Therapeutic drug therapy monitoring is an important clinical activity utilized by pharmacists. It is a means of broadening the multiple professional checks on drug therapy beyond the distribution system, and gives the pharmacist a share of the responsibility in maximising therapeutic drug responses and minimising undesired drug effects.

One plan of attack to therapeutic drug monitoring is via the problem-oriented approach (i.e. SOAP). This plan focuses upon the individual clinical problems and the patient's responses to the therapeutic interventions. It is a useful educational guide since it offers a consistent and concise approach to clinical problem solving. The problem-oriented approach may initially appear cumbersome and time-consuming to the novice but readily becomes a spontaneous clinical skill with practice and experience. This method forces the clinician to organise his/her thought process as he/she proceeds in the problem solving approach and eventually has to report his/her findings verbally or in writing.

The problem oriented approach consists of four steps: Data Collection, Establishment of a Problem List, SOAP of each Problem Identified and the Follow-up Monitoring/Reassessment.

1.0 DATA COLLECTION

The data base contains information which is important to most therapeutic regimens and therefore is recorded for all patients:
- name, age, sex, race, admission date (and time when important) – usually on the addressograph of the chart.
- body weight (actual BW, dosing BW and/or estimated lean BW) & height.
- chief complaint, history of present illness, past medical history.
- medication history (i.e. as per "Basic Skills in Clinical Pharmacy Practice") including prescription drugs, non prescription drugs, recreational drugs, effectiveness, side effects, compliance issues; & allergy status.
- health care providers: pharmacist, physician, family member.
- family and social history; patient goals & desires.
The problem list is simply a collection of the patient's problems. This can be done in many ways. But the two methods that have been established in the FH Residency Program are: a) the Drug Related Problem List method (as per Hepler & Strand); & b) the Medical Problem List method (which lists only the various diagnoses of the patient rather than a list of signs & symptoms) & includes medical/surgical procedures (i.e. pacemaker).

The Drug Related Problem List method identifies EIGHT types of problems:
1. An indication with no drug therapy.
2. An indication with the wrong drug selected or a duplication of therapy. (NOTE: technically these are TWO separate problems=> a) wrong drug (i.e. Docusate for pneumonia); b) duplicate therapy (two drugs with exactly the same mechanism of action. i.e. moxifloxacin & levofloxacin for pneumonia)
3. A drug with no indication
4. Too much drug.
5. Not enough drug
6. Adverse drug reaction
7. Drug Interaction (drug-disease, drug-drug; drug-food; drug-lab)
8. Compliance issues

The Medical Problem List method identifies only a set of diagnoses &/or medical/surgical procedures. Note that this is not the same as a list of signs & symptoms. It usually includes only the active acute problems; but may include the stable chronic problems if a compromise is anticipated as a result of the admission (i.e. DM with steroid administration for acute asthmatic exacerbation). The Medical Problem List used by the clinical pharmacist may be the same or partially the same as that used by other health care professionals. Some of the problems may not require drug therapy. This type of problem list is much more efficient to use when the clinical pharmacist is required to write in the chart.

During the patients' admission, either type of problem list must be kept current by addition, combination, resolution and deletion of problems.

(A problem list should be created each time that the clinician interacts with the patient.)

3.0 THE SOAP OF EACH PROBLEM IDENTIFIED

The SOAP approach format is how all of the information concerning a problem is organised and digested. Monitoring for desired and undesired effects of drug therapy is noted in this section with each SOAP component addressing a specific problem from the patient’s Medical Problem List perspective ideally. The SOAP format section of each problem is organised into Subjective and Objective data, with an Assessment of that data, and a Plan to improve the patient's outcome for that specific medical problem.

It is in this section that the pharmacist must resist the tendency to copy the physician's, nicely-organised problem-oriented notes; and remember that the main reason for the pharmacist to monitor therapy is to optimise the pharmacological treatment outcome of the patient.
The following guidelines should establish the pharmacist's drug monitoring perspective.

3.1 SUBJECTIVE DATA (S)

This is information which is expressed by the patient or family members, but may not be directly observed or measured. 1) **Signs & symptoms**: i.e. pain, nausea, dizziness, SOB; 2) **medications used & drug administration**: i.e. digoxin 0.25 mg po daily @ breakfast; 3) **drug beneficial & adverse effects**: don’t think the drug is helping & maybe reducing vision; & 4) **patient goals/desires information**: eliminate signs & symptoms & go home; wants more information on his cholesterol therapy. **These four components are an essential part of this section and should usually be mentioned.** It is helpful to sub-format this section in the following manner: PQRST (in which you describe the signs & symptoms based on this pneumonic; **P**alliative/Provocative, **Q**uality, **R**egion/Radiating, **S**everity, **T**emporal), drug administration (how was the patient actually taking the meds @ home), benefits & side effects (the actual patient’s opinion) & patient goals/desires.

