University of South Alabama
Cardiorespiratory Care
Guidelines for case report/presentation – CRC 342

- Select a patient who has been admitted for a respiratory problem AND assess the pt.
- Four to five pages long and double spaced.
- Example of beginning “The patient was a _____-year-old, (male or female) who presented in the Emergency Department on March 15th, complaining of cough and shortness of breath…”
- Present the case as a narrative as if you were telling a story.
- Use a formal writing style and avoid slang - A “chest x-ray” should be referred to as a chest radiograph. Patients are not “on oxygen” or “on the vent”. They are “receiving oxygen” or “receiving mechanical ventilation”. Oxygen status is not a “Sat” … it is given as SpO2 or SaO2.
- Provide only the admission day and month (not the year) and do not give the hospital’s name. (These errors are HIPAA violations).
- Use a general day-by-day presentation of the case, summarize days if nothing significant occurred. Delete information that could identify the patient. Follow the HIPAA rules for patient confidentiality. Do not report ID numbers, dates of birth, addresses, or other patient identifiers. If any of this information is in your personal notes, shred your notes after writing the paper.
- See item #7 below for an important focus.
- Proof-read your printed copy and correct all mistakes before turning in the final paper!
- Submit your paper by email (attach as a Word file) to wpruitt@usouthal.edu

POINTS TO BE ADDRESSED: See Written Case Report Scoring Sheet (pg 4) – this is what establishes the final grade. Organize the writing by time, not by the headings below:

1. Admission information: Provide admission date (ie Feb 4); omit any reference to the year. Include the patient’s age, sex, and discharge date if applicable. Summarize the patient’s presenting diagnosis and the development of any secondary diagnoses. Throughout the case study refer to the patient as “the patient” or use two initials. Example: “The patient, or JD, smoked 32 years, averaging a pack a day…” or “JD was diagnosed with…”

2. Social and past medical history: Summarize the patient’s social and past medical history. Include occupation, socioeconomic status, substance abuse (tobacco, drugs, alcohol, etc.). Include any respiratory and heart diseases (and diabetes) for the patient and for the immediate family. Include any deaths in the immediate family from respiratory or heart disease. The medical record may not include all of this information. Report what you can find. If this information is not available, say that it is not known. Include home respiratory therapy and list of home medications – for all medications give both the generic name and trade names (proprietary). Single-spaced listing with three columns is acceptable for medications. (Trade – generic – category). Examples of category: antibiotic, bronchodilator, corticosteroid, or anti-hypertensive.

3. Signs and symptoms: Summarize the patient’s presenting signs and symptoms. Include vital signs and give units of measurement for everything. Example Temperature 98.6 F. SaO2 87 mmHg.

4. Physical exam and patient interview: Describe physical examination and interview of the patient in your own words (but don’t use personal pronouns like I, my, etc. Example: “Physical exam revealed crackles in the lung bases and use of accessory muscles.”

5. Laboratory and test results: Summarize pertinent laboratory data including chest radiographs or other pertinent radiographic exams, ABG results with interpretations, significant blood work.
(CBC, etc.), cultures (blood, urine, sputum, etc.), spirometry, ECG, and other data. For multiple ABG results, provide the initial test, significant actions taken to correct problem, and subsequent ABG results that have clinical significance (summarize the ABGs in between significant events). Remember to include units of measure (mm Hg, mL, mEq/L, etc.) PFT reports – give measured values, predicted values, and the percent predicted values, pre/post bronchodilator results and the interpretation of the PFT. Give infection status/precautions put in place (i.e., contact isolation for MRSA in a wound, airborne precautions for TB.)

6. **Medications**: Report on all drug therapy the patient is receiving beginning from the start of the admission. Provide a general classification for each drug ordered (anti-hypertensive, analgesic, bronchodilator, inhaled steroid, etc.). Give both the generic name and trade names (proprietary) for all drugs. Single-spaced listing with three columns is acceptable for medications. (Trade – generic – category). Highlight all inhaled medications in **BOLD** font.

7. **Respiratory therapy**: Describe respiratory therapy initiated at time of admission and summarize subsequent respiratory therapeutic modalities the patient received. Include indications, actions, trends or changes in condition, and results of therapy. If applicable, include list of home respiratory therapy started after discharge and the indication for home respiratory therapy. This is important- spend time discussing the therapy!! What are the indications that support the orders? Was therapy effective? Was the frequency or the ordering parameters changed as appropriate (i.e. titrating oxygen flow, decreasing therapy as the patient improves). Discuss the issue if therapy should have changed but didn’t…. or took too long to change (i.e. days instead of hours)

8. **Procedures/surgery**: Provide indications, procedures and/or surgery performed, outcomes or findings. Pay attention to procedures or surgery to the thorax. Do they affect breathing or coughing?

9. **Chronology**: Summarize the case at the end of the paper in general terms in a chronological fashion. (1) What caused the admission? (2) What was done to diagnose the problems? (3) What therapy and/or medications were required? (4) What was the outcome? Answer these questions in two to three sentences. Define anything you report. Define unknown words so you will know them when/if you give an oral presentation.

