SOAP Case Study - Asthma

Experiment 6 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional asthma 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 19-year-old reports night symptoms and difficulty coordinating a metered-dose inhaler.
O - supplied findings	Supplied record shows repeated reliever use; technique and prescribed controller plan need review.
A - assessment	Poor technique and/or treatment adherence may contribute to poor control; acute distress must be screened.
P - professional plan	Review the exact inhaler regimen with the care team, correct technique and confirm an individual action plan.

Counselling and Monitoring

Counselling

Demonstrate the device, compatible spacer when indicated and product-specific after-use care.

Monitoring

Symptoms, night waking, reliever pattern, technique and prescribed lung-function follow-up.

Urgent Review

Severe breathing difficulty, inability to speak normally, exhaustion or poor response to the emergency plan.

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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