3.2 OBJECTIVE DATA (O)

This is **information** (obtained by skilled health care professionals) **gained from direct observation or measurement**, and includes physical findings, laboratory data, and results of pertinent diagnostic procedures, other relevant information such as previous and current therapy (i.e. as obtained from the community pharmacist, pharmanet, medinet, hospital pharmacist) and consultant opinions (previous hospital, physician, nurse, physiotherapist, respiratory therapist, social worker, chart, etc.) may also be included. Also included are drug information (i.e. pharmacology of certain medications that may be relevant to the assessment) calculations for dosages, creatinine clearance and drug serum concentrations. It is helpful to sub-format this section in a head-to-toe approach: CNS; HEENT; CVS; RESP; GI/GU/RENAL; LIVER/SPLEEN/ENDO; FLUIDS/LYTES/HEME; MSK/EXTREM/SKIN; CURRENT MEDS; CALC/REF; HCT GOALS (The documentation/statement of the head-to-toe facts usually discloses the beneficial or lack of effects and/or adverse effects of the current therapy. **If the beneficial effects are not evident** (i.e. INR went from 1 to 2.5 while on warfarin), it may be important to state that “MD states that warfarin is effective” (if verbally provided), or “MD writes that warfarin is effective” (if written in chart). **If the lack of adverse effects are not evident** (i.e. Hgb went from 135 to 105), it may be important to state "no documented AE". Other statements that are appropriate for this section could include "two doses charted as given" and/or "serum level drawn @ 07:00 h" etc. In other words, **this section should contain the relevant objective data, or lack there of, that allows the pharmacist to establish/make a confident assessment in the next section**. Therefore, there are four essential parts to this section as well: 1) **signs & symptoms** (listed in the head-to-toe format) of disease improvement/worsening; 2) **current medications** ordered for this specific problem or related meds (i.e. warfarin for TED but ciprofloxacin is also currently ordered); & the number of medication **doses that have been administer or missed** since admission (i.e. to allow for steady state/compliance assessment determination); 3) **the presence/absence of documented medication beneficial &/or adverse effects**; & 4) **the health care team/pharmacist’s goals** for this problem.

3.3 ASSESSMENT (A)
This is your interpretation of the subjective and objective data (i.e. complaints, signs, symptoms, TBW/LBW, renal and liver function, nutritional assessment, drug effects, etc.). What are you treating? In addition, the pharmacist should assess, over time, the patient's clinical response to current therapy (pharmacologic and relevant non-pharmacologic). Also included are the potential drug-related problems such as 1) therapeutic indication without drug(s) ordered; 2) therapeutic indication with wrong medication ordered/medication duplication; 3) medication(s) ordered without an apparent indication; 4) medication dosage is too high; 5) medication dosage is too low; 6) medication induced adverse effects; 7) drug interactions and/or 8) the patient is not taking the medication as prescribed.

Succinctly, the clinical pharmacist's assessment should address, as a bare minimum, the following four components:

3.3.1 What are you treating? What is the status of the medical problem? How severe is it (mild, moderate, severe)? Is it stable, getting worse or improving in the recent past or since admission? For example: “Moderate pneumonia slightly improved since admission”.

3.3.2 Is the pharmacological therapy indicated/effective/optimal? Is this an indication with no drug? Is this the right drug for the problem? Is there a drug with no indication? Is there too much drug? Is there not enough drug? In other words, is this the optimal drug(s), dose, frequency & route to use in this patient in view of the "subjective" and "objective" information? Are there any recent inappropriate changes in therapy? I.e. digoxin dose increased from 0.125 mg to 0.25 mg daily seven days ago.

3.3.3 Is the patient experiencing any adverse effects from the current therapy? State the likely cause (which drug(s) are involved). Is the patient experiencing any compromising drug interactions? Are there any duplications in therapy?

3.3.4 Is the patient compliant with his/her current medications &/or relevant medications prior to admission? Is the patient compliant with all of the current medications in hospital as ordered? (I.e. are any doses missed due to refusal, side effects, away from ward for procedures, etc?)

