PHARMACOTHERAPEUTICS PRACTICALS

PHARMACEUTICAL CARE PLAN
SOAP NOTES

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- The Pharmaceutical Care Plan (PCP) is a written, individualized, comprehensive medication therapy plan based on clearly defined therapeutic goals.

- Care planning involves systematically assessing a patient's health problems and needs, setting objectives(goals), performing interventions, and evaluating results.

Reasons for Documenting Care

Documentation is a key for successful communication between partners (clinical pharmacists).

A systematic way of practice

- Provides permanent record of patient encounter
- Efficient communication with others
- Provides evidence of pharmacist's actions
- Serves as legal record of care provided
- Help back-up for billing

Format for documentation: PWDT, FARM,SOAP etc.

PWDT: Pharmacist's workup of drug therapy

- Pharmaceutical care uses a process through which a pharmacist cooperates with a patient and other health care professionals in designing, implementing, and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient.

- This process involves three major functions:
  1. Identifying potential and actual drug-related problems
  2. Resolving actual drug-related problems
  3. Preventing potential drug-related problems

The “Structure” of a Care Plan

Pharmaceutical Care Plan can be documented in any of the following formats:

SOAP format

- Subjective Objective Assessment Plan

Expanded – SOAP Format

- Subjective Objective Assessment Plan Goals Monitoring Education

HOAP Format

- History Observation Assessment Plan

SOAPIER Format

- Subjective Objective Assessment Plan Implement Evaluation Revision

DAR Format

- Data Action Response

FARM format

- Finding Assessment Resolution Monitoring

- It is a method of documentation employed by health care providers to write out notes in a patient's chart, along with other common formats, such as the admission note.

- All medical, surgical, nursing specialties use the SOAP notes.

- It is a useful tool to pass along information when transitioning patient care from one person to another:
  - Shift changes
  - From one healthcare field to another
  - Guidance for future encounters

- Also, useful tool for the practitioner in the routine patient care

The development of a PCP can be summarized as a five step process involving the SOAP format

Step 1: Gathering Information

Step 2: Identifying Problems

Step 3: Assessing Problems

Step 4: Developing the Plan

Step 5: Evaluating Achievement of Outcomes

The SOAP format - SUBJECTIVE

- SUBJECTIVE data include things that may be observed about the patient, or information obtained from the patient. Subjective findings are those that the patient describes (e.g., 'I feel tired all the time, “I feel bloated,” or "I woke up coughing").

- By its nature, subjective information is descriptive (WRITTEN IN FULL SENTENCES)and generally cannot be confirmed by diagnostic tests or procedures.

- Much of the subjective information is obtained by speaking with the patient while obtaining the medical history.

The SOAP format - SUBJECTIVE

Subjective information includes:

1. Chief Complaint (CC) …46yo M presents to pharmacy for hypertension
2. History of Present Illness (HPI) … reports elevated readings for 2 weeks
3. Past Medical History (PMH) …has had DM II for 6 years, HTN for 10 years
4. Drug History (DH) …currently taking metformin 1000mg BID, HCTZ 25mg daily
5. Family History (FH) …DMII in both siblings, father died of MI at 52yo
6. Social History (SH) …denies alcohol, illicit drugs. Smokes 1 ppd. Adheres to diet ~50% of the time
7. A report on adherence/compliance, response or side effects
8. Allergies if any

The SOAP format - OBJECTIVE

OBJECTIVE findings are those that can be observed or measured or verified by a healthcare provider.

A primary source of objective information is the physical examination.

- Vital signs (BP, HR, RR, temp), weight, height.
- Physical examination findings (systemic)
- Lab tests (blood tests, urine tests, microbiology, etc.) with date
- Diagnostic tests (x-rays, CT/MRI, ECG, EEG, culture and sensitivity tests) with date
- Medications list (from profile or chart)
- serum drug concentrations (along with the target therapeutic range for each level)

Risk factors that may predispose the patient to a particular problem should also be considered for inclusion.

The SOAP format - ASSESSMENT

- The ASSESSMENT section outlines what the practitioner thinks the patient's problem is, based upon the subjective and objective information acquired.
- This section is Organized by disease states, complaints or drug related problems.
- This assessment often takes the form of a diagnosis or differential diagnosis.
- This portion of the SOAP note should **include all of the reasons** for the clinician's assessment.
- This helps other health care providers reading the note to understand how the clinician arrived at his or her particular assessment of the problem.

