SAINT LOUIS UNIVERSITY.

Program-Level Assessment: Annual Report

Program: Family Nurse Practitioner NP and PM	Department: School of Nursing
Family Nurse Practitioner	
Degree or Certificate Level: MSN	College/School: Saint Louis University
Date (Month/Year): April 2022	Primary Assessment Contact: Shellie D. Hill
In what year was the data upon which this report is based collected? 2022	
In what year was the program's assessment plan most recently reviewed/updated? 2017	

1. Student Learning Outcomes

Which of the program's student learning outcomes were assessed in this annual assessment cycle?

Outcome #3: Integrate advanced competencies, skills, theories, and cultural sensitivity in relationships with patients and professionals.

2. Assessment Methods: Artifacts of Student Learning

Which artifacts of student learning were used to determine if students achieved the outcome(s)? Please identify the course(s) in which these artifacts were collected. Clarify if any such courses were offered a) online, b) at the Madrid campus, or c) at any other off-campus location.

NURS 5290 Clinical Studies II: Women and Children

Course detail: a) Didactic component of course is offered online with precepted clinical experiences,
b) no courses or students from the Madrid campus,
c) precepted clinical experiences off site

Artifacts: Clinical evaluation, either by observing direct patient care or through simulation cases at residency. Outcome measure is a score of advanced proficiency, proficient, or not proficient on a variety of adult family practice cases. Goal is 90% of students will receive a proficient or advanced proficiency rating. (see Appendix E)

Indirect Measures:
1. Skyfactor, Overall Learning; rating of 5.5 or higher on a 7-point scale.

3. Assessment Methods: Evaluation Process

What process was used to evaluate the artifacts of student learning, and by whom? Please identify the tools(s) (e.g., a rubric) used in the process and include them in/with this report.

Direct Measures:
Clinical evaluation, either by observing direct patient care or through simulation cases at residency. A direct observation of student clinical performance is evaluated by the FNP faculty through the use of simulated scenarios (Appendix I) during on-site residency experiences. Following completion of the simulated scenarios, the faculty meet and average the scores students received on their cases. If there are any concerns about the student's performance, remediation occurs. Outcome measure is a score of advanced proficiency, proficient, or not proficient on a variety of adult family care cases. Measure: 90% of students will achieve a proficient or advanced proficiency rating.

Cultural sensitivity is assessed during the simulated cases, students reported any cultural considerations in their case and if anything could have been communicated/performed differently. Cultural sensitivity is not scored but is considered in overall proficiency.

Indirect Measures:
Skyfactor, Overall Learning; rating of 5.5 or higher on a 7-point scale.

4. Data/Results

What were the results of the assessment of the learning outcome(s)? Please be specific. Does achievement differ by teaching modality (e.g., online vs. face-to-face) or on-ground location (e.g., STL campus, Madrid campus, other off-campus site)?

Artifacts: 90% of students will achieve a proficient or advanced proficiency rating. (Appendix I)
Data/Results: NURS 5290 (*n*=28) – This course is held in the spring semester. Twenty-seven students completed a simulated case study scenarios and were evaluated by faculty on their clinical performance. One student did not attend residency due to travel restrictions related to Covid-19. This student will undergo an evaluation over Zoom with myself implementing one of the simulated scenarios. All 27 students achieved proficient or advanced proficiency ratings on their first attempt and none required remediation (see appendix A).

Artifacts: Skyfactor, Overall Learning; rating of 5.5 or higher on a 7-point scale.
Data/Results: 2021 SkyFactor (64 number of attempts, 34 number of responses, 53.1% response rate.)
SkyFactor 23: Overall learning was 6.29 on a 7-point scale.

All 27 students demonstrated cultural sensitivity during their case studies by verbalizing to faculty cultural issues regarding their case patient and how they would address or handle these differences.

5. Findings: Interpretations & Conclusions

What have you learned from these results? What does the data tell you?

The vast majority of students completed a clinical performance evaluation at residency and achieved an advanced proficiency or proficient score. One has a delay in this evaluation due to Covid-19 restrictions but is expected to complete the evaluation by the end of the semester.
An overall learning score of 6.29 achieved the goal of a rating of 5.5 or higher on a 7-point scale.
All 27 students demonstrated cultural sensitivity during their case studies at residency.
This data shows that teaching is effective and assessments are good measures.

6. Closing the Loop: Dissemination and Use of Current Assessment Findings

A. When and how did your program faculty share and discuss these results and findings from this cycle of assessment?

The MSN coordinators meet after these reports are made for review. Each case, grading rubric and results are summarized and discussed by MSN program coordinators and the Associate Dean for Graduate Education.
Results will be shared bi-annually at a dedicated ANPPC curriculum meeting with all graduate nursing faculty and representative student body members.

B. How specifically have you decided to use these findings to improve teaching and learning in your program? For example, perhaps you've initiated one or more of the following:

Changes to the Curriculum or Pedagogies	• Course content • Teaching techniques • Improvements in technology • Prerequisites	• Course sequence • New courses • Deletion of courses • Changes in frequency or scheduling of course offerings
Changes to the Assessment Plan	• Student learning outcomes • Artifacts of student learning • Evaluation process	• Evaluation tools (e.g., rubrics) • Data collection methods • Frequency of data collection

Please describe the actions you are taking as a result of these findings.

