Inpatient daily note:

The SOAP note format is the easiest and probably most widely used progress note.

S: Subjective: What the patient (parent or nurse) states about the time from the previous progress note. Try to put it in the patient's own words. This section should be short.

O: Objective: This is all of the information that is recorded by the nursing staff, tests that have occurred, interpretations of consults that have occurred, the physical examination, interpretations of radiographs, ECG, EEG's etc. Basically all of the information that you will use to develop an assessment and describe a treatment plan.

A: Assessment: Here is where you synthesize all of the information from the subjective and objective sections into a problem list or differential diagnosis. ALL abnormal results should be explained to document that you have realized that the results are abnormal.

P: Plan: The treatment plan. It is easier for most people to think of this in terms of organ systems. If an abnormality exists the plan of action must be detailed here. It is acceptable to write "clinical observation to continue", but even with this statement another clinician can determine that you identified a problem, thought about it and have developed a strategy to deal with it. Usually start with the organ system that is involved with the main diagnosis. Then add all of the rest. You should definitely address the following organ systems on all admissions: Respiratory, Cardiovascular, Fluids/Electrolytes/Nutrition (FEN/GI), Neurological, Infectious Disease and Social. These organ systems are directly involved in the vital signs and the orders given to the nurses. The other organ systems can be entered as they are needed.

Sign your notes LEGIBLY and put your pager number after your signature.