Currents in Pharmacy Teaching and Learning xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Currents in Pharmacy Teaching and Learning

journal homepage: www.elsevier.com/locate/cptl

Research Note

Assessment of SOAP note evaluation tools in colleges and schools of pharmacy

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ARTICLE INFO

Keywords:
SOAP notes
Documentation
Assessment

ABSTRACT

Introduction: To describe current methods used to assess SOAP notes in colleges and schools of pharmacy.

Methods: Members of the American Association of Colleges of Pharmacy Laboratory Instructors Special Interest Group were invited to share assessment tools for SOAP notes. Content of submissions was evaluated to characterize overall qualities and how the tools assessed subjective, objective, assessment, and plan information.

Results: Thirty-nine assessment tools from 25 schools were evaluated. Twenty-nine (74%) of the tools were rubrics and ten (26%) were checklists. All rubrics included analytic scoring elements, while two (7%) were mixed with holistic and analytic scoring elements. A majority of the rubrics (35%) used a four-item rating scale. Substantial variability existed in how tools evaluated subjective and objective sections. All tools included problem identification in the assessment section. Other assessment items included goals (82%) and rationale (69%). Seventy-seven percent assessed drug therapy; however, only 33% assessed non-drug therapy. Other plan items included education (59%) and follow-up (90%).

Discussion and conclusions: There is a great deal of variation in the specific elements used to evaluate SOAP notes in colleges and schools of pharmacy. Improved consistency in assessment methods to evaluate SOAP notes may better prepare students to produce standardized documentation when entering practice.

Introduction

Pharmacists are considered essential members of the healthcare team because of their expertise in delivering comprehensive medication management.[1] Consequently, pharmacist documentation of their services is vital to the patient's continuity of care and demonstrates both the value and accountability of the pharmacist's service to the team.[2] Additional purposes of pharmacist documentation include ensuring compliance with laws and regulations for maintenance of patient records and creating a record of

Abbreviations: SOAP, subjective, assessment, objective, plan

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http://dx.doi.org/10.1016/j.cptl.2017.03.010

Table 1
Comparison of national pharmacy organizations recommendations for documenting pharmaceutical care services.

Category	ASHP[2]	APhA[3]	ACCP[5]
Subjective	• Summary of medication history including compliance • Medication allergies and manifestations	• Demographics • PMH • FH • SH • Allergies • Medication history including patient concerns, reports of adverse events	Medication history • Patient's past medication use and related health problems • Current medications and actual use, adherence, attitudes towards therapy • Medication-related allergies and ADE
Objective	• Drugs administered (including investigational drugs) • Clinical and PK data pertinent to drug regimen • Physical signs and symptoms relevant to drug therapy	• Vital signs • Medication lists • Laboratory data	Not specifically stated
Assessment	Actual and potential DRPs that warrant surveillance • Therapeutic appropriateness (including route and method of administration) • Drug-drug, drug-food, drug-laboratory test, and drug-disease interactions • Drug toxicity and ADE	• List of identified DRP • Goals of therapy for each DRP • Degree of control (eg above goal, uncontrolled) for each disease state or DRP	Active problem list with an assessment of each problem • List of current health conditions and supporting data for status of each condition • Emphasize DRPs that impact on desired goals • List of DRPs that may be unrelated to current health conditions
Plan	• Adjustments made to drug dosage, dosage frequency, dosage form, or route of administration • Drug-related patient education and counseling provided • Oral and written consultations to other health care providers	• Specific changes to drug therapy (eg drug, dose, route, and frequency) • Monitoring parameters • Follow-up care • Patient education	• Specific medication therapy plan including drug, dose, route, frequency and relevant monitoring parameters • Collaborative plan for follow-up evaluation and monitoring and future visits
Overall Qualities	Legibility, clarity, lack of judgmental language, completeness, use of standard format (eg SOAP), how to contact the pharmacist (eg pager or telephone number)	Legibility, use objective language, avoid judgmental language, correct spelling and grammar, date/time and patient's name listed, avoid making a diagnosis, completed soon after patient encounter	Compliant with accepted standards for documentation in setting (including billing, where applicable)

Abbreviations: APhA = American Pharmacists Association; **ASHP** = American Society of Health-System Pharmacists; **ACCP** = American College of Clinical Pharmacy; **PMH** = past medical history; **FH** = family history; **SH** = social history; **ADE** = adverse drug event; **PK** = pharmacokinetic; **DRPs** = drug-related problems; **SOAP** = subjective, objective, assessment, plan.

services provided for billing and reimbursement.[3] Standardized documentation of pharmacists' clinical services will be critical to receive reimbursement should national provider status efforts prove successful.

Several forms of pharmacist documentation can be used to record clinical interventions, including unstructured notes, semi-structured notes, and systematic records.[4] Systematic documentation styles include SOAP (subjective, objective, assessment, plan), TITRS (title, introduction, text, recommendation, signature), and FARM (findings, assessment, recommendations or resolutions/management).[4] SOAP documentation is the primary documentation method utilized by pharmacists and other healthcare providers in both inpatient and outpatient settings.

The American Society of Health System-Pharmacists (ASHP), the American College of Clinical Pharmacy (ACCP), and the American Pharmacists Association (APhA) each provide guidelines for the documentation of pharmaceutical care services in the permanent medical record (Table 1).[2,3,5] Each guideline underscores the importance of consistency in the care delivery process as well as standardization in documentation of comprehensive medication management services. The Joint Commission of Pharmacy Practitioners (JCPP) *Pharmacists' Patient Care Process*[6] also emphasizes the importance of documentation to communicate with physicians and other healthcare providers in the provision of safe, effective and coordinated care (Table 2).

The Accreditation Council for Pharmaceutical Education (ACPE) Standards 2016[7] list documentation of clinical activities as essential to the delivery of patient-centered care (Key Element 2.1 – Patient-centered care). Assessment of a student's ability to accurately and concisely document patient care activities is required throughout the Pharm.D. curriculum to ensure students are ready to progress to advanced pharmacy practice experiences ("APPE-ready") and at graduation can provide direct patient care in a variety of healthcare settings ("practice-ready") within an interprofessional collaborative team ("team-ready"). Instruction and assessment of SOAP note writing is frequently delivered in skills laboratory courses, as clinical documentation is a fundamental patient care skill. With increased emphasis on standardizing the patient care process and documentation of pharmacist services within the medical record,[5,6] it is important to understand if our evaluation tools for evaluating student SOAP notes (such as rubrics or checklists) include the recommended components to document a comprehensive medication management encounter. However, there has been no published evaluation of how SOAP notes are assessed within pharmacy education. The purpose of this study is to describe current practices in assessing SOAP notes within skills laboratory courses at colleges and schools of pharmacy.