

Documentation Using the SOAP Format: Useful Tips

EMS Patient Documentation regardless of the format should contain, at a minimum:

1. the patient's chief complaint
2. pertinent information learned from the patient, bystanders, family members or others
3. an objective reporting of the patient's condition and surroundings
4. a factual report of care provided to the patient as well as any changes to the patient's condition

The Paramedic's report becomes part of the patient's medical record. It is a legal and confidential document. The patient report serves many purposes. In addition to serving an immediate medical communication purpose, the report also provides a historical record of this specific incident. In the event of future legal action, the report may also serve as a reminder to the paramedic of the events and details surrounding this patient's medical event. Any detail or information which may benefit the patient's immediate medical care, or which may protect the patient from potential harm related to this incident, or that may prove useful in the event of a future legal action *should be* included in the patient's report.

Key Elements of SOAP Report Format

SUBJECTIVE – THE PATIENT'S STORY

1. Patient Description
2. Chief complaint
3. History of the Present Event: What happened? When did it happen? Where did it happen? Who was involved? How did it happen? How long did it occur? What was done to improve or change things?
4. Past Medical History (Pertinent)
5. Current Medications

OBJECTIVE INFORMATION – THE PARAMEDIC'S STORY

1. The Paramedic's Initial Impression: Description of the scene. What was your first impression of the scene and patient?
2. Vital Signs
3. Physical Exam findings
4. General Observations: Other noteworthy information such as environmental conditions, patient location upon arrival, patient behavior, etc.

ASSESSMENT – THE PARAMEDIC'S IMPRESSION

1. Conclusions made based on chief complaint and physical exam findings
2. Often, this is the "narrowed-down" version of the differential diagnosis
3. It may be prefaced by the term "Rule Out" indicating this condition is most likely the cause of the patient's complaint. This provides an alert to the hospital personnel of a likely condition that should be investigated.

PLAN – THE PARAMEDIC'S PLAN OF THERAPY

1. What was done for the patient? This should include what was done prior to your arrival as well as what you did for the patient.
2. Describe what you did with the patient – Disposition. This could be transported code 1 to North Hospital ED, or "patient signed refusal of transport and is left home with family"

EN ROUTE – AN ADDENDUM TO THE PLAN

1. This is not part of the traditional SOAP format since this format was originally intended for physician use.
2. It should detail information regarding therapies provided during transport as well as changes in the patient's condition during transport.
3. It may also include pertinent events surrounding the transfer of the patient at the hospital.