach to identifying, analyzing and resolving a patient's drug related problems. While different practitioners may have slightly differing views on or terminology for this approach, we believe this document captures the essential elements of the process and presents them in a simple, organized fashion.

The ***SOAP note rubric*** provides a standard approach to scoring and providing feedback to students regarding their abilities to organize and assess patient information, recommend therapy, and effectively communicate those recommendations in the form of a concise note (i.e. one that would be acceptable in practice). The rubric is intended for use with a case-specific answer key and sample SOAP note. This assessment approach should provide more consistent assessment of SOAP notes and more effective feedback to students across reviewers and over time. *** Note that the rubric allows for **differential weighting** of the various elements of the note to accommodate developing expectations and emphasis across the curriculum. Faculty are encouraged to use consistent weighting within the same module, course, IPPE or APPE unless there is a clear justification for doing otherwise. In all cases, the assignment should clearly inform students in advance of how the rubric will be weighted for scoring and grading. ***

Faculty should note that the process for assessing SOAP notes is NOT intended to assess the student's clinical reasoning abilities in depth. Faculty or preceptors wishing to conduct this more in-depth assessment should pair the SOAP note assessment with other performance assessment measures (e.g. probing students during the case discussion / recitation process about evidence and other alternatives considered or writing a side-bar to the SOAP note describing the literature review or problem-solving process used to generate the note).

We feel strongly that consistent use of this approach by faculty and preceptors in the identification or development of patient cases and the assessment of student SOAP notes will minimize student confusion, focus their attention on key elements of the process, and enable them to more effectively internalize and apply these concepts and skills. Use of the standardized rubric and including it in the student's portfolio will also facilitate tracking student development over time and offering remediation when needed.

PROCESS OF CARE:
How to Identify, Analyze, Document and Communicate
Medical and Drug Therapy-Related Problems

The following describes a problem-solving approach used to identify, analyze, and resolve patients' drug related problems. You should consider each of the steps in the process as you approach your pharmacotherapy cases.

- The History and Physical Examination (H&P) is a comprehensive and complete assessment of the patient's past and current medical history and associated problems. You will usually find this in an initial patient assessment. The initial assessment is done when the health care team first encounters the patient, usually at the time of hospitalization or the first visit to an outpatient practice. The H&P documentation is usually done by a primary care clinician.
- A similar, yet abbreviated approach is used in subsequent communications and these are called progress notes. Progress notes are usually written in the SOAP format. SOAP notes focus on information related to the current condition of the patient. Pharmacists commonly write progress notes in the format of SOAP notes when participating as part of the health care team, such as following up on patients' treatments or drug therapy related problems. This document should help you to structure your progress notes in the SOAP format.

STEP 1: SUMMARIZE SUBJECTIVE AND OBJECTIVE INFORMATION (S/O)

I. Identify and Collect Data

Subjective and objective patient information comes from a variety of sources, such as the medical record, other health care professionals, the patient, the patient's family/caregivers, medication containers / labels, medication administration records or pharmacy refill records. Make sure that you have gathered pertinent data from all appropriate, available sources.

A. **Subjective:**

Subjective data is information that a patient provides or tells you or is told to another provider (a nurse upon admission to a hospital or a technician at a community pharmacy). It is information related to the patient's complaints or symptoms that is not directly observed or measured by you, and cannot be easily verified at the time you gather the information.

Information provided by the patient

- Subjective information may include:
  - Chief complaint (CC)- Why did the patient come to you?)
  - History of present illness (HPI)
  - Review of systems (ROS) – subjective / self-reported symptoms
  - Observations of caregivers
  - Allergies (if patient self-reported and reaction was not documented by a health care provider (e.g., not yet recorded in the medical record)
  - Patient-reported medications (e.g., not yet recorded in the medical record)
  - Patient reported adherence with therapies)
  - Past medical history (PMH)
  - Social history (SH)
  - Family history (FH)
  - Home testing data (BP, BG, weight, etc.)
- Listen to *what* the patient says and *how* (s)he says it, observe what the patient does.

