Structured Clinical Case Assessment

Experiment 2 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To organise patient information into a problem-oriented pharmacy case record.

Principle

A SOAP record separates subjective information, objective findings, assessment and a proposed plan. Clinical conclusions must be supported by the recorded case evidence.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm history and symptoms; objective findings and dates; confirmed diagnoses and differential questions; current and previous treatment. Note missing information explicitly.

3. Develop the pharmacy assessment

Record S: the reported symptoms/history; O: examination and test findings; A: a prioritised problem assessment; P: proposed actions and monitoring for supervisor review. Link each medicine to an indication and identify missing information.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded case and date	_____
Presenting problem and diagnosis	_____
Allergies / previous medicines	_____
Relevant clinical and laboratory findings	_____
Pharmacy problem and priority	_____
Proposed plan and monitoring	_____
Supervisor decision and follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. What is the difference between S and O?

S records reported information; O records observed or measured findings.

2. Why link a medicine to an indication?

It helps detect omission, duplication and treatment without a clear purpose.

Disease-area Checklist

Area	Topics	Assessment focus
Cardiovascular	Hypertension, heart failure, angina, myocardial infarction, hyperlipidaemia and arrhythmias.	Indication, vital-sign trend, volume status where relevant, ECG/laboratory context, adverse effects and monitoring.
Respiratory	Pulmonary-function interpretation, asthma, COPD and drug-induced pulmonary disease.	Symptoms, exacerbations, device technique, adherence and response/adverse-effect monitoring.
Endocrine	Diabetes, thyroid disease, contraception, hormone replacement and osteoporosis.	Relevant laboratory trend, comorbidities, patient-specific risks and correct medicine/device use.
Special populations	Paediatrics, geriatrics, pregnancy and breastfeeding.	Age/weight where required, organ function, pregnancy/lactation context and authorised patient-specific information.
Ophthalmology	Glaucoma and viral/bacterial conjunctivitis.	Diagnosis, correct eye-product technique, contamination prevention and specialist follow-up.

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