Registered Nurses
Professional Development Centre

# SOOOAAP Documentation

SOOOAAP documentation is an expansion of the traditional SOAP documentation technique. Resnick (2015) suggest this expanded pneumonic may reduce malpractice allegations and more clearly document the role of the patient in establishing a shared plan of care.

Documentation is generally organized according to the following headings:

**Table 1 SOOOAAP Documentation**

| SOOOAAP Component | Description |
|---|---|
| S: Subjective | Use patient's words to provide indication of their attitude. Should include a complete review of systems and inclusion of additional concerns that were not the primary reason for seeking care. |
| O: Objective | Should be measurable, reproducible data including things like recent lab tests or imaging. All physical exam findings and any concerns about faulty equipment or inability of patient to fully perform test. |
| O: Opinion | This is similar to assessment but further explains that there may be limitations to your assessment-that the final assessment is still ongoing should be made clear. |
| O: Options | Documents information provided to patients, whether or not this is evidence based recommendations or routine practice, and what the treatment side effects might be and what would be the result of no treatment. |
| A: Advice | The is the recommended best choice by the health care provider with a rational for your recommendation. "…If it was my mother…based on what you know."Health promotion activities and recommendations would be documented here. |
| A: Agreed | Plan Pulls discussion together and states what patient has agreed to follow or what he/she makes an informed decision not to do. |

September 2015
Adapted from http://www.nso.com/risk-education/individuals/articles/Documentation-Proactive-Prevention-of-Litigation

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**Sample chart note:**

S: In for refills and review of diabetes. Reports he has been trying to eat healthier. Reports walking 3 times/week for 30 minutes.

O: Blood work – A1C 7.2 (was 7.3), LDL 1.9, Ratio 3. Height 186 cm, weight 82 kg, waist circumference 190 cm, BP 118/70. HR 72 regular.

Opinion: Diabetes, A1C not at target, BP at target, BMI 24, Exercise level not optimized.
Options: Provided with EBI on Hgb A1C, diabetes and targets for fasting blood glucose, BP, exercise and current recommendations regarding SMBG. Patient provided with support and information related to routine nutritional strategies.
Advice: Consider increasing exercise to 5x/week for better cardiovascular protection, and addition of resistance activities with weights or elastic bands 2-3 x/week. Also consider documenting daily intake as a means of monitoring/accountability to self.

Agreed Plan: 1. Agreed to book eye exam. 2. Foot exam deferred until next visit 3. Agreed to increase metformin to 1000mg bid as / Dr. Jones. 4. Repeat labs in 3/12. Will check glucometer with next blood work. 5. Will attempt to exercise for 30 min 4x/week. Not interested in food journaling and resistance training at present. RTC 3/12 after completion of labs.

A1C: Hgb A1C

BMI: Body Mass Index

BP: Blood Pressure

EBI: Evidence Based Information

RTC: Return to Clinic

SMBG: self monitoring of blood glucose

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