3.4 PLAN (P)

This is what the pharmacist intends to do in order to optimise the pharmaceutical care of the patient.

The clinical pharmacist's plan should address whenever possible, as a minimum, the following four components:

3.4.1 What medication recommendations (i.e. medication changes) do you intend to make to the patient's physician &/or other health care professional.

3.4.2 What non-medication recommendations do you intend to make to the patient's physician &/or other health care professional.

3.4.3 What do you plan to monitor in order to improve upon, maintain or ensure optimal beneficial therapeutic effects and minimise any possible side effects. Do not reproduce the CPS monograph here. Consider the signs & symptoms that your patient actually
has; as well as, minimally, the top three potential adverse effects of the medications involved.

3.4.4 **What topics**, if any, do you plan to counsel the patient on in order to improve their compliance & ensure the success of the therapy.

Obviously, the pharmacist writing the Clinical Pharmacy Note (CPN) must know what subjective and objective findings to look for; and how to interpret them before he/she can assess the situation or formulate any plans. This is, at the same time, the difficulty and the beauty of the problem-oriented approach - there is no place to put irrelevant information, and one cannot proceed without understanding the clinical problem.

**4.0 FOLLOW-UP MONITORING/REASSESSMENT**

Ideally, the follow-up notes should account for every initiation or change in drug therapy that the patient receives; and/or change in problem status. It should also document each recommendation made by the pharmacist. By definition, the follow-up notes tend to be much more précis in content; as they are only reflective of the recent changes in the patient's status since the last pharmacist's assessment.

**SAMPLE CLINICAL PHARMACY NOTE**

(An elaborate example of a complicated case outlining the format that may be used in a verbal presentation or Clinical Pharmacy Note i.e. if the physician wrote the following order: "Pharmacist to see re medication assessment/review"; or "Pharmacy consult")

3-Aug-10 (11:00 h)    Clinical Pharmacy Note: re drug review

H.G. is a 75 yo 5’4” 135 lb oriental male admitted 1 Aug 10 @ 01:00 h.  *(NOTE: If you were writing on an addressographed page, this line would change to “5’4” 135 lb oriental admitted @ 01:00 h” as the other information is contained in the addressograph. One of the keys to efficiency is to avoid redundancy.)*

C/C (Chief Complaint)  
- poor memory, lethargy and confused  
- increased nausea, vomiting, loss of appetite  
- seeing and feeling funny things *(NOTE: This is just a list; with no qualification of the information. It is what the patient/information source actually says.)*

HPI (History of Present Illness):  
This man is well known to RCH and had been seen by the writer on 21/Jul/10 in the renal clinic. At that time it was discovered that a random digoxin level drawn on 17/Jul/10 was reported to be 3.1 ng/ml. The patient and his daughter was given a new prescription and instructed according to the chart to decrease his dose of digoxin from 0.125 mg po daily to 0.125 mg po every other day. In addition, @ the end of the clinic visit (21/Jul/10) the patient was instructed to stop taking the drug until further notice and another random digoxin serum level was drawn two days later. This serum level turned out to be 2.2 ng/ml (23/Jul/10). The patient was then instructed to hold the drug for another two days, then to take 0.125 mg po every other day. However, according to the daughter, the new prescription was never taken to the pharmacy. The old prescription was simply refilled and its directions instructed the patient to take 0.125 mg digoxin po daily. The patient's state at home apparently worsened a few days PTA and was brought to RCH via car by his daughter with the above chief complaints.

PMH (Past Medical History):

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1. CRF x 4 y
2. Hemodialysis M, W, F x 3 1/2 y
3. Chronic anaemia x 3 y
4. CHF x 3 y
5. Hypertension x 15 y
6. TUPR 1975
7. Rectal Ca--> resected--> colostomy 1985
8. Degenerative Joint Disease/Cervical spondylosis x 25 y

MPTA (Medications Prior to Admission):
- digoxin 0.125 mg po daily x 3 y
- multivitamins i po daily x 3 y
- Folic acid 5 mg po daily x 3 y
- NaHCO3 650 mg po TID x 3 y
- FeSO4 325 mg po daily x 2 y
- CaCO3 1250 mg po QID x 3 y
- Calcitriol 0.25 mg po daily x 3 y
- Kayexalate 15 g on non-dialysis days po x 3 y
- Quinine 300 mg po prn leg cramps x 2 y
- Nandrolone decanoate 200 mg IM once weekly x 1 y
- Amphogel 30 ml po QID x 3 y
- Docusate Sodium 100 mg po BID x 3 y