This information will address key components of advanced nursing practice and will identify gaps in knowledge and skills essential for high quality care that is safe, morally sound and patient centered. Recommended changes will be implemented into the curriculum the following academic year. The students completed an evaluation of residency (see appendix B). The evaluation did not specifically address the clinical check offs. The only comments regarding the clinical check offs were that we schedule the out-of-town students on the first day and the local students on the second day of residency due to easier travel.

If no changes are being made, please explain why.

7. Closing the Loop: Review of Previous Assessment Findings and Changes

A. What is at least one change your program has implemented in recent years as a result of assessment data?

I will redo the residency evaluation to include questions about the clinical check off process and assessment of cultural sensitivity.
I will make every effort to schedule out of town students to do check offs on day one of residency.

B. How has this change/have these changes been assessed?

Through evaluation of student residency evaluations.

C. What were the findings of the assessment?

See above.

D. How do you plan to (continue to) use this information moving forward?

I will redo the residency evaluation to include questions about the clinical check off process and assessment of cultural sensitivity.
I will make every effort to schedule out of town students to do check offs on day one of residency.

IMPORTANT: Please submit any assessment tools and/or revised/updated assessment plans along with this report.

Appendices for the Family Masters NP and Family Post Masters NP Certificate

APPENDIX A

Student	Advanced Proficient	Proficient	Not Proficient
SO	x		
TP	x		
AD	x		
CW	x		
MP	x		
TP	x		
BO		x	
SB		x	
MA		x	
AM	x		
TA		x	
CZ	x		

JB	**x**		
BC		**x**	
AP		**x**	
SD	**x**		
LH		**x**	
AS	**x**		
RS	**x**		
PW		**x**	
ND	**x**		
CL	**x**		
SW		**x**	
JT	**7/87**	**x**	
SG	**x**		
GJ	**x**		
JV	**x**		

FAMILY NURSE PRACTITIONER (FNP)

APPENDIX B
Family Masters NP and Family Post Masters NP Certificate
Residency Evaluation

1. I am a(n):
   - **a.** MSN-FNP student
   - **b.** BSN-DNP-FNP student
   - **c.** Post-Masters Certificate student

2. The advising and preceptor sessions contributed to my learning
   - **a.** Yes
   - **b.** No
   - **c.** Not Applicable

3. The Basic EKG class contributed to my learning
   - **a.** Yes
   - **b.** No
   - **c.** Not Applicable

4. The Office Procedures class contributed to my learning
   - **a.** Yes
   - **b.** No
   - **c.** Not Applicable

5. The Suturing Workshop contributed to my learning
   - **a.** Yes
   - **b.** No
   - **c.** Not Applicable

6. The Radiology class contributed to my learning
   - **a.** Yes
   - **b.** No
   - **c.** Not Applicable

7. The School of Nursing reception provided a relaxing occasion to meet faculty and students

- **a.** Yes
- **b.** No
- **c.** Not Applicable

8. Overall evaluation of the Residency

- **a.** Excellent
- **b.** Good
- **c.** Average
- **d.** Poor
- **e.** Unacceptable

ADD COMMENTS

APPENDIX E

Saint Louis University

School of Nursing Student Clinical Evaluation

Family Masters NP and Family Post Masters Certificate NP

Student: _____ Site: _____

Preceptor: _____ Date: _____

Course: _____

Please rate your student using the following:

4= Above average 3= Average/Satisfactory 2= Needs improvement

1= Unsatisfactory N/A=No Opportunity or Non-Applicable

PROFESSIONALISM	**4**	**3**	**2**	**1**	**N/A**
Arrives to clinic prepared and professionally dressed					
Demonstrates self-directed learning					
Respects patients privacy					
Relates well with staff					
Relates well with preceptor					
Articulates the scope of NP practice					
SKILLS					
Uses appropriate interviewing techniques (obtains history)					
Performs organized & timely physical exam					
Performs appropriate physical exam					
Uses exam equipment properly					
Identifies appropriate ancillary test (labs/ imaging)					
Presents findings to preceptor accurately					
Uses correct medical terminology					
Utilizes electronic resources (web-based;					

apps) for evidence-based care (standards, medications, practice guidelines)					
Readily identifies normal and abnormal findings					
Develops reasonable differential diagnosis					
Therapeutic Planning					
Demonstrates knowledge in the treatment and evaluation of patients					
Formulates appropriate plan using evidence based practice					
Identifies appropriate indications for specific diagnosis					
Implements appropriate strategies for health promotion and patient education					
Identifies therapeutic pharmacological and non-pharmacological treatment (patient education)					
Recommends appropriate follow up and referral					
Outcomes					
Demonstrates culturally sensitive care					
Demonstrates appropriate developmental care					
Provides patient centered safe care					

In your opinion, did this student appropriately apply the knowledge and skills during this clinical experience? Yes_____No_____

Preceptor comments/ suggestions:

Preceptor Signature / Date

_____

Student Name _____

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

Definitions:

Advanced: Performs/demonstrates at a superior level with no verbal cues or prompting (91-100)

Proficient: Performs/demonstrates at the expected level with minimal verbal cues or prompting (80-90)

Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

APPENDIX I
Family Masters and Post Masters NP

Saint Louis University School of Nursing

Case 1
Jose
Instructions to the Student:

Chief Complaint:

Jose is a 42 year old male, construction worker, who was in his usual state of health until 2 days ago when while playing soccer in an over 30 league he injured his left knee.

Vital signs, height, weight	BP: 136/86 P: 84 R: 18 T: 99 Ht: 70" Wt: 230 lbs.

