UNIT 6 CLINICAL CASE STUDY

Structure

6.0 OBJECTIVES

After going through this unit, you will be able to:

- develop a "case-study" in the clinical field of nursing;
- grasp the significance of the clinical case study method;
- develop insight into the holistic picture of a patient's/client's problems;
- develop an in-depth analysis of the central problem/other problems by marshalling evidence;
- make decisions that help solve the problems;
- present data through diagrams, tables; and
- document effectively for presentation or submission.

6.1 INTRODUCTION

The case-study approach to developing content has been used by several professions. Law and Medicine have used this method to help practitioners in making professional decisions and to help the researcher in scientific investigations. More recently the case study method has come to occupy a significant place in the tool-kit of management education.

A case study may be defined as "narration of facts and other evidence in relation to the health care problem of the individual under study". In the nursing context, case study represents a holistic picture of a client's health care problems and requires an in-depth analysis of these problems.

A case study is based on a client for whom the student is responsible for care, and is derived from a clinical situation in which the student has been previously involved. When using case-studies, it is important that students possess sufficient depth of understanding and the theoretical background necessary for analysing the clinical situation under review.

6.2 SIGNIFICANCE OF CASE STUDY METHOD : SOME FEATURES

The significance of case study method has been proved beyond doubt both for gaining sound foundation in principles of nursing management and for developing requisite

practice and experience in decision-making in actual clinical situations. This method is not to be regarded as a substitute to other methods of teaching. For best use students must first understand the basic principles of nursing and then go on to analyse the case. This method provides students opportunities to develop their analytical abilities and decision-making skills and to utilise their knowledge in devising feasible solutions to the problems encountered by the client. Certain valuable skills that care-analysis enables one to learn are as follows:

i) Thinking logically and meaningfully.

ii) Identifying the basic problem(s).

iii) Analysing, and interpreting the data and other available history or results of investigation examination.

iv) Recognizing the limits on efficient decision-making where complete data is not available or obtainable.

v) Recognizing what additional information can possibly be acquired.

vi) Arriving at a decision in co-operation with others.

vii) Evolving strategies by preparing the nursing care plan based on clients' needs.

6.3 HOW IS A CLINICAL CASE STUDY PREPARED

Studies of individual patients/clients and of individualized nursing care, give students the best foundation on which to build their professional knowledge in order to meet the needs of contemporary society. The study should be in consonance with the objectives listed.

Objectives

1) To improve the students ability to solve nursing problems by detailed study and analysis of nursing situations.

2) To individualise nursing care.

3) Be aware of preventive aspects of nursing.

4) Familiarise and seek support from other relevant agencies.

5) To learn to collect information about patient/client with tact and skill.

6) To record nursing observations in an organised, systematic way.

7) To be able to work out a nursing case plan based on the needs of the individual patient/client and his/her special problems.

8) To become familiar with professional literature which has special bearing on nursing situation confronted.

9) Include health teaching, in hospital/clinic/home

Outline for Clinical Case Studies

The following outline is suggested as a help in collecting and organising pertinent material. It is a general outline which is applicable to many different types of patients and their problems.

I) **Introduction**

The introductory paragraph is intended to orient the reader as to what the writer plans to do. It may contain a general descriptive statement of the individual or family group being studied. It may also describe in general the nurse's first contact with the patient and her reasons for selecting him/her for intensive study.

The nursing case study should provide information on the patient's social and cultural background, his/her own health and that of the family, his/her economic status, events leading up to his/her present illness, and relevant details of the illness, the treatment given, the nursing care, prognosis and plans for rehabilitation. Special emphasis should be placed on the nursing care and measures aimed at promotion of health and preventing recurrence of the condition.

II) **Social-economic Background and Present Status**

The main purpose here is to understand and present the social background, in order to recognize those factors affecting the patient's present condition, and to note those conditions in his/her environment which have contributed to his/her present illness and which may hasten or retard his/her recovery.

The age, sex, status, nationality, citizenship, and religion of the patient and members of the immediate family may be included.

Describe in general from available information the kind of family of which patient is a member.

1) What is the attitude of family members toward each other?

2) What are the aptitudes, chief interests, and achievements of the members?

3) What is the educational background and present interests of the patient and other family members ? (If patient is a child, note how illness is affecting school attendance, etc.)

4) What is the vocational history and present employment of each worker in the home?

5) What will be his/her vocation in the future ?

6) What is the economic condition of the family ? How is it being affected by the present illness ? What resources do the family have to meet any illness ? Do they carry insurance, have savings, etc.?

7) What recreation does patient and family indulge in ? Will it be affected by this illness?