ALL (Allergy) NKDA (No Known Drug Allergies)

FH (Family History):
- wife dead x 10 y; father had bad kidneys;
- daughter is bartender and owns her own bar; daughter away at job most of day;

SH (Social History):
- C: 3 cups coffee daily;
- A: 1 oz Wine with supper;
- S: smokes PPD;
- E: no exercise routine; minimum ADL;
- L: lives with only daughter who is responsible for care (dialysis and medication administration);
- O: retired trucker;
- A: daughter administers/organizes meds
- D: poor diet - 1000 cal/day; (NOTE: CASE LOAD pneumonic)

MPL (Medical Problem List): OR
1. CHF
2. Anaemia
3. CRF
4. Constipation NYD

DRPL (Drug Related Problem List):
1. Adverse effect to digoxin that requires reassessment of drug therapy.
2. Indication & no drug: Patient is hypoxic & requires optimization of drug therapy.
3. Dose too low: Hyperkalemia that requires reassessment of drug therapy.
4. Dose too high: Hypercalcemia that requires reassessment of drug therapy.
5. Hypermagnesemia that requires reassessment of drug therapy.
6. Etc...
(Notice that the DRPL can be very extensive & result in many more SOAPS & a greater potential for redundancy.)
Problem # 1: CHF

S: Poor historian;
P: takes digoxin (yellow tab) every day at home; thinks it's helping; denies that the drug is causing any bad effects; "eating makes me feel sicker"
Q: "I was seeing things"..."don't feel to eat"; "poor memory"; no dyspnea; no orthopnea; no PND.
R: "sick to my stomach"
S: feeling much better; Denies any hallucinations now; denies any nausea now; the daughter also described how her father had been getting increasingly lethargic, anorexic, and hallucinatory over the past few months.
T: since admission; has "not refused any meds" in RCH; but cant remember if he received digoxin since his arrival;
- patient just wants to go back home.

O: The daughter demonstrated a very poor attitude towards her father's care. This writer got the impression that she felt that it was bad enough that she had to do the hemodialysis every other day; how could she be expected to make sure that the father takes all of his meds correctly when she's got to go to work as well.
CNS: mildly confused; no hallucinations; O x 2; GCS= 15; T= 37.3
HEENT: wnl (within normal limits)
CVS: 1/8 BP=128/70; Pulse=72; 2/8 BP=110-120/84-90; Pulse=80; No EKG done
RESP: R= 15; clear; O2 sat= 84% ORA; no rales; no CXR done
GI/GU/RENA: no vomiting or diarrhea documented;
renal function = see problem #3
LIVER/SPLEEN/ENDO: no ascites LFT= not done
FLUIDS/LYTES/HEME: 1/8 Dig= 3.0; K=6.1; Ca=3.5; Mg=1.5
2/8 Ca=2.7
2/8 K=5.4
2/8 hemodialysis
3/8 Digoxin level = 1.6
MSK/EXTREM/SKIN: foot edema +1; wt=60 kg

no digoxin ordered since admission
HCT: no confusion; O x 4; O2 sat> 90% ORA; target digoxin= 0.9; Ca= 2.3; Mg= 1; K= 4; wt=59 kg

A: 1. Mild CHF much improved since admission.
2. Agree with holding digoxin therapy
3. Digoxin was causing side effects but improved since admission.
4. Poor Compliance at home. Compliant in hospital.

P: 1. Continue to hold digoxin dose. Redo digoxin level pre next dialysis.
2. Restrict fluid intake to 1 L/day.
3. Monitor mental status & weight daily.
4. Discuss the importance of medication compliance with the patient and his daughter.
5. Educate the patient and his daughter re the signs of digoxin side effects.
6. Phone the community pharmacy and inform them of the current situation.

Problem # 2: Anaemia

S: Feels lethargic & weak all over: rated 5/10; felt this way for months now; Vitamins & iron i tab of each taken daily qam; no apparent effect noticed; no SE; daughter not sure if these meds are taken regularly; pt says he takes these meds as instructed ???; GP administers Nandrolone "one shot weekly"; not sure

| HCT: no confusion; O x 4; O2 sat> 90% ORA; target digoxin= 0.9; Ca= 2.3; Mg= 1; K= 4; wt=59 kg | A: 1. Mild CHF much improved since admission. 2. Agree with holding digoxin therapy 3. Digoxin was causing side effects but improved since admission. 4. Poor Compliance at home. Compliant in hospital. |
of its effects; denies any SE; goes to GP whenever the office calls re need for dose. Pt just wants to have some energy to do things.