Tasks: You have 30 minutes to complete the following:

1. State the pre-examination differential diagnoses.
2. Obtain a focused History.
3. Perform a physical examination.
4. Re-examine and list the tentative differential diagnoses.
5. Identify your differential diagnoses, knowing that it will become conclusive.
6. List diagnostic tests you would obtain.
7. Assuming your diagnosis is correct, develop a therapeutic plan.
8. Educate the client.

Student Name _____ CASE # 1

Instructor _____

Date _____-

Instructor solicited information:
Pre-examination diagnoses after chart review and before seeing client.

1. **Possible muscle strain or ligament strain left leg**
2. **Obesity**

Grade: History:		**30pts _____**
	PE:	**30 pts_____**
	Diagnoses	**15 pts _____**
	Treatment	**25 pts _____**
	Total: _____	

Student Name _____ CASE # 1

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

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Proficient: Performs/demonstrates at the expected level with minimal verbal cues or prompting (80-90)

Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

History : 30pts

(1pt)	Confirm chief complaint	
(8pt)	**HPI:** onset	
	Duration	
	Quality / Quantify Pain	
	What makes it better	
	What makes it worse	
	Popping noise	
	Weight bearing	
	Demonstrates cultural sensitivity while establishing rapport	
8pt	**Past Medical History**	
	Demonstrates cultural sensitivity during history gathering	
	Medication/Allergies	
	Previous illness	
	Hospitalizations	
	Trauma	
	Surgeries	
	Chronic illness	
	Health maintenance	
2pt	**Family History**	
	Parents	
	Grandparents	
8pt	**Social & Personal History**	
	Marital status, children	
	Work	
	Exercise	
	Smoking, ETOH, drugs	
	Diet	
	Self-testicular exam	
3pt	**Review of Systems: negative except**	
	Blackened thumb nail Left index finger	

Client – Script for Physical Assessment

Instructor Check off (30pts)	**System**	**Findings**
	Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	BP: 136/86 P: 84 R: 18 T: 99 Ht: 70" Wt: 230 lbs.
	General appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant
	Skin	Warm dry, no lesions, cuts or bruises, suntanned, callused hands, blackened nail bed index finger left hand
	Eyes	PERRLA, red reflex intact, optic disc margins well defined, no nicking or hemorrhages, EOM's intact
	Neck	Supple, full ROM, no thyroid enlargement, or bruits
	Heart/peripheral vascular	RRR without murmur or gallop, S1 and S2 within normal limits, all pulses present equal and strong, no bruits or thrills appreciated.
	Lungs	Clear to auscultation A and P, vesicular sounds throughout
	Abdomen	Bulky, rounded, soft BS X 4, soft, not tenderness masses or bruits, liver right midclavicular line 10 cm.
	Neurological	A and O X 3, gait antalgic, stiff left knee favors right, with limp, sensation intact, DTR's 2 + except left knee which was not tested.
	Extremities	Full ROM and strength without deformity all joints and extremities except left knee. No edema except left knee Left knee: + ballottement, effusion ROM 10º -90º with pain at extremes + medial joint line tenderness + Lachman's + Anterior drawer - Posterior drawer + McMurray's sign Normal sensation of foot Calf soft

<u>Key Critieria for Complete Eval of Knee</u>:

1. ROM all extremities, **left knee 10-90ºwith pain at extreme**
2. position of patient standing, looks at both knees with knees exposed
3. position patient sitting, legs dangling over end of table
4. palpates each patella
5. presses thumb into joint
6. palpates along inner side – **pain on left**
7. palpates along outer side
8. positions patient supine (laying down on back)
9. ballottement: milk from above and below towards the knee – **positive effusion**
10. presses or taps on outer side
11. pushes patella
12. ask patient to bend right knee to chest; then straighten and lock
13. ask patient to bend left knee to chest; then straighten and lock.
14. with leg bent at 90º, hold knee and heel, rotates foot (McMurray's) **pain on left when rotated out**
15. Lachman's sign +
16. Anterior drawer +, Posterior drawer –
17. Repeat all on opposite side
18. Check calf, to eval for compartment syndrome – **soft**

*** Normal ROM knee (0ºto 130º-135º**

<u>List of Tentative Diagnoses:</u>

1. ACL tear
2. Medial meniscus tear
3. Possible fracture
4. Obesity
5. Lack of Exercise/Unhealthy life style
6. Pre-hypertension??

Instructor Grade:
Pre-exam diagnoses (5 points)_____

Post-exam diagnoses (10pts) _____

Management Plan

Instructor check off	(30points)	Comments
	Accurate treatment decisions (15pts)	
	Diagnostic tests	
	Blood work: SMA 6 & SMA12 are WNL, total chol (246) HDL (36), LDL (190), possible FBS, urine (WNL)	
	AP, Lat L knee (no fracture)	
	MRI left knee (torn ACL, and medial meniscus)	
	Therapeutic Communication(10 pts)	
	Explanations easily understandable and culturally appropriate	
	Professional approach	
	Explained findings & diagnosis clearly	
	Referrals	
	Patient education addresses health promotion	
	Supportive therapies (see below)	

<u>Conclusive Diagnoses and Management Plan</u>

Torn ACL and Medial Meniscus	Rest and elevation Ice or heat Ace wrap when up Anti-inflammatory, NSAIDS with food Either Motrin 600-800 TID Naprosyn 500 BID etc…. Give 2 weeks supply Educate on ACL and Meniscus tear: You can sometimes get by without this particular ligament, with the meniscus you have to wait and see. Try the anti-inflammatory meds and rest for 2 weeks if no improvement will refer to orthopod
Obesity/lack of exercise	Cholesterol and liquid panel for baseline either at this time or fasting on follow-up Evaluate 24˚ diet history, discuss basis healthy eating plan Refer to dietitian Discuss exercise program Importance of warm up and cool down Aerobic vs. Anaerobic Ease into exercise, discuss plan Starting with walking advance over time to run work in other activities Explore social value of exercise

