

SOAP & PIE Charting Methods

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Introduction

Documentation in nursing practice is a term defined as anything written or electronically computerized that describes the medical history and status of the patient. Documenting a patient's medical record is one of the most pivotal steps in the field of nursing. The documentation of a patient's report should be comprehensive and accurate. These documented records fulfil their purposes in nurse audits, education, and the medical history of the concerned patient. The documented records further pave the way for the patient's diagnosis and medical treatment. This paper is a schematic representation of the case scenarios. SOAP & PIE charting methods have great significance in the documentation of patient records in medical institutions. Therefore, the purpose of this research is to explicate the paradigms of SOAP and PIE charting methods by using case scenarios for each type.

SOAP Method of Documentation

A SOAP method is used to record the patient's interaction in his medical history chart. It is the most commonly used progress in the field of nursing. SOAP is a short form for ("S stands for- Subjective data, O - Objective data, A - Assessment, P - plan"). A SOAP note is written documentation used by health care professionals such as nurses to record patient's medical information. According to Weed, this method is the most common and widely used documentation method for progress notes (Weed, 1968). However, this method is limited to current/present problems only and does not focus on past problems. The SOAP method is more focused on one problem than the entire history and physical documentation of the patient. A SOAP entry of a patient is usually made every 24 hours. A SOAP note should include "subjective data, objective data, assessment, and plan."

S- Subjective (Patient's observation about his/her medical issue)

This part involves what the patient tells the medical officer or the nurse about his medical problem. It is the record of subjective findings that occurred during the evening, overnight, and in the morning that patient is being examined. These examinations involve how the patient felt during the evening, night-time, and morning hours and what happened during these hours.

This section is usually recorded in two paragraphs/parts. The first paragraph addresses the main

concerns or complaints from the patient. If this is the first time a medical officer/ nurse is seeing a patient, then he/ she will take a “History of Present Illness”. The next paragraph includes pertinent portions of past medical history. The second paragraph will explain the information of the past medical history and is generally less focused than the first paragraph.

O-Objective (Observations and tests by the nurse)

This section involves the observational diagnosis by the medical officer or nurse of the patient. A focused physical exam is carried out on the patient. This involves the observation of vital signs (Blood pressure and Sugar levels). The objective data includes the assessment of respiratory, cardiac, abdominal, CNS, and observational abnormalities. The laboratory data and medication list is also a part of this section.

A-Assessment (Nurse’s understanding of the problem)

This part involves the assessment after a medical officer/ nurse’s observation. In simple words, the nurse assesses the problem according to her/his observation of the patient’s condition. It is the most cardinal point of the SOAP method. This section starts with a one-sentence summary of the problem. It should be organized by the newest or acute problem first. The information incorporated for each problem should include the statement of the problem, differentials (acute problem), and the present status (chronic problem) of the patient. At the end of the statement of the problem, clinical reasoning for and against the problem is mentioned.

P-Plan (Goals, Actions, Advice)

This is the final step of the progress note of the patient. A plan must be recorded in the SOAP note for addressing every problem related to the patient. In this step, the medical officer/ nurse plans for the medical treatment of the patient. This involves the diagnostic tests suggested for the medical problem, such as a Complete Blood Check (CBC), LFT, RFT, stool examination, urine test, and Neuro-imaging. The treatment plan includes intravenous fluids, injectable appropriate antibiotics, Antipyretics, and anticonvulsants.

PIE Charting Method of Documentation

A PIE chart method is also a progress record method used to record a patient’s medical progress. It is a problem-oriented charting similar to the SOAP method. The acronym word PIE stands for “P-Problem Identification, I-Interventions, and E-Evaluations.” The inclusion of timing along with each step taken

is very important in the documentation. The PIE charting notes are numbered according to the patient's problems. The continuing problems of patients are documented daily by the nurses. These problems are documented in the form of PIE charting notes in the patient's documented record. (Potter, 2006).

The PIE charting method of documentation helps the nurses to ensure that their complete diagnosis is recorded in the form of problem, intervention, and evaluation. The PIE charting method in the documentation of the patient's medical problem increases the quality and accuracy of the reports. Furthermore, this method improves the scientific and professional performance of the nurse. The PIE method improves the quality and accuracy of problem-oriented documentation. (Ehsani, 2014).

P- Problem Identification

In the first section, the medical problem is identified by the patient and told to the nurse/ medical officer. For instance, a patient reports a severe headache to the nurse.

I- Intervention Problem

In the second section, the nurse or the medical officer performs a test or gives medicine to the patient according to the medical problem he or she has stated. The nursing care (Intervention) is provided according to their nursing diagnosis (Problem) and is recorded/ documented in this section. For instance, the nurse assessing the blood pressure and giving medicine to the patient comes under the Intervention Problem.