8) Does religion play a significant part in the life of the patient and family ? Do any religious conflicts exist ?

9) What is the physical environment of the home ? Does the family occupy a flat, a whole the house, furnished rooms, etc.? (If home is not visited, student may get a general description of the home from patient, visitor, or representative of a social agency. Note source for this information if not obtained first-hand.)

10) Are ventilation, lighting, sanitation, number of rooms, and furnishings adequate for the needs of this family ?

11) What is the general character of the neighborhood in which the patient lives ? Why does the patient choose to live in that particular neighborhood?

12) Are changes in the home, or moving to another community, advised because of this illness? How are these to be carried out ?

13) Is the patient known to a social agency ? If so, what special needs necessitated that help ?

14) Is patient known to the medical social service department in the hospital ? If so, why?

III) **Medical and Health Backgrounds**

Present only those factors which have a direct bearing on the nursing situation, which may have significance for the nurse in her contact with this patient. In presenting the clinical signs and symptoms, as well laboratory examinations, always relate them to the nursing aspects and point out the nurse's responsibility, if any, in this particular phase of the patient's history and treatment.

1) What has been his/her physical development? Has she had any childhood disease? Do these bear any significance to his/her present condition?

2) What is the family history in relation to cancer, tuberculosis, allergy, heart disease, etc.? Is there any relation between such history and the patient's present condition?

3) Has the patient been treated for this same condition before?

IV) **Present Illness (or condition which necessitated medical examination and treatment at this time.)**

1) What were the earliest symptoms noted by the patient?

2) How long after onset of symptoms did she seek medical advice? What care did she have previous to present admission?

3) If preventive measures exist, why were they not used by patient? If used, why were they ineffective?

4) What significant points were discovered in the physical examination, laboratory, and x-ray findings?

5) How did the above findings deviate from the normal?

6) How did they differ from the usual clinical picture? (Describe very briefly).

7) Progress, prognosis, and medical future for this patient.

V) **Therapy**

In this part the student will present and describe all treatments, medications, diet, operations, and special therapy prescribed for the patient's recovery. Note particularly the nurse's responsibility in treatment.

1) What special treatments (including operations) were performed? What preparation did the patient have for these and what was his/her reaction, physical and mental, to them?

2) What medication or dietary treatment was ordered? What success did the nurse note?

3) What was the daily progress of the patient? What were the nurse's daily observations?

4) In all the above medical treatments, what were the results expected and what were the results obtained?

5) What are the patient's rehabilitation needs and plan?

VI) **Nursing Care and Problems**

In this part of the study present all topics related to nursing care. If nursing procedures are described, tie up definitely with the patient being studied. Be particularly explicit in presenting problems encountered and describe attempts made to solve them.

1) What were the nurse's observations during her first contact with the patient?

2) What responsibilities did she have when diagnostic tests were performed?

3) What problems arose in carrying out special treatments, dietary measures, or medication? How solved?

4) What was the patient's reaction to the hospital environment and to the treatment prescribed?

5) What problems arose in giving nursing care?

6) What deviations from usual nursing routines were indicated and how carried out?

7) What particular nursing care was indicated for the relief of symptoms? What results were observed?

8) Did you use information collected to make out a plan of individualized nursing care for this patient? (If advisable, include plan or part of it in study.)

9) Did patient's personality, or general outlook in life, help or hinder nursing activities?

10) What course did the convalescent period take ? Describe the nurse's responsibility for the patient's rehabilitation.

VII) **Health Teaching**

Here the student should describe the special needs of this patient for health knowledge, as well as his background and apparent interest in, and attitude to, matters of health and prevention of disease. Special instructions given to the patient, or his/her family, and his/her preparation for discharge should be described.

1) What are the educational possibilities for this patient?

2) What evidence existed that patient needed instruction in personal hygiene?

3) How did you attempt to teach this?

4) What results did you observe from your teaching?

5) What evidence existed that this patient needed special instructions with regard to general mode of life, diet, rest, etc.?

6) How did she/he accept these instructions?

7) What evidence do you have that the patient will carry out these instructions when she/he has returned to his/her accustomed environment?

8) If a “key” person in the family group was given instructions regarding the patient’s mode of life after discharge, describe her interest in and attitude to the total illness situation.

VIII) **Conclusion**

Here the student may present observations as well as the prognosis. The patient's condition on discharge or at the completion of the study should be noted. The student should list specific items which she learned in making this study. These may include among other things, treatments and plans, clinical information, or knowledge about social agencies. Any difficulties encountered in collecting and analyzing data included in study should be noted.

