SOAP Case Study - Chronic Obstructive Pulmonary Disease

Experiment 7 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional chronic obstructive pulmonary disease 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 67-year-old has diagnosed COPD, continues smoking and describes worsening breathlessness.
O - supplied findings	Supplied spirometry report documents persistent airflow obstruction; current oxygen saturation and infection features need clinical assessment.
A - assessment	Assess whether this represents baseline limitation or an exacerbation; COPD diagnosis and severity use appropriate spirometric/clinical review.
P - professional plan	Arrange assessment of deterioration; review prescribed bronchodilator devices, cessation support and rehabilitation plan.

Counselling and Monitoring

Counselling

Demonstrate the exact inhaler and discuss avoiding smoke exposure and the prescribed preventive plan.

Monitoring

Symptoms, exacerbation history, device technique and clinician-directed oxygen/therapy monitoring.

Urgent Review

Severe breathlessness, cyanosis, confusion or acute deterioration.

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.

First Hope

COMPLETE NOTES

Click here to visit our website

PHARMACY PRACTICAL NOTES

Complete subject and semesters are available on FirstHope app only.

Scan or click here

Click here to get the app >

Available on Google Play

JOIN THE FIRSTHOPE COMMUNITY

Join our Telegram channel

Click here to join Telegram >

Scan or click here

@FirstHopeNotes

Instagram

@firsthope.official

Click here to follow >

YouTube channel

FirstHope-Pharmacy / Live streams

Click here to watch >

WhatsApp channel

Follow FirstHope on WhatsApp

Click here to join >

FirstHope website

firsthope.co.in

Click here to visit >

B.Pharm / D.Pharm / M.Pharm / Pharm.D

Complete subjects and semesters are available in the FirstHope app.