10. **Relevant literature**: Following the case report include your summary of a relevant article in the literature that relates to the primary cardiopulmonary disease affecting your patient. **This article must be published in a peer-reviewed journal** such as Chest, Lancet, Thorax, Respiratory Care, New England Journal of Medicine, Respiratory Medicine, American Journal of Critical Care Medicine, Journal of Perinatology, Pediatric Pulmonology, etc. **If you are in doubt about a peer-reviewed article – ask the faculty.** Cite the article according to the format used in the Respiratory Care journal – follow this format exactly! (see below for example) Summarize the article in your own words and explain how it relates your case. English language publication, no abstracts allowed. Must be published within the last 15 years. **Print and include a copy of the article with your case study.**

Example of proper citation format: Jones, M, Sanderson B, Bittner V. The 6-minute walk test: how important is the learning effect? Am Heart J 2003; 146(1):129-133.
KEEP PATIENT IDENTIFIERS CONFIDENTIAL AND SHRED THIS DOCUMENT WHEN PROJECT IS COMPLETED. USE N/A if not available or not applicable. Leave nothing blank. Note units of measure to put in case report.

Patient name: _________________________ Rm _______ Age:_______  Circle:  M   -   F

Admission date: ____________ Chief complaint:___________________________________

Height ______ weight _______ Discharge date: __________________

Social & Past Medical History: ____________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Signs & Symptoms:__________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

On admission: Blood pressure _______ temperature _____ respirations ____ pulse ____
Lab -Electrolytes Na⁺ _____ K⁺_____ Cl⁻ ______ HCO₃⁻ _______ Theophylline level ___
Comments _________________________________________________________________
__________________________________________________________________________

CBC:  WBC _____ Hb ____  RBC ____Micro:(infections, location) ___________________
Comments _________________________________________________________________
__________________________________________________________________________

ABGs: pH ____ PaCO₂ _____ PaO₂ __________ HCO₃⁻ _______ B.E. _____ SaO₂ _______
FiO₂ _____ O₂ delivery device ______ SpO₂ _______ ET tube size________
Comments _________________________________________________________________
__________________________________________________________________________

PFTs results

Comments

____________________________________________________________________________

CXR Results: ________________________________________________________________

Meds (Date)   Generic       Trade            Classification
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________
(_____________)  _______________     _______________     _______________

Physical exam (appearance, breath sounds, cough, etc.):

_________________________________________________________________________
_________________________________________________________________________

Write day-by-day notes on what was done, subsequent findings, patient’s progress on additional pages. Use this information to create you case report.

SHRED THIS AND ALL OTHER NOTES FROM PATIENT WHEN THE PROJECT IS COMPLETED.
University of South Alabama – Cardiorespiratory Care CRC 345
Written Case Report Scoring Sheet

Student: _____________________________________  Date:________________

Rank the case according to the following scoring system:
N/A – not applicable, 1 – Far below expectations (F), 2 - Below expectations (D),
3 - Meets Expectations (C), 4 – Exceeds expectations (B), 5 – Far exceeds expectations (A)

1. ___ Interpret ABGs and PFTs.
2. ___ Include units of measure for lab work, ABG, PFT, etc.
3. ___ Explain significance of abnormal lab work, radiology, other studies.
4. ___ Avoid slang or being too informal. Don’t say vitals were obtained. These are vital signs. A chest x-ray is really a chest radiograph. Patients are not “on oxygen” They are receiving oxygen.
5. ___ Double space all typing except drug lists. For all drugs provide generic name, trade name, and general classification (examples: albuterol – Proventil- bronchodilator; furosemide-Lasix-diurectic)
6. ___ Use proper grammar and complete sentences. Watch for verb endings and tense …. “Chest tube was place…” should be “A chest tube was placed…..”
7. ___ Proof-read and eliminate all misspelled words.
8. ___ The case should “flow” well, not be choppy or disjointed. Nothing should be awkward or confusing to the reader
9. ___ Remove any patient identifiers – avoid HIPAA violation (do not give the year of the admission)
10. ___ Don’t surprise the reader; cover the significant things as they occur and follow them through the case (for example; a chest tube placed one day and the tube is never mentioned again, or a chest tube removed on day 6 with no mention of it ever being placed)
11. ___ Give the citation: Follow RC Journal formatting exactly to give the reference for your article. Include a copy of the article with the case report. No abstracts, must be peer-reviewed.
12. ___ The article should link to the case (relevant in some way). Discuss the connection to your case

Multiply the following response by 2 – it counts “double”

13. ( ___ x 2) = _______ The main focus of the report should be on respiratory therapy - indications, actions, trends or changes in condition, and results of therapy. Address titrating therapy as condition changes.

   A. Total score: __________ out of a total possible 70 points (adjust for N/A)
   B. Ratio of total to possible: __________
   C. Calculate percentage from this scoring system: __________
   D. Assign final grade (subjective and objective review) __________

Reviewer signature: _____________________________________________________