IX) **Sources**

1) Patient

2) Relatives and friends

3) Professional workers both inside and outside the hospital or clinic

4) Patient's record

5) Any other source.

X) **Bibliography**

The case study method is an opportunity for the student nurse to refer and read a wide variety of medical, pharmaceutical and nursing literature related to the case. The student will need to refer and read from other areas and subjects too, to be in a position to give holistic care. The clinical case, the problems presented, the individualised needs may require a basic understanding, knowledge and expertise in related fields; e.g. nutritional problems or awareness of Alternative Systems of Medicine and so on. If this extensive reading and reference to related literature is done in the course of preparing the case study,

these must be listed in a systematic manner, called Bibliography. The name (title) of the book, the edition, the author(s) name(s), the name of the Publisher, year of publication and the page numbers are written of all the books used while conducting the case study. Sometimes literature from Research studies may also be used. It is proper to use the latest findings or editions of the books used to study. The formatting of the Bibliography may also vary and the method or system used by the institution may be used for the purpose. E.g. in Harvard style of referencing: use the following sequence — Surname, Initials, Year of Publication, Name of book/article, edition(ed) and Publishing House.

Van Ort & Putt; Suzanne R. and Arlem M, 1985, Teaching in Collegeiate School of Nursing, Little Brown & Co. Boston Toronto.

Check Your Progress 1

State true (T) or false (F) :

1) When using case studies it is important that students possess sufficient depth of understanding and theoretical background. (T/F)

2) The case study method is regarded as a substitute to other methods of teaching. (T/F)

3) The case study method helps certain valuable skills to be developed in case analysis. (T/F)

4) An introductory paragraph is mandatory while planning to write a clinical case study. (T/F)

5) We present only those factors which have a direct bearing of the patient/ client on nursing situations while describing the medical/health background. (T/F)

6.4 ANALYSING THE CASE

Analysis of a case provides opportunity for the students to:

1) examine the interrelationships of multiple phenomena in the clinical situation.

2) enlarge own knowledge base.

3) acquire skills in problem solving.

4) examine creative approaches to the solutions of problems and present a supporting rationale to them.

5) organise ideas logically in written form.

The cases are not all alike and a student if familiar with the case method may be at a loss while encountering the diverse features of the cases as regards their presentation, explicitness of the problem involved, adequacy of material included and so on. Cases may be long or short. The length of the care varies with the amount of factual and descriptive material available in the case and the problem(s) that has given rise to the situation.

Besides material relevant to decision-making, related material may also be included with a view to enhance the general understanding of the issues and problems by the students. Logical sequencing of events, history, investigations and prioritising of the nursing needs of the patient needs to be adopted while dealing with the patient/client holistically. Additionally it is possible that adequate data or outcome of investigations or tests may not be available which prompts the student to analytically reconsider the adequacy of data.

Finally in some cases, the problem is clearly defined so that the student can analyse and interpret the facts relating to the conclusions, diagnosis, treatment, etc. It may also describe the action taken to solve problem(s).

Analysing the Case

We may now briefly outline the procedure for analysing the case. There need not be a single stereotype procedure suitable for every case. However the following steps would be useful.

1) Clearly define the diagnosis and related problems in the case.

2) Marshal the facts, data and other evidence around the problems.

3) Prioritize the nursing needs of the patient/client.

4) Determine and evaluate alternatives.

5) Decide the best course of action: short-term and long term.

Check Your Progress 2

1) List five opportunities analysis of a case offers to nursing students using clinical case study method.

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2) List five major headings under which data for the case study will need to be collected.

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3) How are issues for health teaching assessed and what special instructions will be given to the patient or his/her family in preparation for his/her discharge. (100 words)

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6.5 DOCUMENTATION AND PRESENTATION

After collecting the data, reviewing the related literature and finalizing the care plan, the documentation commences. The content will adhere to the similar sequence as has been mentioned in the outline for Clinical case studies (mentioned in this unit). It will include the following sub-headings:

1) Introduction

2) Socio-economic background and present status.

3) Medical and health backgrounds (History)

4) Present illness (History)

5) Therapy (Treatment)

6) Nursing care and problems (includes nursing care plan)

7) Health teaching

8) Conclusion

9) Bibliography

The content may be supplemented where necessary with other material e.g. X-rays, reports, graphs, laboratory findings etc. Illustrations and drawing of anatomical structures, depiction of physiological or pathalogical phenomena in the human body related to the case demonstrates the depth of understanding of the student and augments the Clinical Case Study. It is significant that the theoretical background gets fortified and the student and teacher find the entire process interesting and innovative clear statements, lucid language and neat documentation contribute to a high standard of documentation.

