Tips for Effective Daily Rounding and Writing Excellent SOAP Notes

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This is an introduction to the clinical skills which you will need to acquire over the course of your training. These skills will serve as the foundation for not only your clerkship, but also your residency and the rest of your career.

On CTU, you will be assigned several patients which you will be following throughout their hospital stay. Typically, these will be patients which you have admitted while on call. Take ownership of your patients by trying to acquaint yourself with them as much as possible. Read everything you can about their history from the available documentation in the computer.

Your daily notes will be in the "SOAP" format. The SOAP acronym stands for subjective, objective (including physical exam, new laboratory investigations, new imaging investigations), assessment, and plan. The structure is outlined below:

CTU MSI 3 (or your level of training)

Date & Time (For medico-legal reasons, always date and time any note or order that you write.)

Identification (ID): age, sex, (optional: up to 1-2 relevant comorbidities), reason for admission
e.g. 58M with a history of ischemic CHF admitted for NSTEMI

Subjective (S):

- any pertinent information obtained by interviewing the patient
- ask about any changes to symptoms or new symptoms

Physical Exam (P/E):

- vital signs
- Note that patients on oxygen in the hospital may not actually require oxygen. If your patient is on oxygen and is not in any respiratory distress, get an oxygen saturation probe from the ward and apply it to the patient. Then, turn the oxygen down to zero and wait a few minutes (you can do this before you start the interview). If the patient is clearly desaturating under 88%, then immediately increase the oxygen again to an appropriate

level. If the patient remains above 92%, then they do not require any oxygen.

- physical exam findings, listed by system (e.g. H&N, CVS, Resp, Abdo, Neuro, MSK)

Laboratory Investigations (Labs)

- report any new labs; use shorthand format
- Circle any abnormal values in order to alert yourself to address these abnormalities in "plan" section.
- You should be able to detect important trends by using the graph function as needed. Is the patient's sodium decreasing with each day? Is the patient's hemoglobin decreasing? Is the creatinine rising?
- For patients with diabetes, check the recent capillary blood glucose values which will be located in a separate chart (ask the nurses if you are unsure of the location). Glucose values within 5 to 10 are within target.

Investigations

- sometimes patients will have new imaging investigations, some of which you may have ordered
- to listen to radiology reports at UHNBC, press 2020 and when prompted for hospital site, enter *1; if you want to advance through dictations, press *8
- If you ordered an investigation but it is not up yet, ask the patient and/or nurse whether it has been done. If it has not been done, ask whether there has been a time scheduled. If it has not been scheduled, find out what must be done to schedule it (e.g. filling out a form, calling someone)

Assessment & Plan

- list the active issues in a numbered list
- under each issue, mention the cause, what we are doing to address this issue, and what progress we have made
  e.g. back pain: secondary to spinal stenosis, patient not an operative candidate, pain currently treated adequately with acetaminophen
- if an issue has been completely resolved, you don't need to mention it every day (but include it in the discharge summary)
    - e.g. patient has hypertension but their blood pressure is 140/90 every day - this is not an active issue and need not be mentioned daily

- the last issue should be disposition: where is the patient going after hospital stay, and what are the barriers to discharge?
  e.g. disposition: patient is to return to nursing home after finishing course of antibiotics
  e.g. disposition: patient is to return home when able to mobilize

For medico-legal reasons, always end your notes and orders with your signature, your printed full name, your designation, and your pager number below in case any clarifications are necessary.

The hospital is a place where patients acquire infections which increase morbidity and mortality. Each day, ask yourself if the patient still needs to be in hospital. If the answer is yes, think about what you need to do in order to get the patient closer to a condition that would be appropriate for discharge.

When you round on your patients, also make a habit to look in the patient's Medication Administration Record (MAR). Try to be aware of what medications your patient is taking, and pay attention to which medications are newly started in hospital, as well as the ones which have been held. Think about whether new medications need to continue, and whether the held medications can be re-introduced. In most cases, patients will not be able to go home with IV medications, so the need for these also need to be re-evaluated each day. Note whether the patient is on any PRN medications, and if so, how frequently these are being used.

Perhaps the most important clinical skill to develop is to know whether your patient is improving, unchanged, or deteriorating. Many clues about the patient's clinical status can be obtained as soon as you walk in the room. Does the patient have increasing oxygen requirements? Is the patient responding to you? Is the patient more confused than usual? If your patient is acutely deteriorating, it is vital to alert your senior as soon as possible.

As always, if you are uncomfortable with any aspect of your clinical encounter with your patients then please do not hesitate to contact your senior resident.