**DIETETIC CASE STUDY INFORMATION FOR PLACEMENTS B AND C**

**Purpose of the case study**
During your B and C placements you will be required to complete a written case study report, which will be assessed. A case study aims to develop your ability to obtain, assess and present relevant information. Throughout your case study you should demonstrate an understanding of the importance of a patient’s medical, cultural, social and economic circumstances in relation to clinical conditions and how these link to any dietary treatment given. You will receive feedback on your case study, but there will be no grade or mark awarded. The content of a case study may, however, contribute to the assessment of the following placement learning outcomes;

- **B Placement:** K1, C2, C3, P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P14, P15
- **C Placement:** K1, C2, C3, P1, P2, P3, P4, P5, P6, P7, P8, P9, P10, P11, P13, P14

**Choosing your case study patient**
You should begin looking for your case study patient 2-3 weeks after starting your placement. Your supervising Dietitian will be able to help you decide if a particular patient is suitable as well as helping you to obtain any permission that is required. This will normally include consent from the patient and the lead clinician. When choosing a case study, this should be a patient with whom you have been involved in the dietetic care - but you may also need to liaise with the Dietitian who was previously (or still is) involved with that patient’s care. You do not need to have looked after this patient from the start of their treatment. You should, however, have ideally taken an active part in the assessment / monitoring / treatment of the patient to enable you to demonstrate your critical review and clinical reasoning skills.

- **Placement B**
  On placement B, the patient selected should not be too complex. They should ideally have one diagnosis (or one main diagnosis that can be the focus of the case study). Examples of suitable conditions include diabetes, weight management, hyperlipidaemia, coeliac disease, and nutrition support with sip feeds or a ‘straightforward’ enteral feed.

- **Placement C**
  On placement C, the patient selected should be more complex, perhaps with more than one diagnosis. Examples of suitable conditions include Crohns disease, renal disease, liver disease, HIV or cystic fibrosis

**What to include in your case study**
The case study assessment form overleaf provides an indication of the sorts of information that should be included. You will notice that this assessment form is based on the clinical reasoning tool that you have used previously at the university. Please note that whilst it may not be necessary for you to cover every minor point in the table overleaf, it is important that you include information that is relevant to your case study. Remember that the aim of completing a case study lies in helping you to develop your ability to obtain, assess and present relevant information.

The written case study should be approximately 1500-2000 words excluding references/appendices. It should include relevant information assembled in an informative and understandable way. You may wish to use a combination of written text, graphs, tables and diagrams. The discussion, conclusion and recommendations are expected to comprise approximately 50% of the case study. You will submit your written case study to your placement supervisor on an agreed date.
Case study presentation
You will also be required to present your case study to the dietetic department. The structure of this presentation should broadly follow that of your written work. The information should be presented clearly and concisely, identifying relevant points and using tables/charts/graphs to illustrate points where possible. The presentation should last 15-20 minutes and should be delivered on the date agreed with your supervisor.

Observing confidentiality
All information concerning the case study patient is confidential. Their name, hospital, patient identification number, date of birth, ward or clinic, name of the consultant and Dietitian must not be stated in your case study report. If your case study is discussed on return to university it is very important that this confidentiality is maintained.

Support with writing your case study
If you have any questions or concerns regarding your case study, please discuss these with your clinical educator. You will also be able to submit a draft of your case study to your clinical educator for brief feedback, prior to handing in your finished piece of work.

Key dates related to your case study
The following dates need to be agreed with your clinical educator:

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<tr>
<td>The case study patient is to be identified by</td>
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<td>A draft of the written case study is to be submitted to the clinical educator by</td>
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<td>The finished written case study is to be submitted to the clinical educator by</td>
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<tr>
<td>The oral presentation is to be delivered to the dietetic department on</td>
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# Case Study Assessment Form

Student’s Name ………………………………………………………………… Placement B / C (please circle)

This template should be used as a guide when writing your case study report.