Preventive care	FLU Shot, Tetanus, Annual TB testing Referral to optometrist Skin screening and safety precautions since he is a construction worker Self testicular exam
Follow-up	2 weeks to eval knee, annual screening tests if not done at this time

Client – Script for the Client History (Instructor copy):

CC: "my knee is hurt and swollen"

1. History of Present Illness

- It swelled within 30 minutes
- When it occurred you were done for the day, you couldn't bear weight and had to be carried off the field.
- It really hasn't gotten any better, that's why you came in, your were unable to do your job so work sent you home.
- You never had any problem like this before.
- You can't move your knee like normal. It's very stiff. It doesn't lock, you don't think it gives out, but you have been trying not to use it.
- You haven't really done anything about your knee, except ice at the game and a few beers after for pain control.

2. Past Medical History

- The only surgical procedure/hospitalization you have had is a hernia repair at age 20.
- No previous medical problems, ulcers or GI problems
- You don't take any medicines. You have no known allergies, or current immunizations.
- You wear glasses, but your last eye exam was about 5 years ago.

3. Family History

- Your mom and dad are alive and well, you think maybe your dad has high Blood pressure.

4. Personal and Social History

- You do not smoke. You never took any illicit drugs.
- Your are a social drinker, you drink a few beers at games and after work with the guys.
- You have been married for 6 years and have 2 children.
- You have worked for the same company since you were 20 years old.

5A. Health Promotion

- You have never thought too much of health care
- You gained about 10-15 lbs. over the last few years, like everyone else. Eat a lot of fast food, no breakfast, eat late at night, snack regularly, don't really care about what you eat.
- When the injury occurred, you heard a pop, everyone did.

5B. Health Promotion

- You consider your work your exercise. You just got into this soccer league, it was your first game, you used to play a lot about 12 years ago. Your wife thinks this is "kid stuff".

6. Review of Systems

- In general you feel well
- You wear glasses, your last eye exam was five years ago
- Black nail bed index finger – left hand, from hammer 2 weeks ago, growing out fine.

Student copy of PE findings

System	Findings
Vital signs, height, weight	BP: 136/86 P: 84 R: 18 T: 99 Ht. 70” Wt. 230 lbs.
General Appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant
Skin	Warm, dry, no lesions, cuts or bruises, suntanned, callused hand,, blackened nail bed index finger left hand
Eyes	PERRLA, red reflex, intact, optic disc margins well defined, no nicking or hemorrhages, EOM’s intact
Neck	Supple, full ROM, No thyroid enlargement, or bruits
Heart/Peripheral vascular	RRR without murmur or gallop, S1 and S2 within normal limits, all pulses present equal and strong, no bruits or thrills appreciated.
Lungs	Clear to auscultation A and P, vesicular sounds throughout
Abdomen	Bulky, rounded, soft, BS X 4, soft, no tenderness masses or bruits, Liver right midclavicular line10 cm.
Neurological	A and O X 3, gait antalgic, stiff left knee favors right, with limp, sensation intact, DTR’s 2+ except left knee which was not tested
Extremities	Full ROM and strength, without deformity all joints and extremities except left knee. No edema except left knee Left knee: + ballottement, effusion ROM 10º -90º with pain at extremes + medial joint line tenderness + Lachman’s + Anterior drawer - Posterior drawer + McMurray’s sign Normal sensation of foot Calf soft

Client – Script for the Client History:

CC: "my knee is hurt and swollen"

1. History of Present Illness

- It swelled within 30 minutes
- When it occurred you were done for the day, you couldn't bear weight and had to be carried off the field.
- It really hasn't gotten any better, that's why you came in, your were unable to do your job so work sent you home.
- You never had any problem like this before.
- Your can't move your knee like normal. Its very stiff. It doesn't lock, you don't think it gives out, but you have been trying not to use it.
- You haven't really done anything about your knee, except ice at the game and a few beers after for pain control.

2. Past Medical History

- The only surgical procedure/hospitalization you have had is a hernia repair at age 20.
- No previous medical problems, ulcers or GI problems
- You don't take any medicines. You have no known allergies, or current immunizations.
- You wear glasses, but your last eye exam was about 5 years ago.

3. Family History

- Your mom and dad are alive and well, you think maybe your dad has high Blood pressure.

4. Personal and Social History

- You do not smoke. You never took any illicit drugs.
- You are a social drinker, you drink a few beers at games and after work with the guys.
- You have been married for 6 years and have 2 children.
- You have worked for the same company since you were 20 years old.

5A. Health Promotion

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- When the injury occurred, you heard a pop, everyone did.

5B. Health Promotion

- You consider your work your exercise. You just got into this soccer league, it was your first game, you used to play a lot about 12 years ago. Your wife thinks this is "kid stuff".

6. Review of Systems

- In general you feel well
- You wear glasses, your last eye exam was five years ago
- Black nail bed index finger – left hand, from hammer 2 weeks ago, growing out fine.

Case #2
Mike Kelly
Instructions to the Student:

Chief Complaint:

Mike is a 22 year old male, college student, who was in his usual state of health until 3 days ago when he noticed ear fullness, nasal congestion, and a sore throat. He is new to your practice.