B. **Objective**:
This is observable or measurable information and can be easily verified at the time of your visit with the patient. This information may be measured by you during the patient visit or found in lab reports or other medical reports

Info. observed or measured by YOU, or found in medical record

- Objective information may include:
  - Vital signs (VS)
  - Physical exam (PE)
  - Labs
  - Diagnostic tests (X-ray, CT, EKG, etc.)
  - Medications and medication adherence (current and past, from medical records, medication administration or pharmacy profile / refill records)
  - Allergies, adverse drug reactions (as documented in a medical chart)
  - History (PMH, SH, FH) documented in the medical record

II. Organize and Interpret Available Information

A. Filter information to include only data that is pertinent to the current problem list)
B. Organize information according to subjective and objective format
C. Analyze data
- Identify missing or incomplete data (What additional data do you need; questions answered? What assumptions have you made?)
- Question the validity, accuracy, and consistency of data
- Identify normal/abnormal data

D. Synthesize data:
- Connect and relate data; interpret relationships
- Identify / define data patterns; note trends
- Determine baseline measurements (e.g. based on published guidelines)
- Perform calculations, if needed

IV. Summarize Information

A. Summarize patient information to "tell the story" (be thorough, but concise and relevant); begin to build the problem list

STEP 2: ANALYZE AND EVALUATE THE INFORMATION TO IDENTIFY DRUG THERAPY-RELATED PROBLEMS

The problem list usually consists of the patient's diagnoses or conditions, as well as drug therapy-related problems that have been identified. It may include social or economic issues for the patient, particularly as these relate to the patient's health and wellbeing or access to health care. While most notes will not include a separate "list" of problems, it is a good idea to make a problem list to organize your thoughts before continuing to write your note.

V. Evaluate appropriateness of all drug therapy

A. Medication matched to appropriate indication
B. Correct drug, dose, route, frequency, duration
C. Therapy is effective
D. Therapy is safe and well tolerated
E. Therapy is cost-effective
F. Therapy is evidence-based and patient-centered
G. Therapy is justified over other alternatives

VI. Integrate information to generate a problem list

A. Connect and relate data
B. Recognize any assumptions you may be making

VII. Generate a complete problem list

A. Take into account untreated/new problems (current problems not included in past medical history) that need to be addressed (from subjective and objective data).
B. Take into account past medical history (active and chronic problems)
C. Prioritize the problem list for this encounter with the patient
D. Consider "medication management" as a problem (i.e., how do they pay for their medications, where do they get their medications, what is their system of medication administration, are they adherent)

Categories of drug-related problems

- Adherence problem with therapy
- A medication is needed (untreated indication or finding)
- A medication is used without a medical indication
- A change in medication is warranted (e.g. lack of control/efficacy, intolerable side effect scientific evidence, guidelines)
- Drug interaction is present (potential or actual)
- An intolerable side effect or adverse drug reaction is present (potential or actual)
- A change in medication dosage regimen is warranted (too low or high)

Modified from Hepler and Strand.[1]

STEP 3: FORMULATE AN ASSESSMENT AND PLAN FOR EACH PROBLEM (A/P)

VIII. Assessment: Provide an assessment for each problem, based on your appraisal of subjective and objective information. Your assessment should summarize the significance of and your conclusions regarding the findings (i.e. what you think the S/O data means in terms of the patient's current health and medication use status). Your assessment serves as the studied basis upon which to make recommendations (i.e. provides the logic rationale for your recommendations).

A. Include your appraisal/assessment of each problem, often worded as controlled or uncontrolled (consider etiology, risk factors, status, severity, duration of problem)
B. State desired therapeutic goals and endpoints (what are you trying to achieve?)
C. Assess the appropriateness of current drug therapy
   - Indication
   - Effectiveness
   - Safety (tolerability / toxicity)
   - Adherence

IX. Plan: Recommend an appropriate plan for treatment and monitoring for each problem, consistent with your assessment.

A. Treatment plan
- Recommendations related to current therapy (continue / discontinue / modify)
- Recommendations for new drug therapy (must include drug, dose, route, frequency, anticipated duration; *don't interchange brand/generic names – be consistent)*
- Recommendations for NON-drug therapy (e.g., nutrition / lifestyle modifications)
- Justification / rationale for proposed plan (why do you recommend this therapy?)

B. Monitoring parameters
- Monitor to assess <u>effectiveness</u>: problem-specific AND drug-specific parameters to assess response
- Monitor to assess <u>safety</u> problem-specific AND drug-specific parameters to assess toxicities, adverse effects, drug interactions and tolerability
- State intervals and frequency for monitoring. Be Specific!
- Indicate need for referral
- Establish plan for follow-up care; be specific with regard to type and timeframe (e.g. f/u visit to practice site, phone call, FAX results, etc.)

