The Brief Patient Case Presentation

The ability to briefly present and discuss an oral/verbal patient case presentation is an important skill that allows students across professions to be able to communicate patient care activities with preceptors and other health care providers. It differs from a patient case write up or formal case presentation in that it is shorter and more focused on relevant patient information gathered and assessed, and key decisions made (i.e., identification of DTPs and recommendations). Providing students with regular opportunities to prepare and present brief oral presentations will help learners share their assessment of assigned patients during clinical rotations and will support the development of clinical decision making. The learner's ability to take responsibility and accountability for assigned patients on clinical rotations is reflected by their ability to effectively summarize a patient case, and discuss issues identified and addressed with both preceptors and collaborating health care providers. The SNAPPS approach has been used in medicine and has been shown to facilitate concise patient summaries, clinical reasoning, and case-based uncertainties in a brief presentation (~ 5 min) that is driven by learners rather than preceptors.[1] The SNAPPS approach below has been modified to fit the Pharmacist's Patient Care Process taught at the Dalhousie College of Pharmacy. A brief presentation that describes the SNAPPS approach for students can be found **HERE**.

SNAPPS Approach

- ***SUMMARIZE* (briefly the history and findings):** Gather information and present a summary of findings of the presenting patient and situation
- ***NARROW* (the DTPs identified):** Provide an initial impression of what the actual or potential drug therapy problems (DTPs) and health care needs are; discusses why the patient presentation supports or refutes the DTPs identified (student thinks out loud to preceptor with reasoning process)
- ***ANALYZE* (compare and contrast options to resolve the DTPs):** Discuss potential options to manage the DTP (i.e., drug, non-drug, triage, referral) for the patent and provide rationale and evidence for options considered and chosen (student thinks out loud to preceptor with reasoning process)
- ***PROBE* (the preceptor by asking questions about uncertainties, difficulties, or alternative approaches):** Discuss and ask questions of the preceptor (preceptor provides guidance as needed or clinical pearls)
- ***PLAN* (management of the patient and care plan)**: Decide and commit to plan (decisions and recommendations, monitoring and implementation) and outlines next steps within the student's scope of practice and preceptor's direction
- ***SELECT* (a case-related issue for self-directed learning)**: Identify learning issues related to the patient encounter (as needed); discuss the findings with the preceptor

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Tips for The Brief Patient Case Presentation Using SNAPPS

***SUMMARIZE* (briefly the history and findings):** Gather information and present a summary of findings of the presenting patient and situation

This first step in the oral case presentation is often the hardest one. It requires that you include only what (and all that) is relevant to the patient's presentation to support your assessment of the DTPs identified and recommendations in a brief, organized and logical way. The type of patient information that may be presented during a case presentation are found in **Table 1**.

The opening statement of an oral case presentation usually begins with some patient demographics, then a brief description of the patient's chief complaint (i.e., the patient's main concern, problem, symptom, condition, or why they are seeking health care), followed by focused patient medical or medication history supporting the chief complaint, and may include why the pharmacist is seeing or has been consulted in the care of the patient.

- E.g., *GL is a 65 year old cis gendered female admitted to the unit last night for an acute exacerbation of COPD presenting with productive cough and shortness of breath.*
- *E.g., MK is a 45 year old transgender male with a new diagnosis of Type II Diabetes who is calling to report daily episodes of diarrhea after starting metformin one week ago.*
- TIP: Don't add a lot of extraneous information to the opening sentence. Get to the chief complaint and main reason for pharmacist consultation quickly.
- TIP: Present only factual (i.e., objective, subjective) information gathered; no assessment yet.

Then, the history of present illness (HPI) (i.e., a chronological description of the progression of the patient's present illness from the first sign and symptom to the present) usually flows directly from the opening statement and should relate directly.

- TIP: Have some organization in mind. Chronological organization is easy to follow.
- E.g*., GL has a past history of poorly controlled COPD at home. This is their first admission with an AECOPD. The BMPH taken in ER noted that GL stopped their inhalers 3 weeks before admission due to inability to afford the medication. Chest x-ray was normal and patient's symptoms have improved slightly in the last 12 hours with inhaled bronchodilators.*

After the HPI, list the medical conditions and medications (current and past) in decreasing order of importance and relevance. Expand on relevant elements of the patient medical history and medications as needed.

