**King University MSN/NP Program**

**Clinical SOAP Note Format**

**Adult, Women, Geriatrics**

Student: Erica Miller       Course: Adult Geriatrics NURS5019   Date: 6/3/24

SOAP Note # 2                                     Acute

**Patient Information**

Initials: TD Age: 28 Gender: Male

DOB: 2/20/1996   LMP: N/A

**(S)ubjective Data**

**CC:** “I have been coughing for 2 weeks.”

**HPI for acute visit:**28-year-old Caucasian male presents to the clinic with c/o a cough lasting about 2 weeks with the production of white/green mucus several times a day. The patient stated that he recently began running a fever of 101 but is relieved with 1000mg of Tylenol every 4 hours. Other symptoms include headache, fatigue, shortness of breath, and wheezing.

**Past Medical Hx**: Asthma

**Past Surgical Hx**: N/A

**Family Medical Hx:** Father: HTN, Hyperlipidemia Maternal Grandfather: Type 2 Diabetes

**Personal & Social Hx:** The patient is married with one child age 2. The pt states he works full-time as a Helicopter Mechanic and his wife is a Hairdresser. States he is active with his toddler and attends the gym 2-3 times a week when he has the time. Consumes carbonated beverages and caffeine. Denies smoking or vaping. States he does consume alcohol, but only on occasion. Denies drug use.

**Immunization status:** All immunizations UPD, Flu: 11/15/23

**Medications:** Albuterol inhaler, Singular, Tylenol 1000mg PRN: fever

**Allergies & Reactions:** No known food or drug allergies.

**Review of Systems**

 **General Constitutional:**Pt states he has a cough, shortness of breath, fever, fatigue, and headache. Pt denies unexpected weight loss or gain. Denies any trouble eating or sleeping.

**Skin, Hair & Nails:** Pt states he uses sunscreen occasionally when out in the sun. Denies any changes in the skin, rash, bruising, or open areas. Denies any hair loss. Denies any nail deformities, discoloration, or thickness.

**Head & Neck:** Pt denies headaches, or any past trauma involving his head. Denies any lumps, swollen lymph nodes, or stiffness.

**Eyes, Ears & Nose:** Pt denies any blurred vision, difficulty focusing, peripheral changes, or dry eyes. Pt denies any vertigo and any hearing loss or changes in hearing. Pt also denies any recent epistaxis or nasal congestion.

**Throat & Mouth:** Pt denies hoarseness, oral lesions, or dental problems.

**Lymphatic:** Pt denies any swollen glands or lymph nodes.

**Chest and Lungs:** Pt states he has been coughing for 2 weeks with occasional wheezing and sputum production. Pt denies any tightness, tenderness, or pain. Denies SOB.

**Breasts:** N/A

**Heart & Blood Vessels:**Pt states he exercises 2-3 times a week at the gym. Denies any history of heart murmurs, current chest pain, palpations, edema, or dyspnea.

**Peripheral Vascular:** Denies any numbness or tingling in upper or lower extremities. Denies any edema or varicose veins.

**Hematologic:** Pt denies any unusual bleeding or bruising, fatigue, or hx of anemia.

**Gastrointestinal:** Pt denies dysphagia, reflux, n/v, constipation, and diarrhea and states no changes in bowel habits.

**Diet:**  Pt states he feels his diet is adequate.

**Endocrine:** Pt denies thyroid problems, cold or heat intolerance, unexplained changes in weight, changes in nail or skin texture, and changes in body or facial hair.

**Gender-Related:** Pt states he is currently sexually active, and his wife has an IUD as her primary form of birth control.