STEP 4: DOCUMENT AND COMMUNICATE YOUR RECOMMENDATIONS

Pharmacists may be called upon to document or communicate their recommendations in a variety of formats, including progress notes in the medical record (chart, patient profile), consultation notes, or case presentations on rounds or in a more formal presentation setting). The following format and style are appropriate for writing your case notes, consistent with the SOAP structure outlined above.

X. SOAP NOTE STRUCTURE AND CONTENT

Subjective	• Information provided to you by the patient or the patient's representative. • Commonly includes the chief complaint and history of present illness. • May include information provided by the patient from home monitoring.
Objective	• Information that is measured or observed by the clinician, including vital signs, findings of the physical examination and reports from various medical or laboratory tests. • Information previously recorded in the medical record. • Medications listed in a medical record or patient medication profile.
Assessment	• The patient's problem list, including medical diagnoses and drug therapy related problems (see table of categories in section 2). May include social or economic issues that impact medical care and other health care needs (e.g., preventative care, health and lifestyle risks, and immunizations). • For each problem, provide o an assessment of the current status (e.g., stable, not well controlled, acute worsening, on therapy) and o treatment goals (e.g., control pain, reduce cardiovascular mortality).

Plan	• Should be specific and detailed. • State the actions taken and recommendations (e.g., what was done and what is planned). Includes medication name, dose, route, frequency and duration (if applicable) and non-medication related strategies. • Include monitoring parameters • Include specific plans for follow-up care and referrals. • May include counseling points provided to patient.

XI. Rules, requirements and etiquette

A. Structure:

- Labeled with header indicating date and time; may also include location if numerous practice locations. *Notes for PharmD courses - must be word processed; signed by the student; and include student name, date and case title (also TA name and lab day for PCL course or preceptor name for IPPEs and APPEs).*
- Adheres to SOAP format (see example below and cases presented in class). In some settings, S&O or A&P are combined into one section, or all assessments (A) are clustered together followed by all plans (P).
- Is organized and logical (i.e., easy to follow and understand).
- Statements of problems and recommendations are specific and listed in priority order (highest to lowest). The amount of detail, justification, and supporting evidence in a progress note will vary based on practice setting and clinical situation.
- Handwritten progress notes should be in blue or black ink. The medical record is a legal document. If an error is made in an entry, it should be marked but not completely obliterated or removed (e.g., never use black out or white out).

B. Style and professional etiquette

- Conforms to standard conventions of written language. No misspellings, typographical errors, grammatical/mechanical problems, or nonstandard abbreviations.
- Written in objective and professional tone
  - Language is appropriate to the context and recipient
  - Conveys confidence (but not arrogance)
  - Persuasive; convinces another to do something specific
  - Not rushed, sloppy, judgmental, or accusatory
  - Consistent throughout document

Example of organization of information into the SOAP format.

Note: This is NOT a complete SOAP note, but provides examples of information that might be found in each section of the note.

S CC: "I'm tired all the time. I just don't feel right."
HPI: E.H. is a 48 y.o. man seen today for follow-up at the outpatient diabetes clinic. He reports ongoing fatigue, lethargy, polydypsia, polyuria, and nocturia x 6 weeks. He reports taking his medications most days, with no serious side effects. He reports walking 1 mile on a treadmill every day during the past 6 months, but notes being unable to adhere to an 1800 calorie ADA diet though he has seen a dietitian a number of times in the past. He reports that he lost his blood glucose meter 3 months ago, so he has no recent record of glucose levels.

O PMH: Type 2 DM x 8 years, HTN, CAD (s/p MI, 2005)
Meds (from patient profile; refill records demonstrate adherence to therapy):
glipizide 10 mg po bid
metformin 500 mg po qday
ramipril 5 mg po qday
aspirin 81 mg po qday
metoprolol succinate 50 mg po qday
ALL: NKDA
PE: WDWN mildly obese Caucasian man in NAD
VS: BP: 182/82; P80, RR 16, T 39.6°C, Wt 82.2 Kg, Ht 66.5"
Labs: 5/20/20 A_{1c} 8.5; 11/24/09 (today): BG (fasting) 236, A_{1c} 9.2, Cr 1.1, K 5.8, AST 16, ALT 16, no other labs in past 2 years