E – Evaluation

In the third section, the patients report the feedback after the intervention by the nurse or the medical officer. As stated in the above sections of the PIE charting method, the patient reports that his or her headache is lessened under Evaluation.

Recommendation and Improvements

In contemporary society, there is significant room for improvement in health care services and nursing documentation data. Jefferies emphasizes that it is beneficial to assess other nursing documentation methods. This will help to achieve quality documentation in a comprehensive, logical, organized, and accurate manner (Jefferies, 2010). The nursing documentation methods have many issues reported in these years. Some issues are connected to nurse care, and some are related to the format of these documentation methods.

In this evolving society, Computerized Documentation is highly recommended in medical institutions.

Digital documentation or computerized documentation increases the quality of documentation (elimination of bad writing style and grammatical mistakes). Furthermore, it saves time, and increases the legibility and accuracy of the information. The physician can access the documented information easily online without visiting the patient/ ward. This type of documentation is highly recommended and purposeful during the tough times of the Covid-19 pandemic. This systematic approach of documenting data improves the patient's care in remote areas also where the physician cannot reach the patients easily. It reduces documentation time, easy to read, provides the entire medical history of the patient, and is easily accessible. According to Singh, in many medical institutions, the medical situations change over time influencing the diagnostics requiring a change of treatments. The SOAP format for progress notes lacks explicit integration of time into its cognitive framework and thus has a significant gap (Singh, 2012).

The EHR method is the most relevant documentation process recommended in this contemporary society. EHR is an acronym that stands for Electronic Health Record. This computerized documentation can include the nurse's progress notes in SOAP, PIE formats, and many more. Many modern medical institutions incorporate computerized documentation in the documentation of the patient's medical history. This type of documentation is also known as computer-assisted charting. During the global pandemic, the computerized charting of patient records has served the best purposes. Therefore, further development and innovation is required in this field.

SOAP Charting (Case Scenario)

The respective case scenario is about Mr. John Smith (DOB 08-10-1951). Mr. Smith came into the clinic to see Dr. Jerry Jones. Below are the notes that were taken during Mr. Smith's visit to the clinic in a SOAP format.

S- Subjective

Mr. Smith complains of leg weakness which increases with going up steps. He further tells about inflammation in both lower legs. According to him, the pain is aching. But the pain is better when he elevates the legs. The pain is worse at night. He rates pain 5 out of 10.

The patient has diabetes and a medical history of Heart Disease.

O-Objective

- Blood Pressure: 165/85
- Pulse Oximetry: 97% Pulse: 60 bpm
- Temperature: 98.5
- Weight: 165 kg

- Height: 182 cm
- Respiration: 16 bpm

A-Assessment

Diagnosis: Hypertension, presence of bilateral edema in both legs and ankles. The X-rays show no fractures. There is Peripheral edema in both ankles.

P-Plan

Prescribe Hydrochlorothiazide, 25 mg tablet, 1 per day in the morning. The patient is advised to wear support stockings till the next appointment. Elevate legs for 1 hour 4 times a day. He is asked to return for a follow-up in two weeks.

PIE Charting (Case Scenario)

The following case scenario explicates the documentation of Mrs. Moira Harold. She is 45 years old. She is admitted to the hospital in I.C.U. with Chronic Renal Failure. Following is her progress report in PIE charting format.

P- Problem identification

The Patient has complained of pain. The patient reports extreme chest pain with weakness. She associates SOB (Shortening of Breath) with chest pain. The patient is pale and sweating profusely.

I-Intervention Problem

The patient is on examination. The vitals of the patient are checked first. The Blood pressure is 170 by 90. The sugar level is high. The heart rate is 125/min, though. Saturation: (Oxygen saturation is usually above 95 % it dropped to 88-89%) The patient is tachypneic with reap. Rate of 25 per minute. The supply of O₂ is 89% at room air. The patient is afebrile and had crackles all over the chest on auscultation. The Doctor is informed about the patient's condition. The ECG (Electrocardiogram) of the patient is taken, and CXR (Chest X-ray) is recorded.

E – Evaluation

The patient managed lines of acute coronary syndrome. The ECG report of the patient showed ST-segment depression in anterolateral leads. The Chest X-ray report showed B/L Lung Infiltrates. The

patient is made to sit in a propped-up position. Supplemental oxygen is used to maintain the supply of oxygen O₂ above 95%. Anti-ischemic and Diuretics are given to the patient. The workup for ACS (Acute Coronary Syndrome) is sent. Echo cardiology is planned for the patient.

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