Case Study Format

(MUST BE TYPED)

1. The case study must have a separate title page with the following information:
   - Student’s name
   - Hospital & Unit
   - Date of Admission
   This counts for 5 points

2. The body of the case study should include the following information:
   - Family & Social History — i.e., patient’s family medical history like heart diseases, COPD, smokers, diabetics. Does the patient have an active relationship with family.
   This counts for 5 points

   - Patient’s Medical History — Healthy, active, medications, surgery, age, weight, illnesses, etc. Try to illustrate the overall condition on the patient prior to being admitted to hospital. I.e., “This is a healthy, active 34 year old white male with history of heart surgeries.”
   This counts for 10 points

   - Patient’s Current Illness or Problem — Include a good illustration of the patient’s current medical condition. Include your feelings about the patient’s condition and the disease process. Include information about treatments, therapy, surgery, and doctor orders and reasons for these courses of treatment. Include positive or negative comments in progress noted by nurses and doctors.
   This counts for 30 points

   - Prognosis — (A forecast as to the probable outcome of an attack or disease, the prospect as to recovery from a disease as indicated by the nature and symptoms of the case) Write about the prognosis of the patient from the physician’s notes. Also your assumption of this case from your observations.
   This counts for 5 points

   - Textbook Portrait of the Patient’s Disease Process — Use two different sources of studies done on patient’s disease process. Use references other than class text.
   This counts for 20 points

   - Drug Profile — Write a drug profile of all medications used in treating the patient in the hospital and on discharge.
     Include: • Drug group • Trade name • Actions • Recommended dosage & route
     • Patient’s dosage and route • Effects & side effects • why was this drug given?
   This counts for 15 points

   - Bibliography — A list of reference materials used in preparing the case study
   This counts for 10 points

3. Spelling and grammar counts. Prior to turning in your document:
   - Your document should be checked for spelling and grammatical errors
   - Your document should be proof read
Student Name

Clinical Unit: North Florida Regional Hospital Emergency Department

Clinical Date: April 25, 2006

Patient’s Date of Admission: April 22, 2006

Student’s Name:
OVERVIEW

The patient I selected for my case study is a 30 year old female who came into the ER on 04-22-06 with acute mental status changes that began around 5pm this afternoon. She was brought to the ER by two of her friends who states she has been under a lot of stress lately. They state she started acting bizarre and unusual from her normal activity and there is a chance that she could be pregnant. They also state that work has been really hard for her lately. She is in and out of verbal response and in and out of combative behavior at this time. Patient denies any CP, SOB, N/V, fever, chills, weight loss or diaphoresis.

FAMILY AND SOCIAL HISTORY

The patient is a doctor here in town and she lives with the two friends that brought her in today. She has no other family here in Gainesville, they all live overseas. The patient denies any alcohol, tobacco or drug use.

MEDICAL HISTORY

The patient denies any medical history. Her only medication she takes is birth control and she has no allergies to medications, just an allergy to eggs. The patient presented to the ER staff initially with an altered mental status, not willing to follow any commands. She had an eye flickering and was responsive to painful stimuli. She had a normal gag reflex. Her vitals were as follows: BP-155/87, pulse-108, resp.-20, SaO2-99% on RA, temp-99.4, skin warm and dry, good cap. refill and GCS-13. Patient has a clear HEENT, pupils are PERRL, trachea is midline, no JVD noted, lungs are clear, with equal chest rise and fall bilaterally, abdomen is soft and non-tender, all four extremities are good range of motion and (+) PMS, with no signs of edema. Labs were drawn and came back normal, with a negative pregnancy test and a negative drug screen. Chest X-ray was normal and the EKG showed a normal sinus rhythm with a rate of 91 and no ST/T wave changes. She was given 2 mg of Ativan which seemed to calm her down significantly.

CURRENT STATUS

It was diagnosed that the patient suffered from an acute anxiety reaction. She is now completely awake and oriented to person, place and time. She was told that she wasn’t pregnant. She able to now have a full conversation and has now explained to the doctor that she felt a lot of stress and anxiety from work that she did not know how to deal with. She denied any suicidal thoughts at this time as well. Her two friends feel that it is safe to take her home and she was told to follow up with Dr. McSwain, neurology this week. Her vitals were: BP-130/72, pulse-92, resp. 16 and SaO2 99% on RA. She was told she could return to the ER if she has any further problems.