The SOAP format - ASSESSMENT

Consider the following during assessment:

- ✓ Correlation between drug therapy and drug related problem (untreated problem or indication)
- ✓ Appropriate drug selection
- ✓ Dosage regimen (subtherapeutic /supratherapeutic)
- ✓ Therapeutic duplication
- ✓ Drug allergies and intolerance
- ✓ Adverse drug reactions
- ✓ Interactions (drug-drug, drug-food, drug-disease)
- ✓ Failure to take or receive therapy
- ✓ Financial impact
- ✓ Patient knowledge of drug therapy

The SOAP format - ASSESSMENT

Your clinical judgment of the patient's drug related problems

- Problem list (numbered)
- Each item should include - problem, solution, evidence/reason for your solution

  Alternative therapies should be considered (brief discussions on options considered) and then the rationale for why this is the best drug for this patient should be explained (safety, tolerability, efficacy, cost, simplicity).
- Prioritize problems

  start with most urgent (usually relates to CC) end with least urgent

…HTN is currently uncontrolled on HCTZ alone. Patient should be on combination therapy with an ACE-Inhibitor as per JNC-7 guidelines.

The SOAP format - PLAN

- The plan may include ordering additional diagnostic tests or initiating, revising, or discontinuing treatment.
- If the plan includes changes in pharmacotherapy, the rationale for the specific changes recommended should be described.
- The drug, dose, dosage form, schedule, route of administration, and duration of therapy should be included.
- The plan should be directed toward **achieving a specific, measurable, goal or endpoint**, which should be clearly stated in the note.

The SOAP format - PLAN

- The plan should also outline the efficacy and toxicity parameters that will be used to determine whether the desired therapeutic outcome is being achieved and to detect or prevent drug-related adverse events.

The PLAN includes:

- Desired or determined goals of therapy
- Specific pharmacotherapy suggestions for each problem outlined in the assessment
- Numbered list to match the Assessment
- Recommendations for drug dose, frequency, duration
- Monitoring parameters and frequency
- Educational measures
- Scheduling follow-up and evaluation..

The SOAP format – PLAN - GOAL

Goals of Therapy as SMART Objectives

- ✓ Specific
- ✓ Measurable
- ✓ Achievable
- ✓ Realistic
- ✓ Time-bound

General Goals of Therapy

- Curing a disease
- Eliminate signs and/or symptoms
- Slow progression of a disease
- Prevent a disease
- Normalize laboratory values
- Assist in the diagnostic process
- Educate the patient about medication
- Improving compliance with drug regimen
- Applying life-style changes

The SOAP format – PLAN - GOAL

Examples of SMART Goals of Therapy

Medical Condition	Goal of Therapy
Strep pneumonia, tuberculosis, constipation	✓Cure of a disease
Depression, asthma	✓Reduction or elimination of signs and symptoms
Diabetes, hypertension, dyslipidaemia	✓Slow or halt the progression of disease
MI, osteoarthritis	✓Prevent a disease
Anaemia, hypokalemia	✓Normalize lab values

The SOAP format – PLAN - GOAL

SHORT-TERM GOALS: examples

- eliminate symptoms
- lower blood pressure (BP) to 140/90 within 6 weeks
- manage acute asthma flare up without requiring hospitalization

LONG-TERM GOALS: examples

- prevent recurrence
- maintain BP at less than 135/80
- prevent cardiovascular complications
- prevent progression of diabetic nerve disease

The SOAP format – PLAN - Interventions

- The purpose of interventions in the care plan is to achieve goals of therapy, and address DRPs
- Each intervention is documented
- Each intervention should be expected to help achieve desired outcomes (goals)
- **The SIX Interventions**
  - Initiate new drug therapy
  - Increase dosages
  - Decrease dosage
  - Discontinue drug therapy
  - Referrals
  - Provide instructions for optimal use of medications

The SOAP format - PLAN

Scheduling Follow-up and Evaluation

- Schedule a follow-up meeting to monitor (ensure timeframe suitable to measure change) pre-set desired outcomes: clinical, lab, subjective

- A plan for follow-up monitoring of the patient must be documented and adequately implemented.

- This process is likely to include (to assure that it results in an optimal outcome)
  - questioning the patient,
  - gathering laboratory data, and
  - performing the ongoing physical assessments necessary to determine the effect of the plan that was implemented

The SOAP format

<u>Common documentation mistakes:</u>

- Inclusion of extraneous information
- Information in the wrong place
- Vague or unclear information
- Lack of clear reasoning – supporting problem existence or choice of recommendation.

The text should be succinct and organized, leaving no questions in the readers mind as to the suggested course of action.