- **Title page and a Contents page**
  - With word count stated

- **Introduction (~ 50-100 words) (P1, P7)**
  - Include;
    - Patient details (e.g. age, gender etc.) and the reason for referral

- **Nutritional Assessment (~ 300 – 400 words) (K1, P1, P2)**
  - Include relevant patient history, (including interpretation of information, where applicable)
  - **Anthropometry:**
    - E.g. weight, height, BMI, waist circumference
  - **Biochemistry:**
    - Clinical history:
      - Outline relevant information only
      - PC: e.g. primary diagnosis, symptoms, investigations, interventions from other members of the MDT
      - Medications: drug names and purpose
      - PMH: e.g. diagnosis, duration, symptoms, effects on quality of life

  - **Dietary Information:**
    - Previous nutritional intake / eating pattern. If information is not available explain why it is missing. Diet history and analysis / estimation of intakes of relevant nutrients.
    - Rationale for assessment method(s) used.
    - Assessment of nutritional requirements;
      - Clearly show workings (in appendix) when calculating nutritional requirements for all nutrients relevant to the patient
      - Provide rationale for calculations
      - If changes to requirement occur as treatment progress, show all re-calculations clearly with the rationale for change i.e. what were the reasons behind the change.

  - **Environmental / behavioural / social info e.g.**
    - Relevant factors that affect dietary intake e.g. social factors such as; SES, occupation, education, ethnicity, environment, shopping/cooking/storage facilities, mobility etc. Also communication needs, behavioural factors and ethical considerations

  - **Service-user Focussed information**
    - Focus on your client’s agenda

  - **Provide an overall assessment / statement of the patient’s nutritional status.**

- **Nutrition Diagnosis**
  - **Nutrition Diagnosis (consider order of priorities)**
  - **Nutrition Statement (PASS: Problem, Aetiology, Signs and Symptoms)**
### Nutrition Intervention and Monitoring (~400-500 words) (P3, P4, P5, P7, P8)

Outline the rationale behind the nutrition intervention and the evidence and/or guidelines on which it is based.

If the aims / objectives change as treatment progresses then these should be clearly documented.

Note: relevant information on both medical and dietetic intervention (treatment) should be included and focus should be on how the medical treatment links to the nutritional therapy.

It may help to use a day number system e.g. Day 1, admission etc.

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| A. Aims / goals of nutrition intervention | What did you want to achieve overall? Provide justification. N.B. short term and long term goals may be appropriate, aim for SMART goals |
| B. Implementation plan: objectives / strategies for achieving the goals of nutrition intervention | Include plan of intervention (treatment);
- State objectives i.e. how did you try to achieve the aims/ goals of nutrition intervention?
- Provide justification i.e. explain / justify chosen nutrition intervention.
- Include strategies used to influence nutrition intake (where relevant).
- Barriers with implementation? - how overcome?
- If information was provided to the patient, explain rationale
- Detail communication of plan to others involved |
| C. Evaluation: monitoring progress/outcome measures | How did you know if the plan was effective?
- What outcomes were monitored? Provide a rationale. Timescale involved?
- Relate to aims / objectivities of nutrition intervention
- Barriers achieving outcomes? - how overcome?
- Evaluation of patient’s understanding / motivation / compliance with the plan |

### Discussion (~650-800 words) (K1, P1, P2, P3, P4, P5, P6, P7, P10, P14(B), P13(C))

This section should be used to discuss what you did with the patient and why you undertook the treatment you did;

- Critically review the nutrition intervention plan, with reference to the current relevant literature regarding treatment of the patient. Discuss any limitations.
- Identify areas of controversy and interest (this does not need to cover everything about the case study)
- Comment on the effectiveness of MDT working and the impact on patient-centred care.
- Reflect on what went well, not so well, what would be done differently next time - how has this experience changed your future care planning?
- What learning outcomes have I met through this experience?

### Conclusion(s) and Recommendation(s) (approx. 150-200 words) (K1, P1, P3, P4, P7)

Summary of findings

### References

| Comments |  |
All references should be listed at the end of the case study

- **Appendices** (K1, P1, P7)
  (e.g. information about drugs, diet sheets)
  - Concise and understandable
  - Included only if information is relevant and it helps the reader
  - Referred to in the text of the case study

- **Presentation of case study** (C2, C3, P9, P14 (B), P15 (B), P13(C), P14 (C))
  - Typed, numbered pages, font size (Arial 12)
  - Format e.g. layout clear, use of headings, tables appropriately formatted
  - Correct use of English, terminology and abbreviations
  - Logical progression (flows well)
  - Adherence to case study guidelines (e.g. includes word count)

Adapted from; The Nutrition & Dietetic Care Process (BDA 2009) and The Model & Process for Nutrition & Dietetic Practice (BDA 2016)

Any additional comments from supervisor

Any comments / reflections from student

Signed:

**Student Dietitian:** ...........................................  **Supervising Dietitian:** ...........................................