A Type 2 diabetes mellitus: uncontrolled; A_{1c} exceeds goal of < 7% for this patient and has increased over the past 6 months. Currently adherent on glipizide 10 mg po bid and metformin 500 mg po daily and tolerating this regimen well. Patient continues daily exercise (walking), but struggles to adhere to ADA-recommended diet. Goals: AIC < 7; prevent hypo or hyperglycemia; minimize risk of vascular complications of diabetes; *then lead into plan*…

P Type 2 diabetes mellitus:
1. Referred to nutritionist for assistance with meal planning / dietary control.
2. Provided new BGM and taught patient to monitor and record blood glucose. Recommended testing in morning (fasting) and 2 hours after lunch and dinner. Recommended to primary care provider: continue glipizide 10 mg bid and increase metformin to 500 mg po bid to better control blood glucose and reach A_{1c} goal.
3. Pharmacist to review blood glucose measurements in 4 weeks; repeat fasting glucose and HgA1c in 3 months.
4. Patient was educated on signs and symptoms of hypo- and hyperglycemia. Will return to clinic in one month.
5. Requested that patient call in 1 week if FBG > 150 or 2-hr post-prandial BG > 200.
6. Advised patient to monitor for GI distress, including diarrhea and abdominal discomfort, secondary to increased metformin dose, and for resolution or improvement of polydypsia, polyuria, and nocturia.

NOTE: You should NOT repeat everything that you already listed in the subjective/objective section of the note. Rather, you should attempt to summarize and integrate the information to formulate an assessment. The reader can refer back to the first part of the note for the specifics, such as dietary details, the A_{1c} *values over the past year.*

HTN: same process (A/P)
CAD: same process (A/P)
Hyperkalemia: same process (A/P)
Medication Management: same process (A/P)

Clinical Pearls on Writing SOAP Notes

Subjective and Objective

- Always start a case note with demographic information and a chief complaint/ history of present illness. You cannot ignore why the patient came to you in the first place. (i.e., were they referred for a particular reason, did they request the appointment).
- Listing the medications with an indication is a clear method for understanding why you are using them in the first place. Also list any known deviations from intended/ prescribed use.
- When you are in the clinical setting, a patient's medication list or prescription record may differ from what he/she is actually taking. Therefore, if you know that the medication history (the information you gather from the patient) is different from prescription drug records, then you should indicate this accordingly. Otherwise, those who read your note will assume that the patient is taking the medication exactly as you have listed it. Often, this information is placed in parentheses behind the "actual" prescription regimen to indicate how the patient is actually using the medication. This issue may be less significant when working with "paper cases." However, if the information you are given indicates that Mr. Jones only takes his atenolol every other day, but the medication list or prescription record states that he should be receiving it every day, then you need to convey this in your note as well.
- Depending on the setting in which you work, the amount of information available to you or that you can obtain will vary (e.g., community versus clinic).

Assessment (analysis and synthesis of S/O)

- Every medication that a patient takes should be related to a condition and an outcome.
- Every medical problem should be addressed by a therapeutic plan (drug or non-drug)
- When stating the assessment, **DO NOT repeat information already listed in the S/O** sections of the note. Instead, ***summarize*** **the significance of these findings and state your conclusions about the information.** The reader can refer back to the first part of the note for the specifics, such as the details about his/her diet, the HgbA1c values over the past year, etc. Refer to case example.

Plan

- Be **specific** when making recommendations (drug, dose, route, frequency, duration, monitoring parameters and frequency, educational points). Be explicit when giving directions on education and monitoring ("monitor hypertension" does not tell me what to do or when to do it). If you say, "hypertension is uncontrolled" justify how you arrived at this assessment (e.g. define treatment goals; state that BP is above goal of 130 / 80).
- **Be clear** about your primary recommendation. Avoid saying, "consider either A or B".

- **Take it one step at a time (usually).** It is typically not necessary to suggest alternatives to your primary recommendation. You can make a new assessment and plan when you see the patient in follow-up
- **However, at times, it may be appropriate to briefly identify the next step that you would consider.** Examples of when this might be a relevant consideration include:

  (1) When there are two equally rational choices for therapy, and you have selected one. In this case, identifying the alternative to the primary recommendation will clarify your choice to the other clinicians reading your note.

  (2) When there is a high likelihood that the initial therapy will not be completely effective or tolerated. In this case, it is helpful to include the next step.