**O:** FLUIDS/LYTES/HEME:
1/8 WBC=9.3; Hgb=59; PCV=0.18; Plts=308
2/8 ferritin = 300
2/8 WBC=5.9; Hgb=64; PCV=0.20; Plts=331
3/8 transfused: 2 UWB (units whole blood)
3/8 WBC=7.2; Hgb=85; PCV=0.26; Plts=298

B12 and folic acid levels pending
MCV and MCH are wnl

**current meds:** Life multivitamins i po daily; 3 doses given;
Folic acid 5 mg po daily; 3 doses;
FeSO4 325 mg po daily; 3 doses;
Nandrolone decanoate 200 mg IM once weekly-nil dose to date;
no benefits or SE documented;
all doses charted as given/prescribed.

**HCT:** Hgb > 90; PCV > 0.30; N => B12 & folate

**A:**
1. Moderately severe anaemia due to CRF; Mechanical breakdown of cells; Blood loss; Slight improvement since admission.
2. Agree with current therapy pending labs.
3. No adverse effects reported. No DI or TD
4. Questionable compliance at home; Compliant in hospital.

**P:**
1. Discuss the dose of FeSO4 with patient (i.e. possible intolerance) and MD. Consider increasing FeSO4 dose to 325 mg po TID.
2. Continue to administer folic acid daily. Adjust dose based on folic acid level (pending).
3. Continue to administer multivitamins.
4. Continue to administer Nandrolone decanoate in view of anaemic state.
5. Encourage a balanced renal diet.
7. Counsel patient on the importance of these agents for his anaemia therapy; & to ensure compliance.

**Problem # 3: Renal Failure**

**S:** According to the daughter, the patient was not eating or drinking very much; and is not drinking the amphogel; she could not comment on the efficacy of these meds; & denies any perceived SE even when asked if the taste of the amphogel or constipation were problems.

**O:** FLUID/LYTES/HEME:
1/8 Na=132; K=6.1; Cl=96; HCO3=20;
   Cr=1671 (Cal CrCl=2.9); Ca=3.5; PO4=3.15
2/8 Ca=2.7; PO4=1.9
3/8 Na=133; K=4.4; Cl=97; HCO3=23; Cr=1220 (Cal CrCl=3.9); (? PTH level)

hemodialysis received on : 2/8 (patient has own home unit)
current meds: NaHCO3 650 mg po TID; 9 doses
                 CaCO3 1250 mg po QID; 10 doses
                 Calcitriol 0.25 mg po daily; 3 doses
                 Kayexalate 15 g on non-dialysis days po; 1 dose

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Quinine 300 mg po prn leg cramps; 0 dose
Amphogel 30 ml po TID; 7 doses
all regular doses charted as given/prescribed
HCT: N => lytes, Ca, PO4; Cr < 1250

A:
1. Chronic severe renal failure. Renal indices slightly improved since admission.
2. Agree with present therapy.
3. Hypercalcemic & hyperphosphatemia with decreased 1,23-dihydroxycholecalciferol production by the kidney. No DI or TD
4. Non-compliant with aluminum prep PTA. Compliant since admission.

P:
1. If the patient finds the amphogel unpalatable and can't tolerate large volumes of fluid (i.e. dilute the amphogel in favourite beverage) would suggest using alu-tabs to control [PO4].
2. Continue: NaHCO3 to control metabolic acidosis of CRF; CaCO3 and calcitriol to control [Ca]; Kayexalate to control [K].
4. Continue to monitor lytes, BUN, Cr, Ca, PO4
5. Will counsel patient and daughter re use of quinine and its relationship to [Ca].