Vital signs, height, weight	BP: 126/76 P: 84 R: 18 T: 99 Ht: 70" Wt: 180 lbs.

Tasks: You have 30 minutes to complete the following:

9. State the pre-examination differential diagnoses.
10. Obtain a focused History.
11. Perform a physical examination.
12. Re-examine and list the tentative differential diagnoses.
13. Identify your differential diagnoses, knowing that it will become conclusive.
14. List diagnostic tests you would obtain.
15. Assuming your diagnosis is correct, develop a therapeutic plan.
16. Educate the client.

Student Name _____

Instructor _____

Date _____-

Instructor solicited information:
Pre-examination diagnoses after chart review and before seeing client.

Otitis media; acute sinusitis; pharyngitis (r/o strep); viral syndrome

Grade: History:	**30pts _____**
PE:	**30 pts_____**
Diagnoses	**15 pts _____**
Treatment	**25 pts _____**

Total: _____

Student Name _____ CASE # 2

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

Definitions:

Advanced: Performs/demonstrates at a superior level with no verbal cues or prompting (91-100)

Proficient: Performs/demonstrates at the expected level with minimal verbal cues or prompting (80-90)

Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

History : 30pts

(1pt)	Confirm chief complaint	
(8pt)	**HPI:** onset	
	Duration	
	Quality	
	Quantify pain	
	What makes it better	
	What makes it worse	
	Associated symptoms—ear fullness	
	Demonstrates cultural sensitivity while establishing rapport	
8pt	**Past Medical History**	
	Demonstrates cultural sensitivity during history gathering	
	Medication (prescription and OTC)	
	Allergies	
	Previous illness	
	Hospitalizations	
	Trauma	
	Surgeries	
	Chronic illness	
	Health maintenance	
2pt	**Family History**	
	Parents	
	Grandparents	
8pt	**Social & Personal History**	
	Marital status	
	Work & Skin protection	
	Exercise	
	Smoking, ETOH, drugs	
	Diet	
	Self-testicular exam	
3pt	**Review of Systems: negative except**	
	As pertinent to HPI	

Client – Script for Physical Assessment

Instructor Check off (35pts)	**System**	**Findings**
	Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	BP: 126/76 P: 84 R: 18 T: 99.6 Ht: 70" Wt: 180 lbs. BMI=25.8
1	General appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant
2	Skin	Warm dry, no lesions, cuts or bruises, suntanned, callused hands, blackened nail bed index finger left hand; No rashes or lesions
6	Eyes/Nose/Sinus	Sclera white. Conjunctiva pink, not injected. Sinuses non-tender. Erythema present but turbinates not swollen; yellow discharge present
6	Ears	Auricles without tenderness. Canals clear. L TM has fluid present but not erythematous; R is pearly with normal landmarks
6	Mouth Pharynx	Dentition good; oral mucosa without lesions; Tonsils without exudate but 3+ and cryptic. Halitosis present Pharynx: Erythema present
6	Neck/Lymph	Supple, full ROM, no thyroid enlargement, or bruits; Anterior cervical lymphadenopathy present bilaterally
3	Heart/peripheral vascular	RRR without murmur or gallop, S1 and S2 within normal limits, all pulses present equal and strong, no bruits or thrills appreciated.
3	Lungs	Clear to auscultation A and P, vesicular sounds throughout
2	Abdomen	Flat, soft BS X 4, soft, not tenderness masses or bruits, liver right midclavicular line 10 cm.

Instructor Grade:
Pre-exam diagnoses (5 points)_____

Post-exam diagnoses (10pts) _____

Management Plan

Instructor check off	**(30points)**	**Comments**
	Accurate treatment decisions (15pts)	
5	Diagnostic tests: Strep screen positive	
5	Appropriate antibiotic (PenVK is first line) And supportive therapies: Salt water gargles, stay home until fever free for 24 hours; Analgesics; fluids,	
5	Smoking-importance of smoking cessation & possible strategies.	
	Therapeutic Communication(15 pts)	
3	Explanations easily understandable and culturally appropriate	
2	Professional approach	
3	Explained findings & diagnosis clearly	
2	Referrals	
2	Patient education addresses health promotion	
3	Supportive therapies (see below)	

<u>Conclusive Diagnoses and Management Plan</u>

Smoking	Smoking cessation
Preventive care	FLU Shot, Tetanus, Annual TB testing Referral to optometrist Skin screening and safety precautions since he is a construction worker Self testicular exam
Follow-up	

Client – Script for the Client History (Instructor copy):

CC: "I have had a sore throat for 3 days"

1. History of Present Illness

You woke up with a really sore throat on Saturday morning (3 days ago). If asked on a scale of 1-10, you rate this sore throat as an "8". You haven't taken your temp but you think you have had a fever because you get chilled and then you sweat. You feel "bad"—you have muscle and joint aches and are fatigued. Tylenol and Advil make you feel better and you have been using Cepacol lozenges. You have no appetite. You stayed home from school yesterday. You have been laying on the couch and sleeping a lot or watching TV. Your housemates are healthy.

Today you ears feel full particularly on the Left side and your nose is more congested. If asked, it has been congested for about 5 days.

Your sister (age 15) had strep and mono a few weeks prior

2. Past Medical History

- The only surgical procedure/hospitalization you have had is a hernia repair at age 6.
- No previous medical problems
- You don't take any medicines. You have no known allergies, or current immunizations.
- You wear glasses, but your last eye exam was about 3 years ago.

