APPENDIX: 27

TITLE: S.O.A.P. GUIDELINES

REVISED: November 1, 2017

Run Report Organization shall (when appropriate) contain the following information. Computerized charting may differ somewhat due to software parameters:

S.O.A.P. Format: DOCUMENT AS APPROPRIATE PER CALL

SUBJECTIVE:

Subjective information:
- Medic unit responding
- Reason for call
- Chief complaint (C/C)
- Information obtained from bystanders and other sources
- Other pertinent history and information
- Response Times (Dispatch, On scene, etc.)
- History of C/C
- Pertinent Negatives

Misc. information (unless included elsewhere)
- Allergies
- Medications
- Past Medical History
- Last meal,
- OPQRST (Onset, Provokes, Quality, Radiation, Severity, Time since onset)

OBJECTIVE:

Physical Exam Including:
- LOC
- Level of distress
- Skin
- HEENT
- Chest/lung sounds
- Spine C-T-L
- ABD
- Pelvis
- Extremities
- Neurological Assessments
- Cardiovascular Assessments

Diagnostics including:
- BG
- EKG
- SPO2
- 12-Lead EKG
- Vitals
- Motor Function
- ET CO2

ASSESSMENT:
Working field diagnosis - consistent with your findings and treatments

PLAN:
Plan should include:

- Document patient contact time.
- ALL treatments, including name and agency of person performing ALS treatment, routes, number of attempts, medications, and doses.
- Treatment per SWO, V.O. (Verbal Order) or specific protocol.
- Results of/response to the treatment and justification for treatment.
- Equipment used.
- Method of removing patient to MICU.
- Destination hospital noted and reason for choice (i.e. patient request).
- Type of transport (non-emergency vs. emergency).
- Any changes or incidents while enroute.
- Report given to whom.
- Disposition of patient on discharge from ALS care, including the patency/position of ET tubes, mental /hemodynamic status, etc.
- Any personal possessions left, removed, or transferred to hospital staff.
- Patients, who refuse care or are treated-and-released, require documentation of informed refusal of services, etc.

Some further notes on SOAP charting:

- Correct spelling, grammar, legibility, proper use of medical terminology, and approved abbreviations will be used.
- Written reports should be written in BLACK ink.
- Complete patient reports and submitting a copy to the destination hospital in a reasonable amount of time.
- Most BLS reports should be completed within 30 minutes, most ALS reports in about 45 minutes.
- Reports with three (3) or more errors will be re-written.
- Reports will include a printed signature block with the printed name and Ada Number corresponding to the signature.
- Responses to treatment should include both subjective and objective changes when possible.

NARRATIVE DOCUMENTATION (If documenting in the narrative form)

Standardization of Narrative

The following summarizes the information designated for inclusion into the Narrative portion of ESO.

Reason for dispatch
Pt appearance
Environment
Chief complaint
HPI
Improved limb lead description (if desired)

Compliance with meds or new dosing (if relevant)
Recent trauma/illness (if relevant)
MD List
Pt safety (if relevant)
Access to medical care (if relevant)
Information generated from a review of systems
How pt moved
Hospital destination (a necessary repeat)
Pt improvement/deterioration
Anything not otherwise documented that is pertinent

It is no longer necessary to revisit a list of treatments in the Narrative portion of ESO. Further, it is generally not necessary to document negative findings.

Physician Pearls:

“No abnormality” can only be documented if all the areas of a standardized physical exam, or a more detailed exam that is injury/illness specific, have been completed and nothing abnormal identified. This assumes that the Paramedic is able to identify grossly abnormal conditions at the examined body locations or reviewed systems.

“No abnormality” may be a relative term. The pt may have an abnormal condition that is normal for them. The finding should be documented as an abnormality (a finding) with reference to onset or the pt’s description of the finding as pre-existing or “normal”.

The physical examination pick lists offered in the current web-based documentation program may be utilized, however that list supplements the areas of exam found in the standardized physical exam/history.

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