  (3) The faculty or preceptor may find it helpful to see your thought process for the next step in treatment of a condition as you are developing your patient assessment and recommendation skills.
- **Think twice before recommending addition of two drugs at once to treat the same problem**. It is typically more rational to start one drug, monitor the patient's response, and then consider adjusting dose or adding a second drug to optimize results. Why start with two drugs if you are not sure how effective a single agent may be? In some cases it may be appropriate to add two agents at once to treat the same condition. In this case, it is important to justify your recommendation.

General Tips

- Avoid interchanging brand and generic names. Be consistent with the information you are given. For example, if the case says the patient is taking glyburide, you can't assume this is Micronase. If a medication list indicates that a patient is taking Prozac or if the patient tells you he/she is taking Prozac, refer to it as Prozac, not fluoxetine.
- Generic names are <u>not</u> capitalized; brand names are capitalized.
- Avoid referring to the physician as "the doctor," rather you should designate this person as the physician, prescriber, primary care provider, MD, cardiologist, etc. Because there are many different kinds of "doctors" and health care professionals, this will minimize confusion.
- Avoid the use of nonspecific terminology and ranges. For example, *regular*, *periodic*, *frequent*, are all nonspecific terms. What does it mean to monitor someone's blood pressure *frequently*? Be specific. For example, have patient record home blood pressure readings once daily for 2 weeks, then return to clinic within 2 weeks for repeat BP check and visit.
- Use only standard abbreviations. Watch for context clues for abbreviations that may have multiple uses. For example: TAH/BOO in the case of a woman is a total hysterectomy with bilateral oopherectomy. However, BOO can also mean bladder outlet obstruction, but this would rarely be listed as a combination abbreviation with TAH. So, make sure you are clear in your abbreviations. Some common mistakes: hypertension is HTN, not HPT. Patient is pt, not PT. Physical therapy is PT not pt. Acetaminophen is APAP, not ACET. Always consult a reference on medical abbreviations.
- Work with what you have. There will always be limitations to a "paper case" as opposed to interviewing and seeing the patient in person, but the case note is not the place to point this out. Imagine that what you write will appear in the patient's chart for all to see. If you have insufficient data to make an assessment or a recommendation, then simply indicate that you need to gather additional data (repeat a specific laboratory test, call the patient's brother to verify

current prescription use and dosing, etc). This happens, as well, in clinical practice. It is important to recognize your limitations or assumptions and indicate how you will address these.

- Check the spelling in your note.
- Verify labs carefully. Transposing letters and numbers is a frequent source of medication errors. There is a big difference between a BP of 150/70 and 50/70.

Professionalism

- Be very careful about professional tone. Remember, the note appears in a patient's permanent, legal medical record. Phrases like, "SB's sugar is out the roof" or SB's life is way out of control" or "Glyburide is the wrong agent for SB" or "SB can get his meds for free through Medicaid, so we don't have to worry about cost," or "SB needs to get a better handle on his medications," should be avoided. *Select words carefully to ensure professional tone.* You do not want to say "I explained to the patient that the physician was wrong to prescribe lisinopril for her HTN, since she is elderly and should be on a diuretic instead" or "Osteo-Bi-Flex is a natural remedy that would never be recommended by any reputable clinician." Again, s*elect words carefully to ensure professional tone.*
- Remember, the medical record is much more than a static storage-and-retrieval device. Medical records "guide and teach" clinicians.
- Always remember the context in which your note is written (i.e., is it being sent to the physician with whom you have not worked with up to this point; have your recommendations already been discussed with the physician either on the phone or in person; have your recommendations already been discussed and implemented in the patient?). Keep in mind the context in which your note is being written and the recipient of your note. Words must be chosen very carefully. If you have never met a physician and are planning to fax him/her your note, it is important to select your words very carefully. You must build rapport through this written note much like you would when meeting someone face-to-face. For example, these notes often begin with a cover letter explaining who you are and why you saw the patient (was a referral sent to you from someone?), that you have enclosed a written summary of your drug therapy evaluation, and how the physician can reach you. The words you chose in your note are very important as well: You may say "**consider** discontinuing Prozac in Mrs. G. It is recommended that this medication be avoided in elderly individuals due to its long half-life and its very stimulating properties. Mrs. G. is experiencing irritability and insomnia; this may be secondary to Prozac. **Consider** substituting Prozac with an agent in the same class that is as effective, but better tolerated in the elderly (e.g., Celexa). *Other examples will be discussed in class.*