3. Family History

- Your mom and dad are alive and well, you think maybe your dad has high Blood pressure.
- You are the oldest of 4 children. Your sister (age 15) had strep and mono a few weeks prior

4. Personal and Social History

- You smoke ½ to ¾ ppd. You never took any illicit drugs.
- Your are a social drinker, you drink a few beers at games and on the weekends with the guys.
- You don't presently have a girlfriend but you have dated in the past
- You have worked as a Barista for the same company since you were 18 years old to work your way through college.
- You share an old house with 2 other guys

5A. Health Promotion

- You have never thought too much of health care
- You gained about 10 lbs. over the last two years. Eat a lot of fast food, no breakfast, eat late at night, snack regularly, don't really care about what you eat.
- You consider your work your exercise. You just got into a soccer league.

6. Review of Systems

Unsure if had fevers at home, but felt hot, +chills, +nausea, no LOC, no neck pain, no visual changes, no tinnitus, some nasal congestion, , no lymph tenderness or enlargement, no cough, no chest pain, not sleeping well because of sore throat pain

No rashes or skin discolorations; no easy bruising

No HA or dizziness; No vision changes; Denies nosebleeds; but does have some yellowish nasal drainage

Feels like he has constant "bad breath"; Occasional tickling cough which makes his throat hurt

Denies cardio-respiratory difficulties

Occasional constipation and gas pain—otherwise no bowel problems

Denies urinary difficulties

Denies any skin or hair changes; heat intolerance

Student copy of PE findings

System	Findings
Vital signs, height, weight	BP: 126/76 P: 84 R: 18 T: 99.6 Ht. 70" Wt. 180 lbs. BMI=25.8
General Appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant
Skin	Warm, dry, no lesions, cuts or bruises, suntanned, callused hand,, blackened nail bed index finger left hand
Eyes/Nose/Sinuses	Sclerae white. Conjunctiva pink, not injected. Sinuses non-tender. Erythema present but turbinates not swollen; yellow discharge present
Ears	Auricles without tenderness. Canals clear. L TM has fluid present but not erythematous; R is pearly with normal landmarks
Mouth and Throat	Dentition good; oral mucosa without lesions; Tonsils without exudate but 3+ and cryptic. Halitosis present Pharynx: Erythema present
Neck	Supple, full ROM, no thyroid enlargement, or bruits; Anterior cervical lymphadenopathy present bilaterally
Heart/Peripheral vascular	RRR without murmur or gallop, S1 and S2 within normal limits, all pulses present equal and strong, no bruits or thrills appreciated.
Lungs	Clear to auscultation A and P, vesicular sounds throughout
Abdomen	Flat, soft, BS X 4, soft, no tenderness masses or bruits, Liver right midclavicular line10 cm.

Client – Script for the Client History:

CC: "My throat has been sore for 3 days"

1. History of Present Illness

You woke up with a really sore throat on Saturday morning (3 days ago). If asked on a scale of 1-10, you rate this sore throat as an "8". You haven't taken your temp but you think you have had a fever because you get chilled and then you sweat. You feel "bad"—you have muscle and joint aches and are fatigued. Tylenol and Advil make you feel better and you have been using Cepacol lozenges. You have no appetite. You stayed home from school yesterday. You have been laying on the couch and sleeping a lot or watching TV. Your housemates are healthy.

Today you ears feel full particularly on the Left side and your nose is more congested. If asked, it has been congested for about 5 days.

Your sister (age 15) had strep and mono a few weeks prior

2. Past Medical History

- The only surgical procedure/hospitalization you have had is a hernia repair at age 6.
- No previous medical problems
- You don't take any medicines. You have no known allergies, or current immunizations.
- You wear glasses, but your last eye exam was about 3 years ago.

3. Family History

- Your mom and dad are alive and well, you think maybe your dad has high Blood pressure.
- You are the oldest of 4 children. Your sister (age 15) had strep and mono a few weeks prior

4. Personal and Social History

- You smoke ½ to ¾ ppd. You never took any illicit drugs.
- Your are a social drinker, you drink a few beers at games and weekends with the guys.
- You don't presently have a girlfriend but you have dated in the past
- You have worked as a Barista for the same company since you were 18 years old working your way through college.
- You share an old house with 2 other guys

5A. Health Promotion

- You have never thought too much of health care
- You gained about 10 lbs. over the last two years. Eat a lot of fast food, no breakfast, eat late at night, snack regularly, don't really care about what you eat.
- You consider your work your exercise. You just got into a soccer league.

6. Review of Systems

Unsure if had fevers at home, but felt hot, +chills, +nausea, no LOC, no neck pain, no visual changes, no tinnitus, some nasal congestion, , no lymph tenderness or enlargement, no cough, no chest pain, not sleeping well because of sore throat pain

No rashes or skin discolorations; no easy bruising

No HA or dizziness; No vision changes; Denies nosebleeds; but does have some yellowish nasal drainage

Feels like he has constant "bad breath"; Occasional tickling cough which makes his throat hurt

Denies cardio-respiratory difficulties

Occasional constipation and gas pain—otherwise no bowel problems

Denies urinary difficulties

Denies any skin or hair changes; heat intolerance

Case: # 3
Kelsey
Instructions to the Student:

Chief Complaint: I feel terrible; I keep getting pain and diarrhea

HPI: Kelsey is an 18 y.o female or male who periodically seen for minor complaints. Today she comes in with a complaint of having problems with abdominal pain following meals. The pain will go away after she has a bowel movement but sometimes she also gets diarrhea. Sometimes she is constipated.