PROGNOSIS

The patient appears to be stable at this time. She has good support at home and a good physician to follow up with. If she finds someway to reduce the stress level in her life she will have no problem recovering from this. She was told to take a couple of days off work and recover. Her prognosis will be good if she can find some way to reduce the things that cause her anxiety.
TEXTBOOK PORTRAIT: ANXIETY

Most people experience feelings of anxiety before an important event such as a big exam, business presentation, or first date. Anxiety disorders, however, are illnesses that fill people’s lives with overwhelming anxiety and fear that are chronic, unremitting, and can grow progressively worse. Tormented by panic attacks, obsessive thoughts, flashbacks of traumatic events, nightmares, or countless frightening physical symptoms, some people with anxiety disorders even become housebound. Fortunately, through research supported by the National Institute of Mental Health (NIMH), there are effective treatments that can help. Anxiety disorders, as a group, are the most common mental illness in America. More than 19 million American adults are affected by these debilitating illnesses each year. Children and adolescents can also develop anxiety disorders.

MY PATIENT’S CURRENT MEDICATIONS/DRUG PROFILE

Lorazepam (Ativan)
Group: antianxiety agent, sedative
Action Effects: Depresses the CNS, probably by potentiating GABA, a inhibitory neurotransmitter.
Recommended Dosage: 1-3mg 2-3 times daily (up to 10mg/day)
Patient’s dosage: 2mg
Side Effects: dizziness, drowsiness, lethargy, hangover, HA, blurred vision, hypotension, bradycardia, constipation and rashes.

BIBLIOGRAPHY


**THIS FORMAT IS SUGGESTED FOR EMS RUN REPORTS**

The **S.O.A.P. method**

**S**ubjective
**O**bjective
**A**ssessment
**P**lan

**S:** **SUBJECTIVE** – Includes the dispatch information, the reason you were called, the patient’s chief complaint, what the patient tells you, the history of the chief complaint, past medical history, medications, and any allergies. In summary, Subjective is what you have been told, whether by the patient, family, dispatch, or bystanders.

**O:** **OBJECTIVE** – Includes your assessment and description of the incident using the senses of sight, smell, touch, or hearing. This would include what you have found in your primary and secondary survey using percussion, auscultation, palpation, and inspection. It also includes vital signs, ECG monitoring, and pulse oximetry. In summary, Objective is what you observe.

**A:** **ASSESSMENT** – Includes the overall interpretation using subjective and objective data. Because EMS providers cannot reach a medical diagnosis, terms used may include “possible”, “suspect”, “appears”, or “rule out”. For example, one cannot say, “The patient had an acute M.I.” but could say, “The patient appears to be experiencing signs and symptoms of a possible M.I.”

**P:** **PLAN** – Includes treatments such as applying oxygen, splinting, or maintaining an airway, as well as the patient’s response to those treatments. The Plan includes treatment during transport and changes in status and disposition. For example, has the patient’s condition improved, worsened, or no change after treatment.

Learn commonly used and accepted abbreviations (don’t make up your own). Write clear and legibly – this is a time when spelling and grammar do count. While a well-written report may be one’s best defense in court, remember it is a permanent record of the care you provided for the patient. If you didn’t write it down, you didn’t do it.
Completion of a patient information run report is probably one of the most critical functions an attendant will perform. The run report is viewed by your peers, nurses, doctors, quality assurance reviewers on a local and state level, and hopefully not as frequently, by attorneys, judges, and the patient. Those who read your run report will formulate an opinion about you by your writing. In the legal sense, you will want that opinion to be both professional and positive. On a personal note, you will want respect from the patient and your peers. Use of SOAP Notes can help by providing a guiding format to better organize your thoughts. Remember you may be called upon in years to come to testify in court on a case you handled. Your notes will provide you the information you need to possibly defend yourself. Do not try to rely on memory. The SOAP Note method of patient information documentation is designed to be a systematic approach to documentation of pertinent medical information.

A description of each component of SOAP Notes, and several examples are listed below. Our use of SOAP Notes differs slightly from the true version as used in the hospital environment and provides an organized effective way for use to document information on the run report. It is the policy of the EMS Program that students complete a run report on all calls, including refusals and cancellations.

