Documenting the Nutritional Care Plan

1. What are the four parts of a SOAP note?
   - S: subjective
   - O: objective
   - A: assessment
   - P: plan

2. What information should be in each part of a SOAP note?

   - S: subjective
     - Information provided by patient, family, or significant other
     - Significant nutritional history
     - Pertinent socioeconomic, cultural info
     - Level of physical activity
     - Current dietary intake (in terms of nutrients)
   - O: objective
     - Factual, reproducible observations (i.e. anthropometric and lab data)
     - Ht., wt., wt. gain patterns, age.
     - Desirable wt. or realistic goal.
     - Pertinent lab data.
     - Diet order.
     - Pertinent meds.
     - Calculation of nutrient needs
   - A: assessment
     - Interpretation of pt's status based on subjective and objective data.
     - Eval. of nut. hx as it pertains to medical condition.
     - Assessment of lab data as they apply to nuthydration status.
     - Assessment of pt's comprehension and motivation, if appropriate.
     - Assessment of diet order and/or feeding modality.
     - Antidcipated problems and/or difficulties for pt. compliance/adherence.
   - P: plan
     - Diagnostic studies needed.
     - Suggestions for gaining further pertinent data.
     - Further work-up, data gathering, consultations, etc.
     - Medical nutrition therapy goal.
     - Recomm. for nut. care.
     - Referrals to other health care providers.