Problem #4: Constipation NYD

S:
P: cheese tends to constipate; Docusate I cap taken very irregularly at home; “does not work”; no bad effects; uses phenolphthalein “one square” 2-3/week; works but tends to cause diarrhea; has also used 30 - 60 mL mineral oil po bid with good effect but hates the taste (not used for months);
Q: poor ambulation at home; poor appetite as above; ? 500 mL fluid daily;
R: abdomen feels bloated
S: c/o hard stool per colostomy bag
T: usually 2-3 BMs/week; last BM PTA

O: Confirmed => RN note; bedridden;
GI/Abdo: mildly distended; BS +; tympanic; nontender
Current meds: Magnolax 25 mL po daily prn x 2 doses
       Cascara 5 mL po daily prn x 2 doses
       no effect documented; no SE documented.
HCT: no abdo distension, BS +2, 3 x BM/week, soft stool

A:
1. Moderate Constipation. No improvement since admission.
2. Therapy not effective to date. No regular laxatives ordered.
3. No adverse effects. No DI or TD
4. Compliant in hospital

P:
1. Consider a regular dose of Docusate sodium of 200 mg po bid with meals.
2. Consider more fruit and fibre in the diet i.e. Fruitlax po tid; optimise the patient's fluid intake once CHF under control and improve AATI.
3. Will monitor BM habits daily.
4. Will educate the patient on the important components of good bowel hygiene.

Thank you for the opportunity of assisting in the care of this patient.

E. Dillon, PharmD
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Remember, that the above example is designed to be fairly comprehensive. One has to use professional judgement in deciding what is to be included in a note. For example, in an emergency department, the clinical pharmacist may be the first health care professional to obtain a comprehensive history from the patient or representative. Therefore, when consulted to provide a written “total” assessment of the patient (ie. “Pharmacist to see re medication assessment/review”; “Pharmacy consult”) the above example may be necessary. If the pharmacist is seeing a patient at a time where a lot of the information is already present in the chart, then aspects such as C/C, HPI, PMH, ALL, MPTA, SH, FH etc. may not necessarily be repeated. If on the other hand, the allergy status or MPTA data were not completely reported, the pharmacist may want to add this information to the chart if it is relevant. [Remember, when you are preparing for a verbal presentation or written report you may decide to read 50 references but you do not repeat all of that information in your presentation; only the information that is relevant.] If the physician only requests a consult on one aspect of pharmacotherapy i.e. "Pharmacist to see re CHF therapy", then the pharmacist should restrict his/her comments to just that problem. Therefore, the entire written consult may simply be:

3-Aug-10  Clinical Pharmacy Note: re CHF  
11:00 h

S: Poor historian …

O: .... (as above)

A: .... (as above)

P: .....inform them of the current situation.

Thank you for the opportunity of assisting in the care of this patient.

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It is also important to realise that if that information, is already contained in the chart, but is very relevant to the medical problem or drug related problem then it should be repeated for emphasis i.e. lytes, serum levels, P/E, renal/hepatic clearance data, past/current relevant medications, allergy status and so on.

It goes without saying that if you were following this patient throughout his stay in the hospital, that subsequent CPNs in the chart would be "updates"; only addressing those new aspects of drug related parameters that were relevant/significant since the last CPN/patient visit. Therefore, it is very appropriate sometimes to write only an “S” note:
Sometimes, it is most appropriate to write only an **“O” note:**

4-Aug-10  Clinical Pharmacy Note: re Pharmanet meds

**O:** Medications PTA as per Pharmanet/Medinet include:
- digoxin 0.125 mg po daily x 18 mo
- Calcitriol 0.25 mg po daily x 3 mo
- Kayexalate 15 g on non-dialysis days po x 18 mo
- Nandrolone decanoate 200 mg IM once weekly x 1 y

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Sometimes, it may be most appropriate to write only an **“OP” note:**

5-Aug-10  Clinical Pharmacy Note: re CHF/Digoxin levels

**O:** Fluids/lytes/heme: digoxin level = 1.1; Cr= 1140 mcM/L
Current meds: Digoxin still on hold

**P:** Continue to hold digoxin

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Sometimes, it may be appropriate to write any other permutation of the SOAP note i.e. an **“SA” note;** an **“OAP” note;** an **“OA” note** etc.
The key is to maintain the format for all of your notes so that the reader can effectively extract the information that is needed. Can you imagine trying to locate information from a journal article if the manuscript was not formatted; or from the CPS if the CPS was not consistently formatted?

This is not an easy skill to learn. Any more than it is easy to deliver an outstanding verbal presentation or write an award winning manuscript. One cannot expect to read this document and be an expert at writing Clinical Pharmacy Notes. The skill is acquired with practice and discussion and feedback. It will take the average resident in FH 2-3 months of deliberate application to master this aspect of practice. So if you are only exposed to this approach for one month, do not be too hard on yourself. It will be your responsibility when you are faced with these opportunities to approach your rotation preceptor &/or Dr. Dillon (PC rotation & Resident seminars) to discuss any possible CPNs before they are entered into the chart.