

SOAP Case Study - Hypertension

Experiment 1 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To prepare a structured assessment and care-plan record for a fictional hypertension 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 52-year-old reports irregular use of the prescribed antihypertensive and no current symptoms.
O - supplied findings	Supplied seated readings on separate visits: 150/94 and 152/92 mmHg; medicine and renal/electrolyte details need confirmation.
A - assessment	The supplied pattern suggests above-target blood pressure with an adherence problem; review measurement quality and patient-specific goals.
P - professional plan	Confirm the actual prescription and barriers; arrange clinician review of repeated readings, relevant tests and the long-term plan.

Counselling and Monitoring

Counselling

Explain regular prescribed use, correct measurement, feasible activity and reduced excess salt.

Monitoring

Repeated BP, adherence, symptoms and drug-specific renal/electrolyte checks.

Urgent Review

Chest pain, severe breathlessness, acute neurological symptoms or other signs of an acute emergency.

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.

Pharmacotherapeutics

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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