**Pregnancy:** N/A

**Genitourinary:** Pt denies incontinence. Denies any burning, irritation, cloudy, or discolored urine.

**Musculoskeletal:** Pt denies any changes in ROM. Denies joint pain, stiffness, or weakness.

**Neurologic:** Denies decreased LOC and confusion.

**Mental Health:** Pt denies current mood changes, suicidal thoughts, depression, and anxiety.

**(O)bjective Data**

**Vital signs**:   Temp: 99.1 method: oral HR: 79   RR:18 BP: 128/62 SP02: 97% RA Pain scale: 0 out of 10   BMI: 23.75      HT: 6’1      WT: 180

 **General:** Well developed. Well nourished.

**Mental Status:** A&O x3. Appropriate attention and cognition intact.

**Skin:** Dry, Smooth, and tan in color. Appropriate for ethnicity.

**HEENT:** Head: Normocephalic and symmetrical. Eyes: PERRLA. Ears: Symmetrical, bilateral ear canals pink and clear with pearly grey tympanic membrane intact with positive light reflex. Nose: Nostrils patent no drainage noted, no pain when frontal and maxillary sinus palpated. Throat: Thyroid no goiter or tenderness upon palpation, no lymph nodes palpated.

**Chest:**  Symmetrical rise and fall. No lumps or bruises noted. No pain noted upon palpation.

**Lungs:** Respiratory rate even and unlabored. Assessment revealed regular rate and rhythm. Unilateral wheezing auscultated in the posterior right upper lobe. No adventitious lung sounds were auscultated in the left lung.

**Breasts:** N/A

**Heart & Blood Vessels:** Carotid pulses 2+ with no bruits or thrills noted. No varicose veins were noted.

**Abdomen:** Soft, flat, non-tender, non-distended. Bowel sounds normoactive x4 quadrants. Pt denies pain with superficial and deep palpation in both upper and lower quadrants. Negative McBurney’s Point.

**Genitalia:** N/A

**Lymphatics:** Preauricular, Tonsillar, Submental, Submandibular, Postauricular, Occipital, Posterior Cervical, Supraclavicular, and Axillary lymph nodes all nonpalpable, non-tender, and no masses noted.

**Musculoskeletal**: Adequate ROM. No tenderness upon palpation.

**Neurologic:** A&Ox3, PERRLA. Appropriate attention and cognition intact.

**Mental Health:** Observed appropriate mood and affect. Pt is pleasant, calm, and cooperative.

LAB Data: include results (if obtained)

Flu: Negative

Covid: Negative

Chest X-ray: Negative for pneumonia

**(A)ssessment**(List as many diagnoses as indicated)

Include ICD 10 code -<http://www.icd10data.com/ICD10CM/Codes>

1.  J22: Acute unspecified lower respiratory infection

2. R05.1: Acute cough

3. R50.9: Fever unspecified

Differentials: (this includes any diagnoses considered when forming the final diagnosis listed above)

1. Bronchitis
2. Covid
3. Pneumonia
4. Asthma
5. COPD

**(P)lan (**create an individual plan for each problem using the categories below)

**Treatment(s):**

Immunizations needed/ recommended: N/A

Nonpharmacologic symptomatic care for an illness or problem:

Pharmacologic care of an illness or problem: Write medications below in the corresponding category: (give name, strength, formulation, dose, frequency, route, duration, quantity dispensed, # refills (i.e.: Lisinopril 10 mg tablet, take one daily by mouth, **dispense # 30,** 3 RFs) Do not use abbreviations such as BID, etc.

RX Medications:

1. Doxycycline 100mg PO every 12 hours x 10 days. Dispense #20. No refills.
2. Methylprednisolone Dose Pack 4mg PO Daily x 6 days. Dispense #1 dose pack or #21 tablets. No refills.
3. Continue Albuterol Inhaler every 2-4 hours as needed for wheezing.

