

Free
Guide

SOAPIER NOTE How to Guide

*Organize Your Patient Documentation
with the SOAPIER Method*

Stay Organized, Stay Accurate, Stay Caring!

The SOAPIER note is a structured method for documenting patient care in a comprehensive and organized manner. Each letter in SOAPIER represents a different component of the note, ensuring that all aspects of patient care are covered. Here's a step-by-step guide on how to write an effective SOAPIER note.



Subjective (S)

Definition: Information provided by the patient about their symptoms and feelings.

Examples:

- Patient reports a pain level of 7 out of 10 in the lower back."
- Patient states they feel nauseous and have not eaten since yesterday.



Objective (O)

Definition: Observable and measurable facts about the patient's condition.

Examples:

- Vital signs: BP 130/85, HR 80, RR 18, Temp 98.6°F.
- Wound on the left leg measuring 4 cm, with moderate drainage.



Assessment (A)

Definition: Your professional interpretation of the patient's condition based on the subjective and objective data.

Examples:

- Patient is experiencing acute pain likely due to post-surgical inflammation.
- Nausea and lack of appetite may be related to medication side effects.



Plan (P)

Definition: The plan of care for the patient, including interventions and treatments.

Examples:

- Administer prescribed pain medication every 4 hours as needed.
- Encourage small, frequent meals and administer anti-nausea medication as ordered.



Intervention (I)

Definition: Actions taken by the healthcare provider to address the patient's condition.

Examples:

- Administered 500 mg of acetaminophen at 10:00 AM.
- Elevated the patient's leg and applied a cold compress.



Evaluation (E)

Definition: The patient's response to the interventions and the effectiveness of the treatment plan.

Examples:

- Patient reports pain reduced to 4 out of 10 after medication.
- Nausea decreased, and patient able to tolerate light meal.



Revision (R)

Definition: Any changes to the treatment plan based on the evaluation.

Examples:

- Continue current pain management plan and reassess pain level in 4 hours.
- Increase frequency of anti-nausea medication if symptoms persist.

By following the SOAPIER format, nurses can provide thorough and organized documentation that supports effective patient care and communication among the healthcare team.



Example of Soapier Note

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Subjective (S)

Patient reports a sharp pain in the right hip, rating it 6 out of 10.



Objective (O)

Vital signs: BP 140/90, HR 82, RR 20, Temp 98.7°F. Right hip slightly swollen and tender to touch.



Assessment (A)



Patient likely experiencing post-operative pain and inflammation in the right hip.



Plan (P)

Administer prescribed ibuprofen 400 mg every 6 hours as needed for pain. Apply ice pack to right hip for 20 minutes every 2 hours.



Intervention (I)

Administered ibuprofen 400 mg at 08:00 AM. Applied ice pack to right hip at 09:00 AM.



Evaluation (E)

Patient reports pain reduced to 3 out of 10 one hour after medication and ice application.



Revision (R)

Continue ibuprofen as needed. Monitor pain levels and reassess in 4 hours. If pain persists above 5, consider alternative pain management strategies.


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Tips for Writing Effective SOAP^{PIER} Notes

- ✓ Be Clear and Concise: Use precise language and avoid unnecessary details.
- ✓ Stay Objective: Separate facts from opinions, especially in the Objective and Assessment sections.
- ✓ Follow Up: Ensure that the Evaluation and Revision sections are completed based on the patient's response to interventions.
- ✓ Keep it Timely: Document as soon as possible after providing care to ensure accuracy.

By following the SOAP^{PIER} format, nurses can provide thorough and organized documentation that supports effective patient care and communication among the healthcare team.



For more resources on nursing documentation, visit Happy Nurse Shop.

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