SOAP Case Study - Angina

Experiment 2 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional angina 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 60-year-old with diagnosed stable angina describes usual exertional discomfort but asks about a newly different episode.
O - supplied findings	A supplied cardiology record documents previous stable disease; current symptom duration and response to the prescribed plan are unknown.
A - assessment	A changed chest-pain pattern can represent acute coronary disease and cannot be assumed to be routine stable angina.
P - professional plan	Assess immediate symptoms and activate urgent/emergency evaluation for ongoing, new or worsening pain; use the existing clinician-approved emergency plan.

Counselling and Monitoring

Counselling

Explain adherence, risk-factor management and knowing the prescribed emergency instructions.

Monitoring

Episode pattern, functional capacity, adherence and medicine adverse effects after clinical review.

Urgent Review

New, prolonged or rest pain, sweating, collapse or breathing difficulty.

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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