The Chirurgeon Incident Report SOAP note

Documentation of patient care is often not the strong point of a first aid training program that is already trying to squeeze in more topics than time allows. Most rescuers don't get much practice at writing patient reports until they are actually thrown to the lions taking care of real patients.

Previous Chirurgeon reports have been largely based on ambulance run sheets. These often contain areas for documenting activities that will rarely be performed, making the form inefficient and less than optimal for the typical SCA event.

In order to improve the quality of documentation in the Chirurgeonate, I have adapted a form developed by the Wilderness Medical Associates using the universal SOAP note format. This form is flexible enough to be used for minor problems that need a short write-up on up to major problems that will be transported off-site.

SOAP is an acronym for ***S***ubjective, ***O***bjective, ***A***ssessment, and ***P***lan. It was first proposed in 1969 by Dr. Larry Weed. He felt medical documentation would be more complete and easier to follow if it were organized in a problem-oriented fashion. Since then it has become the standard method of documenting patient care visits in the medical and allied health care fields.

Wilderness Medical Associates (www.wildmed.com) teach a variety of courses such as Wilderness First Aid, Wilderness Advanced First Aid, Wilderness First Responder, Wilderness EMT, and Wilderness Advanced Life Support. These are all wonderful courses for the Chirurgeon as they deal with handling problems in a remote area while relying on improvised materials. They have been conducting wilderness training since 1978 and therefore have a lot of field experience that has been applied to their methods and materials.

Using the form

Scene. This is where you'd record information regarding the surroundings of the victim such as area found, temperature, conditions. This could be very simple such as "List field, temperature upper 90s and humid" to detailed description of events "fighter was along a ridge, tripped backwards over tree root, fell 15 feet into gully landing on dirt."

***S*ubjective:** This section deals with what the patient tells you. It has prompts to help you obtain a complete "**SAMPLE**" history

- ***S***ymptoms: What the patient is telling you they are feeling. This is best recorded by putting exactly what the patient said in quotes and then any additional comments on what they have said is wrong.
- ***A***llergies: Medication allergies, known food and environmental allergies.
- ***M***edications: Any current or chronic medications the patient is taking currently. Don't forget to ask about nutritional supplements, over the counter meds, and birth control pills. This section may need to be continued on the back or attached on a separate piece of paper.

Past History: Significant medical conditions such as diabetes, or hypertension.

Last Meal: When they last ate or drank. This is important if they would need surgery, but can also give you a clue that they may well be hypoglycemic or dehydrated.

Events: What happened that lead up to their condition. Quoted statements are good here, too. "I got busy with judging A&S and never got around to eating even though I took my normal insulin dose."

***O*bjective:** This is what you see, i.e., your exam. The findings from the primary and secondary surveys are recorded here. The lower part of the *Objective* section contains areas for vitals and a body diagram to mark injuries. Note that besides the normal BP, pulse and respirations, there is also room to note skin (color, wet/dry), temperature (important for exposure injuries but not commonly done in the SCA setting), and AVPU.

AVPU is YAA (***Y***et ***A***nother ***A***cronym) which stands for ***A***lert, ***V***erbal, ***P***ainful, ***U***nresponsive. It is a simple way of recording the mental status of the patient. If they are alert and responsive, code them as ***A***. If they are drifting in and out, but will open their eyes and look at you when you talk to them, they are "responsive to verbal stimuli" and are coded as ***V***. If it takes a sternal rub or they only wake up when their broken arm is moved, then they are "responsive to pain" and get a ***P***. Otherwise, they are ***U***nresponsive.

The back of the form is the ***A***ssessment and ***P***lan section. The left hand column is where you put your problem list – what you think is wrong based on the mechanism of injury and your history and primary and secondary surveys. This doesn't mean you need to try to come up with definitive diagnoses ("fractured proximal 5th metacarpal of the left hand"; "appendicitis"), but rather what you know at the time ("tenderness, swelling, and deformity of the left hand"; "abdominal pain"). The middle column (***A'***) is things you can foresee or are worried about based on what you're seeing now (a patient with an ***A*** of *pain and swelling in femur* should probably have an ***A'*** of *shock*).

The rightmost column is for your treatment ***P***lan. This records what you did for the patient ("splinted L hand with rolled up-Chirurgeon forms", "Called EMS via 911. Patient transported by MVAS to local hospital.")

The bottom gives room to put in any overflow information as well as injury category and complete patient name and address. Make sure the treating Chirurgeon(s) sign the form (legal name, please).