TSHP SOAP EXAMPLE

Subjective: GP 67 yo male who was recently admitted to hospital for dizziness and severe hyperglycemia; need education/counseling since he was recently started on insulin therapy (Novolog and Lantus). Glipizide and metformin has been discontinued.

Objective: *(List pertinent information for this visit FIRST and if time allows you can go back and list more information for completeness)*

PMH: Type 2 DM, Diabetic neuropathy, HTN, Hyperlipidemia, TIA, CKD, Obesity, Osteoarithritis

Social History: Alcohol 4-5 beers/wk; smoke 2 ppd x 45 years

Medications: Lantus 2 units Sub-Q bedtime
Novolog 2 units Sub-Q TID with meals
Lisinopril 40 mg PO daily
Metoprolol succinate 25 mg PO daily
HCTZ 25 mg PO daily
GABA 300 mg PO TID
Aspirin 81 mg PO daily
Simvastatin 40 mg daily

Pertinent/Critical lab values:
HbA1C 8.9
BG levels: 377; at home range from 234-333 (times are inconsistent)
BP 178/95; pulse 101; Wt 255 lbs
Scr/BUN 2.2/12; eGFR 30 mL/min/1.73m2
PT 10.6, INR 1
TC 165 TG 132 LDL 120 HDL 42

Assessment:

A. Diabetes

1) Education on insulin therapy provided
   - Discuss differences between Novolog and Lantus (short vs. long-acting, frequency)
   - Demonstrate how to use insulin pens; Receive adequate teach-back from patient
     i. discuss sites of administration
     ii. discuss mixing of different insulins
   - Emphasize importance of consistency in recording blood sugar levels (useful in dose adjustments)
     i. Record blood sugar readings throughout the day (until next clinic visit) in a notebook
     ii. Optimal times to monitor BG: ideally 2 hours post-meals and first thing in the morning; and occasionally a level right before bed
     iii. BG readings from home are elevated from the past week, will need to increase both Lantus and Novolog doses
   - Discuss S/S of hypoglycemia and how to address them
   - Educate on what to do if a dose was missed
     i. Or if a meal was missed

- Discuss proper storage and expiration date for insulins

2) Discuss routine care:
    - Daily foot care; avoid going barefoot
    - Schedule regular dental checkups
    - Yearly eye exam

B. Hypertension

a. Importance of routinely monitoring and documenting blood pressure trends
b. Not at BP goal < 130/80 mmHg; patient reports compliance so will discuss with PCP and optimize BP medications regimen
c. Encourage keeping a notebook of daily BP readings until next clinic visit

C. Lifestyle modifications

a. Weight loss:
    i. Diet: DASH diet or Plate method; heart healthy diet (ex: low sodium, less red meat, more vegetables)
    ii. Exercise: discuss with PCP if ok to do low-impact exercise at the local gym/park; right now at least try to walk more like park further away from the grocery store
b. Reduce/eliminate alcohol consumption
    i. Limit to 1 drink or less per day
c. Smoking cessation; assess readiness to quit and provide resources to help
    i. Patient expressed interest in quitting
    ii. Provided National Quit Smoking Hotline (1-800-QUIT-NOW)
    iii. Briefly discussed options available to help with quitting
        - Meditation, counseling groups, medications (nicotine patches; Chantix. etc.)

D. Cardiovascular risk reduction

a. Patient with ASCVD risk > 7.5%, however only on moderate intensity statin therapy. Will discuss with PCP and modify current statin regimen

Plan:

Schedule follow-up visit in 3 weeks

1) Follow up on patient's understanding and compliance with insulin therapy
    a. Novolog versus Lantus (short-acting versus long-acting)
    b. Review BG notebook: Assess compliance and efficacy of new insulin therapy
        i. Was any dose missed? How did he address it?
    c. Review sites of insulin administration, proper storage of insulin
    d. Any issues or concerns?
2) Follow up on diabetic routine care
    a. Date of the last foot exam, eye exam, dental exam
    b. Review the latest laboratory results from PCP
    c. Any issues or concerns?
3) Follow up on lifestyle changes
    a. Determine if the patient had implemented…
        i. An exercise program
        ii. A healthy diet
        iii. Reduction in alcohol consumption
        iv. Smoking cessation
    b. Provide additional support/resources to help patient continue positive lifestyle changes
4) Follow up on cardiovascular risk reduction (BP meds, statin)

a. Review BP notebook for compliance and efficacy of BP medications
b. Metoprolol dose was increased to 50 mg po daily
c. Simvastatin was stopped; was started on Crestor 20 mg po daily
d. Monitor for improvement in BP control and any side effects due to medication changes

Note: The SOAP note can have other answers depending on the student's thought process.

For example:
- Metoprolol may have been a good choice given the elevated HR
- BP medication could also be changed to Carvedilol since it targets alpha 1 receptor
- Change to Crestor 20 or 40 mg po daily or switch to Atorvastatin 40 or 80 mg po daily
- May mention that patient may be started on an insulin sliding scale later on in the therapy plan once a better picture of glucose levels/trends are obtained

What matters is if the main topics (diabetes, HTN, lifestyle changes, and statin) were discussed and addressed during the clinic visit (especially insulin therapy). This SOAP note will be read by your colleagues working at the clinic prior to meeting with the patient when he comes back for his next visit.

It is basically summarizing what was discussed during this counseling session, what changes were made from this visit, and what needs to be follow up at the upcoming clinic visit. It needs to highlight the major points in a concise manner, and remember you only have 10 minutes to write this SOAP note.

Keep in mind that Disease State Management focus on: communication skills (20%), interpersonal skills (20%), clinical problem-solving and decision-making skills (20%), educational skills (20%), and documentation skills (20%).