Vital signs, height, weight	Female: Height: 5'4" Weight: 110 Male : Height 5'10' Wt : 165 Temp: 97.8 Pulse =72 Tanner level: V

Task

You have 30 minutes to:

1. State the possible differential diagnoses at the onset
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list differential diagnoses
5. State your diagnosis
6. Develop a therapeutic plan include, all of the following if appropriate: pharmacological, nursing/supportive therapies health promotion and health education, and follow-up.

Student Name _____

Instructor _____

Date _____-

Instructor solicited information
Pre-examination diagnoses before seeing the patient

Abdominal Pain

1) IBS
2) H. Pylori infection
3) Lactose intolerance
4) Infectious diarrhea

Grade: History:	**30 pts _____**
PE:	**30 pts_____**
Diagnoses	**15 pts _____**
Treatment	**25 pts _____**

Total: _____

Student Name _____ CASE # 3

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

Definitions:

Advanced: Performs/demonstrates at a superior level with no verbal cues or prompting (91-100)

Proficient: Performs/demonstrates at the expected level with minimal verbal cues or prompting (80-90)

Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

History : 30pts

(2pt)	Confirm chief complaints	
(10pt)	**HPI:**	
	Demonstrates cultural sensitivity while establishing rapport	
	vague onset	
	Associated symptoms: She has lost 10lbs but was trying to	
	Progression	
	Alleviating factors :	
	Aggravating factors:	
5pt	**Past Medical History**	
	Demonstrates cultural sensitivity during history gathering	
	Medication	
	Allergies	
	Previous illness:	
	Hospitalizations, surgeries, trauma (none)	
	Health maintenance: self-breast exam	
2pt	**Family History**	
	Parents: A&W, father has HTN Should ask about colon cancer and celiac disease	
	Grandparents: A&W, pgf has NIDDM	
8pt	**Social & Personal History**	
	Home environment,	
	School (relationships, grades)	
	Exercise	
	Risk taking (Smoking, ETOH, drugs, seat belt use)	
	Diet	
3pt	**Review of Systems: negative**	
	Student should particularly ask about hair sx, if female – menstrual cycle	

Rome Criteria Irritable Bowel Syndrome can be diagnosed based on at least 12 weeks (which need not be consecutive) in the preceding 12 months, of *abdominal discomfort or pain that has two out of three of these features*:

1. Relieved with defecation; and/or
2. Onset associated with a change in frequency of stool; and/or
3. Onset associated with a change in form (appearance) of stool.

Symptoms that Cumulatively Support the Diagnosis of IBS:

1. Abnormal stool frequency (may be defined as greater than 3 bowel movements per day and less than 3 bowel movements per week);
2. Abnormal stool form (lumpy/hard or loose/watery stool);
3. Abnormal stool passage (straining, urgency, or feeling of incomplete evacuation);
4. Passage of mucus;
5. Bloating or feeling of abdominal distension.

Supportive Symptoms of IBS:

1. Fewer than three bowel movements a week
2. More than three bowel movements a day
3. Hard or lumpy stools
4. Loose (mushy) or watery stools
5. Straining during a bowel movement
6. Urgency (having to rush to have a bowel movement)
7. Feeling of incomplete bowel movement
8. Passing mucus (white material) during a bowel movement
9. Abdominal fullness, bloating, or swelling

Red Flag symptoms which are NOT typical of IBS:

Pain that often awakens/interferes with sleep
Diarrhea that often awakens/interferes with sleep
Blood in your stool (visible or occult)
Weight loss
Fever
Abnormal physical examination

Client – Script for Physical Assessment

Instructor check off (20pts)	System	Findings
	Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	Female: Height: 5'4" Weight: 110/ Male : Height 5'10' Wt : 165 Temp: 97.8 Pulse =72 Tanner level: V
	General Appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant
	Skin	describes wearing no makeup (female) Warm, dry, no cuts or bruises, few blackheads and pimples on face
	Eyes	PERRLA, EOMs intact
	Ears	Auricles NT, symmetric, TMs pearly grey, nl landmarks
	Nose	Nostrils patent, no discharge, septum midline and intact
	Mouth & Pharynx	No lesions, dentition good, uvula rises symmetrically, gag intact, pharynx clear without erythema or exudates
	Neck	Supple, full ROM, No thyroid enlargement, or bruits, no lymphadenopathy
	Heart/Peripheral vascular	RRR without murmur or gallop, S1 and S2 within normal limits, all pulses present equal and strong, no bruits or thrills appreciated.
	Lungs	Clear to auscultation A and P, vesicular sounds throughout
	Abdomen	flat, soft, BS X 4, soft, no tenderness masses or bruits, no organomegaly

List of Differential Diagnoses
Abdomen:
1. IBS

Final Diagnosis
IBS
Management Plan

Instructor check off	**(30points)**	**Comments**
	Accurate treatment decisions (15pts)	
	Diagnostic tests: TSH: normal range CBC: normal limits	
	Pharmacology:	
	Therapeutic Communication(15 pts)	
	Explanations easily understandable and culturally appropriate	
	Professional approach	
	Explained findings & diagnosis clearly	
	Importance of follow up (4weeks)	
	Patient education addresses : goals in life, sexual activity, ETOH health promotion:	
	Medical therapies:	
	Referral to Student Counseling	

