**RSPT 1167**
**GUIDELINES FOR COMPLETING THERAPY EVALUATIONS**

The following guidelines are intended to assist you in completing the Therapy Evaluations required in RSPT 1167. The guidelines are brief by design. The intention is that you will use all clinical information at your disposal to evaluate each patient's therapy individually and independently.

***DIAGNOSIS/TREATMENT***

- Admitting Dx - why was pt admitted? Chief complaint
- RC Dx - why is pt on therapy? Chief resp. complaint -- admitting Dx and RC Dx may be the same
- Therapy ordered/Dates started - list all therapy pt is receiving - write as ordered

***CHART DATA***

- Vital signs - obtain HR, RR & BP yourself, if possible - Temp may be obtained from chart
- WBC - obtain from Lab section in chart - use most recent
- CXR - obtain from Radiology section in chart - list most recent first
- Sputum C &S - obtain from Lab section in chart - use most recent - use Medication section in chart to identify antibiotic started - verify its appropriateness using PDR
- ABG - obtain from RC or Lab section in chart - list most recent first

***THERAPY OBJECTIVES***

Determine by using information from chart to include all of the above plus physician's progress notes, RC progress notes, nurses' notes and your knowledge of the therapy modalities. Be prepared to explain your choices and make sure your objectives make sense. -- Ex. - $O_2$ therapy alone cannot improve distribution of ventilation

***STUDENT ASSESSMENT OF PATIENT***

We will use an abbreviated form of the Weed system which utilizes comments from the patient concerning his condition. We will apply the system primarily to the RC Dx. The Weed system has four portions: 1) Subjective, 2) Objective, 3) Assessment and 4) Plan. This format is known by the acronym S-O-A-P.

See attachment for additional information.

***STUDENT EVALUATION OF THERAPY***

To complete this section, pull together *all* information from chart, pt comments and your personal exposure to pt to evaluate appropriateness of therapy

- Choice one indicates no changes needed.
- Choice two requires that you describe your recommended changes the next section.
- Choice three requires that you check why therapy is inappropriate and describe your recommended changes the next section

***RECOMMENDED CHANGES IN THERAPY REGIMEN***

This section is to be filled in according to evaluation in previous section. You can choose to make no changes, add, alter or delete a modality. Be specific in your recommendations, i.e. instead of “increase therapy,” write “increase SVN treatments from qid to q3hr.”

***JUSTIFICATION FOR CHANGES***

Give a short narrative as to why you think your recommended changes are necessary and what you expect the outcomes will be

**SOAP CHARTING (SUBJECTIVE, OBJECTIVE, ASSESSMENT, PLAN)**

SOAP charting is used as an effective means of ensuring complete and adequate charting. SOAP charting is also called the problem oriented medical record (POMR). The four parts of POMR include: database, problem list, plan, and progress notes. The database contains routine information about the patient such as the history and physical. The problem list is the subjective and objective problems the patient is experiencing, followed by the plan of treatment and the progress noted during treatment.

Respiratory Care Practitioners in healthcare facilities with active Therapist Driven Protocols (TDP’s) or Patient Driven

Protocols (PDP's) frequently use SOAP charting for their patient evaluation process. The components of SOAP charting are described below:

**S) Subjective** - Subjective assessment is described as: What the patient feels. Of ones feelings, rather than facts, that which takes place within an individual's mind and unaffected by the outside world. Basically the patient gives their opinion on what he or she feels. The patient's relatives, or significant other can also give subjective data if the patient is unable to communicate, based on what the patient previously told them.

**O) Objective** - Objective data is described as: Real or actual, not subjective, without bias, have, or having to do with a material object as distinguished from a mental concept, idea, or belief. Objective data is observable and/or measurable, such as vital signs, spirometry data, arterial blood gases, pulse oximetry SpO2, laboratory values, breath sounds, strength of cough, sputum characteristics, and other test results.

**A) Assessment** – An assessment is a thorough evaluation of the patient's condition. The healthcare professional evaluates all of the pertinent subjective and objective data and writes an assessment. Examples are: Bronchospasms, excessive secretions, infiltrates, atelectasis, consolidation, pneumothorax, pneumonia, hypoxemia, metabolic acidosis, ventilatory failure. At times, the assessment may be a continuation, improvement, or worsening of a current condition.

**P) Plan** - The plan of care is a detailed schematic outline for the accomplishment of a goal. The respiratory care plan may include: oxygen therapy, bronchodilator therapy, bronchial hygiene, hyperinflation therapy, or mechanical ventilation. The plan can also entail a change in the current therapy, addition of a therapy, or discontinuance of a therapy.

Respiratory Care SOAP Charting Samples

**Case #1:**
**S)** Patient states “I feel tightness in my chest and I can’t catch my breath. I used my albuterol MDI 3 times today and it didn’t help”.
**O)** Patient is a 30-year-old asthmatic presenting to the ER. Patient is on corticosteroid inhalers daily at home, and has an albuterol MDI for PRN use. Patient is awake, alert and oriented. Auscultation reveals tight inspiratory and expiratory wheezing. No accessory use of respiratory muscles noted. Heart rate 98. Respiratory rate 24/minute. Blood Pressure 140/84. Pulse oximetry on room air is 92%. ABGs reveal respiratory alkalosis. No other laboratory reports are available.
**A)** Bronchospasms/asthmatic exacerbation. Based on $SpO_2$ and ABGs, patient is not hypoxemic – alkalosis is most probably due to increased respiratory rate.
**P)** Bronchodilator therapy with 1.25 mg Xopenex/0.5 mg Atrovent/NS. Measure peak flows pre and post bronchodilator therapy. IV aminophylline (per nursing). Monitor pulse oximetry to evaluate oxygenation. Monitor progress closely and re-evaluate for additional bronchodilator therapy.

**Case #2:**
**S)** Patient states “I feel so congested in my chest but I can’t cough it up”.
**O)** Auscultation reveals coarse rhonchi in the upper airways. Chest x-ray reveals bilateral infiltrates in the upper airways. CBC normal. ABG normal. $SpO_2$ 95% on room air.
**A)** Infiltrates on CXR suggest secretions in large airways.
**P)** Bronchial hygiene therapy to assist in mobilizing and clearing secretions. Vibratory PEP therapy QID. Instruct patient in effective cough techniques.

**Case #3:**
**S)** A 40-year-old male patient states “I feel short of breath since yesterday”.
**O)** Bilateral breath sounds are clear. Chest x-ray done today is clear. Pulse oximetry on room air is 89%. Heart rate 105.
**A)** Patient condition has deteriorated since admission. $SpO_2$ reveals hypoxemia, SOB has increased.
**P)** Oxygen therapy via nasal cannula and titrate to maintain saturation greater than 92%. Monitor oxygen saturation. Arterial blood gases to better assess oxygenation, ventilation, and acid-base balance.