- TIP: include medications that are relevant to the patient's presentation, current illness, and treatment plan. Include doses and frequencies of medications if highly relevant to the care plan or if there is something uncommon or non-standard about the medication or regimen.
- TIP: match the patient's medication with the indication for therapy.
- *GL's prescribed COPD regimen at home is Onbrez (indacaterol) 1 inhalation daily and salbutamol 1-2 puffs QID PRN. Other medications include hydrochlorothiazide for hypertension and oxybutynin for urge incontinence. She is a previous 2 pack per day smoker who quit 2 years ago. Her admission orders were to start ipratropium bromide MDI 2 puffs QID and home meds as per BPMH.*

- E.g.*, The patient, MK reports taking metformin 500 mg BID as a starting dose and forgot to initiate the medication once daily for the first 3 days. They are also taking depo-testosterone IM monthly, ramipril 5 mg for hypertension and started atorvastatin 10 mg for dyslipidemia the same day as metformin. No other medications have been initiated recently other than the patient started taking Pepto Bismol for diarrhea which has not been that helpful. ML does not have other complications due to diabetes. They expressed GI complaints in the past with other medications and is now concerned and wondering if they should stop.*

Include other relevant information in addition to the chief complaint and DTPs identified including review of systems, vitals, physical exam findings, labs and studies should also be included as relevant.

- TIP: Give actual numbers for labs rather than "normal" or "high", "low". Include comparison labs if there has been a change.
- TIP: Attribute information provided from the source (i.e., per pharmacy profile, per patient, per the radiology report
- E.g., MK's most recent *A1c 2 months ago was 8.0 and their fasting blood glucose measured at home this morning was 10 mmol/L.*

Mention medication allergies if relevant to the chief complaint or not already documented and known.

- E.g. *GL has a history of rash due to amoxicillin.*

Include elements of the social and family history that are relevant to the patient presentation or the care of the patient.

- E.g.*, GL has recently had to quit their job to take care of their ailing mom. Their application to Pharmacare has been delayed due to need to complete a recent tax application*.

Table 1. Patient information that may be collected as part of the assessment

ID and Demographics: Brief description of the patient: height and weight (in metric units) patient's age, gender/gender identity, pronouns, biological sex if applicable to case.	**Chief Complaint (CC):** the reason for seeking healthcare. *E.g., why has the patient been admitted to hospital floor, been seen by the pharmacist at the clinic etc.?*
History of Present Illness (HPI): a chronological account of events and symptoms of the chief complaint.	**Past Medical History (PMH):** current and past medical conditions; may be acute or chronic and procedures, surgeries and prior hospitalizations as relevant
Medication History: prescription and non-prescription medications, social drug use, natural health products, immunization status; gather a comprehensive list during assessment but include those most relevant to the chief complaint and identify source of information (i.e., patient, record, BPMH, etc.).	**Physical Exam (PE) findings including Vitals and Review of Systems (ROS):** Pertinent negative and positive findings; pertinent to the chief complaint and medications and identify source (i.e., patient record, nursing flow sheet, pharmacist performed, etc.)
Allergies and Intolerances: Medication allergies and adverse drug reactions (type of reactions and when they occurred).	**Social History and Family History:** Supports at home; language; physical limitations; cognitive limitations; cultural background; medical conditions that are risk factors.
Laboratory Results: Pertinent negatives and positives; include when completed and trends as relevant.	**Diagnostic Test Results:** Relevant tests completed for diagnosis or monitoring

NARROW ***(the DTPs identified):*** Provide an initial impression of what the actual or potential drug therapy problems (DTPs) and health care needs are; discusses why the patient presentation supports or refutes the DTPs identified (student thinks out loud to preceptor with reasoning process)

Provide a summary of what you think are the patient's actual and potential drug therapy problems (DTPS) and health care needs from your assessment. Make the link to the patient's presentation and how this supports your assessment.

- TIP: Keep the DTP statement short and describe why you think the DTP exists along with supporting information to back this up
- NOTE: the DTP statement should include the patient's presentation, the relationship to drug therapy and the drug involved and should be tailored to the audience.
- TIP: If you have identified multiple DTPs, group these according to medical condition
- *E.g., GL's non-adherence with their inhalers may have contributed to their most recent admission for an acute exacerbation of COPD. There is also a potential need to optimize their current LABA plus SABA inhalation regimen on discharge to further control their symptoms at home and reduce their risk of exacerbation.*
- *E.g., The cause of MK's diarrhea is most likely related to them taking a high dose of metformin to start which has been reported in about 50% of patients and is dose related. Atorvastatin is less likely to cause this side effect.*

ANALYZE ***(compare and contrast options to resolve the DTPs):*** Discuss potential options to manage the DTP (i.e., drug, non-drug, triage, referral) for the patent and provide rationale and evidence for options considered and chosen (student thinks out loud to preceptor with reasoning process)

For each DTP discuss the potential options to resolve the problem. This could be the best or possible options, non-drug strategies, and/or the need for triage and referral. Provide some rationale why the options are best for the patient making specific reference to patient characteristics that support your decision.