6.6 CONCLUSION

Once the Clinical Case Study is prepared, documented and presented to the teacher it is evaluated as per the criteria or guidelines provided during the assignment of the case. The weightage of marks pre-decided are adhered to and the case study is evaluated. The positive points are highlighted and remarks for any improvements or learning are made by the teacher and grading is done as per the system adopted by the institution.

The case study method has a proven track record of being one of the best methods of study, be it clinical case study or case studies for corporate strategy.

Check Your Progress 3

1) Write in brief about Interviewing and Health History as part of the Case Study.

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2) Refer to a few books/research articles and write Bibliography for five of them as per the 'Harvard Style of Referencing.'

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6.7 LET US SUM UP

— A Clinical Case Study is a narration of facts and other evidence in relation to the health care problem of an individual under study.

— It requires from the learner an explanation of the relevant theories and principles.

— It is based on a client for whom the student is responsible for nursing care and is derived from the clinical situation where the student is posted.

— Analysing and individualising are the main features contributing to decisions for patient care.

— Evolving strategies by preparing the nursing care plan based on the client's needs.

6.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) T

2) F

3) T

4) T

5) T

Check Your Progress 2

1) i) Examine the inter relationships of multiple phenomena in the clinical situation.

   ii) Enlarge own knowledge base

   iii) Acquire skills in problem solving

   iv) Examine creative approaches to the solutions of problems and present a supporting rationale to them.

   v) Organise ideas logically in written form.

2) i) Introduction

   ii) Socio-economic background

   iii) Past history of illness

   iv) History of present illness

   v) Therapy (Treatment)

   To assess and provide health teaching.

   The student should describe the specific needs of this patient suited to the awareness levels. The evidence provided during care of instruction needed in personal hygiene will mean that inputs in this aspect need to be provided. The general mode of life (life style) diet, (eating habits) rest etc. are other important aspects to be referred to if the health behaviour is not demonstrated by the patient in this context. The response of the patient must be observed and the co-operation of the "significant other" in the family must be enlisted to ensure compliance. However, the instructions should relate to reality if the impact has to remain even when the patient goes home.

Check Your Progress 3

1) Talking with patients and obtaining their health histories are usually the first and often the most important parts of the health care process. We collect the necessary information to form a tentative diagnosis, identify problems and start the beginning of the Nurse Patient Relationship. We need to look at the salient points mentioned below to get the comprehensive history.

   - **Comprehensive History: Adult Patient**

     i) Date of History

     ii) Identifying Data, including at least age, sex, race, place of birth, marital status, occupation, and perhaps religion

     ii) Source of Referral, if any

     iii) Source of History, such as the patient, a relative, a friend, the patient's medical record, or a referral letter

     iv) Reliability, if relevant

vi) Chief Complaints

vii) Present Illness

- **Past History**

i) General State of Health

ii) Childhood Illnesses

iii) Adult Illnesses

iv) Psychiatric Illnesses

v) Accidents and Injuries

vi) Operations

vii) Hospitalizations, not already described

viii) Current Health Status

ix) Allergies

x) Screening Tests

xi) Environmental Hazards

xii) Use of Safety Measures

xiii) Exercise and Leisure Activities

xiv) Sleep Patterns

xv) Diet

xvi) Current Medications

xvii) Tobacco

xviii) Alcohol, Drugs and Related Substances

- **Family History**

i) Psychosocial History

ii) Home Situation and Significant Others

iii) Daily Life

iv) Important Experiences

v) Religious Beliefs

vi) The Patient's Outlook

- **Review of Systems of the Body**

i) General

ii) Skin

iii) Head

iv) Eyes

v) Ears

vi) Nose and Sinuses

vii) Mouth and Throat

viii) Neck

ix) Breasts

x) Respiratory

xi) Cardiac

xii) Gastrointestinal

xiii) Urinary

Genitoreproductive

i) Male

ii) Female

iii) Peripheral Vascular

iv) Musculoskeletal

v) Neurologic

vi) Hematologic

vii) Endocrine

viii) Psychiatric

2) Bibliography- Harvard Style of Referencing:

a) Conley, Virgina C., 1973, Curriculum and Institution of Nursing, Little Brown and Co.Boston.

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c) Lamberstsen, Eleanor C., 1958, Education for Nursing Leadership, J.B. Lippincot Co. Philadelphia and Montreal.

d) Fuerst and Wolff, 1963, Teaching School of Nursing, 4th Edition, J.B. Lippincott & Co. Philadelphia and Montreal.

e) Thakkar, Vimal G., 1992, Nursing & Nursing Education, Vora Publications Delhi.