SOAP Case Study - Rheumatoid Arthritis

Experiment 5 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional rheumatoid arthritis 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 42-year-old has inflammatory joint disease and is uncertain about the weekly methotrexate day.
O - supplied findings	Supplied treatment record lists methotrexate, a prescribed folic-acid plan and scheduled blood monitoring.
A - assessment	A high-risk administration misunderstanding may coexist with inadequately controlled symptoms.
P - professional plan	Confirm weekly dose/day and tablet strength with the authorised record; arrange review of disease control and monitoring.

Counselling and Monitoring

Counselling

Use teach-back of the weekly schedule and distinguish DMARD purpose from short-term pain relief.

Monitoring

Blood counts, liver/renal tests and infection or other adverse-effect symptoms according to the prescribed plan.

Urgent Review

Any daily-versus-weekly dosing error, severe infection symptoms or concerning toxicity needs urgent advice.

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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