

Daily Progress Notes (The “SOAP” note)

Progress notes are to be written by the resident or intern on each covered medical patient on a daily basis. The daily progress note serves as a written medical-legal document that:

- Serves as a record of a patient’s hospitalization
- Must be completed on a **Daily** basis and includes all “events” that occur during the hospitalization
- Records “events” in terms of subjective and objective findings
- Must include new and active patient health/social issues (“problems”)
- Each problem is evaluated/assessed and an appropriate plan is formulated
- Must be legible and well written so to avoid any misunderstanding by the reader
- Must have a time and date and be signed on each page by the author in legible fashion.

The daily progress note is traditionally organized as a “SOAP” Note. Many, however, organize the Progress note as “HSOAP” where the H stands for history and contains one or two sentences summarizing the patient’s case.

S=Subjective

- Record of subjective findings that occurred during the evening , overnight, and in the morning that patient is being examined.
- Essentially how the patient felt during the evening, night time and morning hours and what happened during those hours.

O=Objective (Includes all the following)

- Physical Exam: Vital signs, focused physical exam but almost always should include:
 - LUNG
 - CARDIAC
 - ABDOMINAL
 - EXTREMITIES
- Laboratory data
- Diagnostic Imaging
- Microbiology
- Please note that a **Medication List** which includes a listing of all scheduled and PRN (as needed) medications that are relevant to active problems is always helpful and recommended but is not required.

A/P=Assessment and Plan:

- **THIS IS THE MOST IMPORTANT PART OF YOUR NOTE**
- The Assessment section of the progress note should be organized by problems. (Thus writing a problem list on the margin of the progress note is helpful in organizing your note but is not always necessary. Problems must be included in your assessment.)
- Assess each problem and include relevant differential diagnosis, evidence suggesting or not suggesting a diagnosis. It is essentially “what do you think caused the problem & why do you think that.”

- Once the assessment has been made a plan must be formulated to address each problem (see below). Plan should be complete and those who read your note should know exactly what you are doing and why.
- Some secondary problems are stable and do not need an assessment but rather just a plan (see below).

Example Assessment and Plan:

2. Chest Pain: Differential diagnoses remain broad with exact etiology still unclear. Most concerning at this time remains pericarditis because of the nature of chest pain and EKG changes. Acute coronary syndrome remains in differential but is less likely given the normal cardiac enzymes and the nature of the EKG changes. PE is very unlikely given the normal oxygenation and complete lack of risk factors. Dissection is unlikely as the patient has no history of HTN and symmetric blood pressures.

If w/u for above life threatening causes negative will further expand differential to include GI, infectious, musculoskeletal and other causes of chest pain.

Plan:

- Serial EKG
- Stat ECHO
- Follow cardiac enzymes
- Morphine for pain control
- Continue ASA
- Hold Beta Blocker as SBP <100 and HR 60
- Consider cardiology consult depending on above workup

2. Mild Anemia: Differential diagnoses includes: decreased production, sequestration, destruction/loss. At this time most concerning is occult GI blood loss given the patients guaiac positive stools and microcytic indices.

Plan:

- Needs routine health screening (colonoscopy as age recommended).
- Check FE studies
- Follow serial HCT (check daily)

3. Tobacco abuse: Smoking cessation counseling

4. Code: Full

5. FEN: Cardiac prudent diet

13. Disposition: No plans for D/C within next 24 hours.