- *E.g., Options for optimizing chronic COPD management for GL includes the addition of a LAMA, as this class of agents has been shown to be effective for symptom control and may reduce the risk of exacerbations. There is a once daily combination formulation that contains indacaterol, that patients current LABA, with glycopyrrolate (Ultibro Breezehaler) or alternatively there are slightly cheaper combination agent formulations include aclidinium/formoterol (Duaklir Genuair) a dry powder inhalation twice daily or tiotropium/olodaterol (Inspiolto Respimat) a soft mist inhaler once daily. Patient preference usually dictates the best option.*
- *E.g., Considering metformin is an important agent to manage MK's diabetes, you could consider holding the agent for 1 day and starting again at a lower dose, 250 mg once daily and titrating by 250 mg every 3 days as tolerated. Alternatively, the risk of GI side effects including diarrhea may be lower with extended-release metformin formulations, such as Glumetza, with diarrhea being reported in as many as 15% of patients. However, extended-release products are not always covered by drug plans.*

PROBE ***(the preceptor by asking questions about uncertainties, difficulties, or alternative approaches):*** Discuss and ask questions of the preceptor (preceptor provides guidance as needed or clinical pearls)

Discuss and ask questions you have about the case related to information gathered, uncertainties and approaches with your preceptor. This is the time to 'pick their brain' about how they would handle the situation, interpret information or how they make their own clinical decisions.

- *E.g., There are so many COPD options, which inhalers do you most commonly see in practice? Also, this patient was prescribed a LAMA and SABA together for therapy? Is this customary? In my reading the use of a short acting anticholinergic agent was preferred with a LABA due to the differences in mechanism of action.*
- *E.g., In this case I think that metformin is first choice for this patient, but if metformin dose not get the patient's A1c to target, would you consider a DPP4 inhibitor or a sulfonylurea? I guess the patient does have 2 CV risk factors so a SGLT2 might also be considered?*

***PLAN (management of the patient and care plan)*:** Decide and commit to plan (decisions and recommendations, monitoring and implementation) and outlines next steps within the student's scope of practice and preceptor's direction

Now commit your decision as to what is the best option(s) or recommendation(s) for the patient and how this will be implemented. During the rotation your preceptor or other members of the health care team may have to provide some guidance for you as to how to implement care plans in the practice setting (i.e., who to talk to, what to document, what is covered etc.). In this step you should also make a plan for follow up (for efficacy, safety and adherence).

- TIP: Prioritize your care plan. What problems are the most important to tackle first?
- TIP: Identify what you will need to follow up on to make sure your plan is working.
- *E.g., I checked with the GL and they would like to try a cheaper once daily option for a combination inhaler. In this case writing a discharge prescription for the new inhaler would be an option. What is the process for this on the unit?*
- *E.g., I think I would suggest for MK to try the lower dose of metformin. The intermediate release option is covered by their health plan. Is it Ok if I call the patient back to discuss this? My plan would be to stop metformin for 1 day and then start 250 mg once daily with a main meal for 3 days and then increase every 3 days until they reach the 100 mg daily dose. I will instruct the patient to monitor for diarrhea and to check their fasting blood glucose at least twice weekly during initiation. I will seek their consent to call them in 2 to 3 days to see how they are doing. I think it is very possible that the patient will need a dose of 1500-2000mg per day if tolerated to get their A1c closer to target so will need to monitor their A1c in 3 months.*

***SELECT (a case-related issue for self-directed learning)*:** Identify learning issues related to the patient encounter (as needed); discuss the findings with the preceptor

Identify any learning issues that you encountered and try to expand your knowledge on the management of the issue.

- *I.e., I wonder if there is a real difference in efficacy related to lowering of A1Cof immediate release metformin vs. the extended-release product. I will do a quick literature search as this information could change how I balance therapeutic options in the future.*

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