Reflection

- Review the framework and the criteria for writing notes. Once you have completed your note, you should get into the habit of critiquing what you wrote and proofing your own work before turning it in. If you take a few minutes to reflect on and assess your own work before submitting it, you will likely avoid many common mistakes and will identify areas requiring attention and revision.
- One way to ensure that you have not overlooked any problems and that your problem list is complete is to review the patient's PMH, review the note for new problems warranting attention that may not be listed in PMH (e.g., hyperkalemia as evidenced by high K in lab section, patient complains of constipation), and review the medication list (you should have accounted for each and every medication in your problem list).

- Ask yourself…
  - Is the problem solvable?
  - Are your goals/endpoints realistic and practical? (what are you trying to achieve?)
  - Are your goals and endpoints evidenced-based?
  - Have you interconnected all information; how do the problems interrelate?
  - Have you identified possible solutions (non-drug therapy and drug therapy)?
  - Are your assessments appropriate/ Do your recommendations answer the problem?
  - Are your recommendations realistic and practical?
  - Are your recommendations evidenced-based?
  - Can you justify and explain your plan for each problem?
  - Are your recommendations inclusive? (have you accounted for all drugs? all problems?)
  - Is the note organized?
  - Is the note easy to understand and follow (i.e., does it make sense)?
  - Is the tone professional and persuasive (i.e. does your writing sound clear and credible)?

SOAP Note Scoring Rubric										
			NOT ACCEPTABLE *(0 points)*	**NEEDS IMPROVEMENT** *(3 points)*	**COMPETENT** *(4 points)*	**EXCELLENT** *(5 points)*	**Score**	**Weight**	**Value**	**Comments**
Qu	**S**	***Subjective Information***	Not addressed, grossly incomplete and/or inaccurate.	Poorly organized and/or limited summary of pertinent information (50%-80%); information other than "S" provided.	Well organized; partial but accurate summary of pertinent information (>80%).	Complete and concise summary of pertinent information.				
	O	***Objective Information***	Not addressed, grossly incomplete and/or inaccurate.	Poorly organized and/or limited summary of pertinent information (50%-80%); information other than "O" provided.	Partial but accurate summary of pertinent information (>80%).	Complete and concise summary of pertinent information.				
E	**A**	***Problem Identification and Prioritization***	Few problems identified, main problem missed, problems not prioritized and/or identified nonexistent problems.	Some problems are identified (50%-80%); incomplete or inappropriate problem prioritization; includes nonexistent problems or extraneous information included.	Most problems are identified and rationally prioritized, including the "main" problem for the case (>80%).	Complete problem list generated and rationally prioritized; no extraneous information or issues listed.				
		Treatment Goals	Not addressed or inappropriate therapeutic goals.	Appropriate therapeutic goals for a few identified problems (50%-80%).	Appropriate therapeutic goals for most identified problems (>80%).	Appropriate therapeutic goals for each identified problem.				
S		***Current Medical Condition(s) & Medication Therapy***	No assessment of current medical condition(s) or medication therapy.	Partial assessment of current medical condition(s) and/or medication therapy for a few identified problems (50%-80%).	Assessment of current medication therapy for most identified problems (>80%).	Thorough assessment of current medical condition(s) & medication therapy for each identified problem.				
T	**P**	***Treatment Plan***	Inappropriate or omitted for some identified problems.	Partially complete and/or inappropriate for a few identified problems (50%-80%); information other than "P" provided.	Mostly complete and appropriate for each identified problem (>80%).	Specific, appropriate and justified recommendations (including drug name, strength, route, frequency, and duration of therapy) for each identified problem.				
		Counseling, Referral, Monitoring & Follow-up	Not addressed or inappropriate counseling, monitoring, referral and/or follow-up plan.	Patient education points, monitoring parameters, follow-up plan and referral plan (where applicable) for a few identified problems (50%-80%).	Patient education points, monitoring parameters, follow-up plan and referral plan (where applicable) for >80% of identified problems.	Specific patient education points, monitoring parameters, follow-up plan and (where applicable) referral plan for each identified problem.				
Format			Heading includes date and time, course or clinical site, patient initials, sex, age and reason for visit; length does not exceed 1 page (11-point font; 1-inch margins); student first and last name is on top of page							