# SOAP documentation

SOAP documentation is a problem-oriented technique whereby the nurse identifies and lists the patient's health concerns. It is commonly used in primary health-care settings.

Documentation is generally organized according to the following headings:

**S = subjective data**

Example: What is the patient experiencing or feeling, how long has this been an issue, what is the frequency, intensity, duration, what makes it worse or better, any past history, family history, home monitoring results (BP, weight, glucose monitoring), etc.

**O = objective data**

Example: Results of the physical exam, relevant vital signs, what the nurse observes, etc.

**A = assessment**

Example: What is the nursing diagnosis or medical diagnosis (for existing problems), identification of the problem, etc.

**P = plan**

Example: What interventions are done during the visit, what is the follow-up, what medications have been prescribed or changed, what further testing or investigations are required, when will the patient be seen again, etc.

**Sample chart note:**

**S:** In for refills and review of diabetes. Home glucose monitoring – taking BG readings 3 times/week in morning only (fasting). Average BG 7-8. Has been trying to avoid sugary snacks but has just quit smoking so is finding this difficult. Walking 5 times/week for 30 minutes.

**O:** Blood work – A1C 7.2 (was 7.3), LDL 1.9, Ratio 3. BP 118/70. HR 72 regular.

**A:** Diabetes (A1C not at target)

**P:** Provided with information on A1C, diabetes and targets. Provided with support and information related to nutrition and strategies to reduce sugary snacks. Reviewed blood glucose testing and will check postprandial sugars 2/week until next visit.

1. Encouraged to book eye exam
2. Due for foot exam next visit
3. Increase metformin to 1000mg bid
4. Repeat BW in 3/12 (annual inc nephropathy screening) – encouraged to check glucometer with bloodwork
5. RTC 3/12