**S:** The “S” of SOAP stands for **SUBJECTIVE.** In this section, you will provide a brief statement as to how you received the call, and what the patient tells you is the problem, or why did s/he call the ambulance. This is typically a one line comment.

**O:** The “O” of SOAP stands for **OBJECTIVE.** In this section, you will provide information provided by bystanders, relatives, the patient, etc. You will document your findings from your physical exam, patient questioning, and on scene observations. In this area, document patient complaints, vital signs, medications, allergies, physician names, signs & symptoms and all other case related information.

**A:** The “A” of SOAP stands for **ASSESSMENT.** In this section, you will give a brief statement regarding what you suspect the problem to be. This is a “definitive diagnosis” as we are not physicians. Always precede the statement with terms such as “possible”, “suspect”, “rule out”.

**P:** The “P” of SOAP stands for **PLAN.** In this section, you will list in chronological order all treatment provided for the patient. This includes assessment, care rendered, changes in complaint or signs & symptoms, consultation or hospital contact, transport, receiving facility, patient priority and any other information relative to the treatment phase of the patient.
### PATIENT ASSESSMENT ACRONYMS

#### AVPU

<table>
<thead>
<tr>
<th>Letter</th>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Alert</td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Responds to Verbal stimuli</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Responds to Painful stimuli</td>
<td></td>
</tr>
<tr>
<td>U</td>
<td>Unresponsive</td>
<td></td>
</tr>
</tbody>
</table>

#### SAMPLE HISTORY

*Obtain information from patient, or if patient is unresponsive, obtain from family, friends, or bystanders.*

<table>
<thead>
<tr>
<th>Letter</th>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S</td>
<td>Signs and symptoms <em>(also look for medical ID TAG)</em></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>Allergies <em>(to medications, foods, environment)</em></td>
<td></td>
</tr>
<tr>
<td>M</td>
<td>Medications <em>(currently or recently taking, including over-the-counter remedies)</em></td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Pertinent past medical history</td>
<td></td>
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<tr>
<td>L</td>
<td>Last oral intake</td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Events leading up to injury or illness</td>
<td></td>
</tr>
</tbody>
</table>

#### OPQRST

<table>
<thead>
<tr>
<th>Letter</th>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>O</td>
<td>Onset *(When did the pain first start?) Sudden or Gradual Onset?</td>
<td></td>
</tr>
<tr>
<td>P</td>
<td>Provocation <em>(What causes the pain? What makes the pain worse or better?)</em></td>
<td></td>
</tr>
<tr>
<td>R</td>
<td>Radiation <em>(Does the pain travel from one area to another?)</em></td>
<td></td>
</tr>
<tr>
<td>S</td>
<td>Severity <em>(0 – 10: Does the patient think the pain is mild, moderate, or severe?)</em></td>
<td></td>
</tr>
<tr>
<td>T</td>
<td>Time <em>(Duration. Is the pain constant or intermittent? Has the pain occurred before? Does it change?)</em> <em>(How long)</em></td>
<td></td>
</tr>
</tbody>
</table>

#### DCAP-BTLS

<table>
<thead>
<tr>
<th>Deformities</th>
<th>Burns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contusions</td>
<td>Tenderness</td>
</tr>
<tr>
<td>Abrasions</td>
<td>Lacerations</td>
</tr>
<tr>
<td>Punctures/ Penetrations</td>
<td>Swelling</td>
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</tbody>
</table>
SOAP Note Worksheet

Date: ___________________________ Age: ________________ Sex: _________________

SUBJECTIVE: What you were told by patient, family, bystanders, or other personnel
Chief complaint - Mechanism of injury (MOI)

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
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OBJECTIVE: What you Observe - Physical Exam findings
SAMPLE history - OPQRST

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

SAMPLE
Signs/Symptoms: Onset/Origin:
Allergies: Provoke/Palliation:
Medications: Quality:
Pertinent Medical History: Region/Radiation:
Last Oral Intake: Severity:
Events leading to event: Time:

ASSESSMENT: Problem list

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

PLAN: A plan for each problem - treatment - transport - What you are going to do for patient

__________________________________________________________________________________________
__________________________________________________________________________________________
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