OTC Medications:

1. Continue OTC Tylenol 1000mg/Ibuprofen 400mg PRN for fever.

**Diagnostics/ labs**:

Medications: Doxycycline $20-$40, Methylprednisolone $8-$16

Xray: $66-$364

Covid: $30-$100

Flu: $33-$45

(Include costs of tests, medications, etc. (find resources for this at [www.epocrates.com](http://www.epocrates.com/), <https://www.healthcarebluebook.com/ui/consumerfront>; [http://www.goodrx.com](http://www.goodrx.com/) )

**Referrals:** N/A

**Follow-up instructions**: If symptoms worsen or fevers persist return to clinic.

**Patient Education:** If you miss a dose of Methylprednisolone, take it as soon as possible however if it is close to your next dose skip your missed dose and continue the dose pack do not double dose. Be sure to complete the full round of antibiotic therapy unless otherwise directed by your provider.

**Preventive care recommendations**: n/a (per USPSTF <https://www.uspreventiveservicestaskforce.org/webview/#!/> )

**Other**: include any actions not previously addressed

**Competency Reflections**

**TN Pain Competency**

Review the core competencies for pain and addiction at the website below. Identify a competency and how it was addressed while providing care for this patient [https://www.tn.gov/content/dam/tn/opioids/documents/PAME\_Report\_July2018.pdf )](https://www.tn.gov/content/dam/tn/opioids/documents/PAME_Report_July2018.pdf%E2%80%AF%29)

For this Pt the TN pain competency used was pain evaluation during his assessment the patient rated his pain a 0 on a scale of 0 to 10 on the faces pain scale rating.

**NONPF Competencies**

Discuss how you addressed at least 3 NONPF competencies during this visit. **Identify the competency area and the specific core competency for each.**  (See NONPF competency list available at     <https://cdn.ymaws.com/www.nonpf.org/resource/resmgr/competencies/20170516_NPCoreCompsContentF.pdf> )

During this visit, the 3 NONPF competencies were:

1. Critically analyzing data for improving advanced nursing practice: This competency was addressed by ensuring that all the correct information was asked and gathered at the time of this visit to be able to properly treat/manage this patient's symptoms.
2. Demonstrates leadership that uses critical and reflective thinking: This competency was addressed by collecting all the subjective and objective data and using the information gathered to reflect on any diagnosis you can rule out.
3. Applies clinical investigative skills to improve health outcomes: This competency was addressed by ordering the correct diagnostics for this patient based on the information provided.

**Interprofessional Collaboration Competencies**

Provide a brief reflection for each competency. Discuss how you addressed or would address collaboration with another member of the health care team in relation to your patient’s care. Optimally, this should be someone other than a primary care provider and reflections should be completed on different interprofessional roles throughout the program.

Interprofessional Education Collaborative. (2016).*Core Competencies for Interprofessional Collaborative Practice: 2016 update*. <https://nebula.wsimg.com/2f68a39520b03336b41038c370497473?AccessKeyId=DC06780E69ED19E2B3A5&disposition=0&alloworigin=1>

**Competency 1 Values and Ethics for Interprofessional Care (VE1, VE3, VE4, VE5)**

Discuss how cultural diversity, individual values, and interests of the health care team (including the patient) may have impacted care decisions.

Individual values and interests as well as cultural diversity did not affect this particular patient care, but could have been possible if the patient refused medications to treat the illness or testing to determine the illness.

**Competency 2 Roles/Responsibilities (RR2 & RR4)**

Recognizing your scope of practice, what elements of treatment, health promotion or disease prevention could another member of the health care team offer your patient that you can’t?

As an NP I would be able to fully assess, diagnose, and treat this patient. Prescription antibiotics and steroids were sent in by the NP for this patient's diagnosis.

**Competency 3 Interprofessional Communication (CC2 & CC3)**

What communication strategies can be used to ensure understanding of information, treatment, and care decisions between patients, families, and other health care team professionals?

 Communication strategies like patient education in the office can be very beneficial to try and help the patient understand the correct ways to take the medications and avoid any possibility of rebound sickness.

**Competency 4 Team/Teamwork (TT1, TT3. TT7, TT11)**

What principles of teamwork can be used to effectively plan, deliver, and evaluate care given to the patient?

Collaboration with the scheduling team would be indicated to ensure that the patient gets scheduled for his follow-up appointment in the appropriate time and manner.