SOAP Case Study - Stroke

Experiment 10 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional stroke case.

Principle

SOAP separates subjective history (S), objective information (O), assessment (A) and plan (P). A pharmacy case report links medicine-related problems, authorised actions, monitoring and counselling.

Fictional Case and SOAP Guide

Section	Model teaching content
S - history	A fictional 70-year-old develops sudden facial droop, arm weakness and speech difficulty.
O - supplied findings	Family gives a last-known-well time of 10:00; current time is 10:30. Imaging and glucose assessment are not yet available.
A - assessment	The presentation is a simulated time-critical suspected stroke; bleeding versus ischaemia must be assessed clinically.
P - professional plan	Activate the emergency stroke pathway, report last-known-well and medicines; defer oral intake until swallowing is assessed and do not choose antithrombotics before the team assessment.

Counselling and Monitoring

Counselling

After stabilisation, discuss the authorised secondary-prevention and rehabilitation plan.

Monitoring

Team-directed neurological status, swallowing, functional recovery and medicine safety.

Urgent Review

Any new focal neurological deficit is an emergency even if it improves.

Key Points

- All case details below are hypothetical teaching data.
- Separate known information from missing information that must be confirmed.
- Prioritise urgent problems before routine medicine optimisation.
- The plan documents professional review; it does not issue a new prescription.

Practice Scenario

Original fictional case for discussion only.

Activity Procedure

1. Extract S and O

Read the history and report; identify missing symptoms, medicines, allergies and patient factors.

2. Assess

List the main problem, possible medicine-related issue and supporting evidence.

3. Prioritise

Check emergency/referral needs before routine counselling.

4. Plan

State the authorised review, counselling and monitoring steps.

5. Write

Complete the blank SOAP record and a concise handover using the model guide.

Record and Observations

SOAP field	Student record
S - subjective history	_____
O - objective information	_____
A - assessment / priorities	_____
P - actions / review	_____
Monitoring / follow-up	_____

Result

Complete the record using your activity, then state the findings, the action required and the reason for that action.

Precautions

- Do not represent the case as a real patient record.
- Do not invent missing test results or medication doses.

Viva Questions and Answers

1. What belongs in S?

The person's reported symptoms, concerns and relevant history.

2. What belongs in O?

Measured or documented findings such as examination and laboratory reports.

3. What makes a plan useful?

A clear action, responsible professional, monitoring and review timing.

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