Smoking: TTM: pre-contemplation Bring up at each visit

Best combination of medicine (Imodium, antispasmodic, antidepressant, Lotronex) diet, counseling, and support to control your symptoms. Lotronex has been reapproved with significant restrictions by the U.S. Food and Drug Administration (FDA) for women with severe IBS who have not responded to conventional therapy and whose primary symptom is diarrhea. However, even in these patients, Lotronex should be used with great caution because it can have serious side effects such as severe constipation or decreased blood flow to the colon. (Prescriber must be registered) Evidence is poor to fair for the use of antidepressants.Stress management is an important part of treatment for IBS. Stress management options the student should include

- stress reduction (relaxation) training and relaxation therapies such as meditation
- regular exercise such as walking or yoga
- changes to the stressful situations in your life
- adequate sleep

Script for Patient (Instructor copy)

You are an 18 year old girl and comes in alone.
You don't appear to be in any immediate distress.

CC "I feel terrible, I keep getting pain and diarrhea"

History of Present Illness
You have noticed that you seem to get diarrhea frequently. You find it potentially embarrassing. But sometimes you get constipated too. You eat at the school cafeteria and try to get some fruits and vegetables but it seems they always serve the same thing. Menarche at 13 and her menstrual periods have been regular). The diarrhea comes after meals. The pain goes away as after you have had a BM, but it seems to take a while before you feel finished. You haven't really tried to take any medicine because you don't know what to take. You are embarrassed in answering questions.
You tend to get cold easily.

Past Medical History
No known allergies. No prescription medications
You have enjoyed good physical health in the past
No major illness, but had atopic dermatitis as child, none lately
No significant skin problems in family, parents alive and well

Personal and Social History
You smoke with friends—not more than ¼ ppd, has an occasional drink at a party, has never been sexually active. Likes camping and skiing and helps out at a local veterinarian's office. Doesn't do SBE; no pap to date. No exercise exactly but occasionally plays volley ball.

You don't want to stop smoking (if asked) wants to be like friends
Will play volley ball more often (if asked)
Will check BP once a year
Eats fruits and vegetables and occasionally chocolate you eat dairy products and have not noticed any symptoms related to the intake of dairy.
Lives in college dorm. Gets along well with mother and father. No gun in house.

You have not traveled out of the country.

ROS: negative

Physical Exam:
You are a little concerned about the physical exam and ask questions about what the nurse practitioner is finding. For example, why are you looking in my ears? "They are fine."
When the nurse practitioner tells you, you want to know what that means

Treatment Plan:
You want to know what the medicine is and why your have to take it.

For the IBS you look sad/perturbed. Ask many questions and have difficulty understanding the directions. Say you just want to take a pill to keep you regular.

Student copy of physical findings

System	Findings
Vital signs, height, weight	Female: Height: 5'4" Weight: 110/ Male : Height 5'10' Wt : 165 Temp: 97.8 Pulse =72 Tanner level: V
General Appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant
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You tend to get cold easily.

Past Medical History

No known allergies. No prescription medications
You have enjoyed good physical health in the past
No major illness, but had atopic dermatitis as child, none lately
No significant skin problems in family, parents alive and well

Personal and Social History

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Eats fruits and vegetables and occasionally chocolate You eat dairy products and have not noticed any symptoms related to the intake of dairy.
Lives in college dorm. Gets along well with mother and father. No gun in house.

You have not traveled out of the country.

ROS: negative

Physical Exam:

You are a little concerned about the physical exam and ask questions about what the nurse practitioner is finding. For example, why are you looking in my ears? "They are fine."
When the nurse practitioner tells you, you want to know what that means

Treatment Plan:

You want to know what the medicine is and why your have to take it.

For the IBS you look sad/perturbed. Ask many questions and have difficulty understanding the directions. Say you just want to take a pill to keep you regular.

Saint Louis University School of Nursing

CASE 4

Mrs. H.
Instructions to the Student

Mrs. H. is a 41 year old white female who first visited the clinic one month ago for a women's health exam (all negative) under the Missouri Department of Health Breast and Cervical Cancer Project, because she is uninsured. Her income is at the 150% poverty level. At the time of her women's health exam, her mean blood pressure was an asymptomatic 154/94 (LA) with no orthostatic changes, no history of hypertension. Since that time, she has returned twice to the clinic for a blood pressure check. Two weeks ago, her mean left arm blood pressure was 162/98; and, one week ago, 166/96. There were no significant right arm/left arm differences. She has brought her B/P record with her. She returns today to consult with you regarding diagnosis and treatment.

Vital signs, height, weight	Baseline information	170/96 LA (sitting and standing, large cuff) 166/94 RA (sitting) HR: 72 R: 18 T: 97.8 F Height: 5'6" Weight: 190#

Tasks:

You have 30 minutes to

1. State pre-examination differential diagnosis and their rationale.
2. Obtain a focused history.
3. Perform a physical assessment.
4. Re-examine and list tentative differential diagnoses.
5. Identify your diagnosis, knowing that it will become conclusive only after diagnostic test results are obtained.
6. List diagnostic test you would obtain.
7. Assuming your diagnosis is correct, develop a therapeutic plan, including goals blood pressure.
8. Educate.

Student Name _____ CASE # 4

Instructor _____

Date _____-

Instructor solicited information
Pre-examination diagnoses before seeing the patient

High BP

Cushings, pheocromocytoma, coarctation of the aorta, aldosteronism, meds, renal artery stenosis, renal disease, essential hypertension

Thirst

Diabetes mellitus, dehydration, diabetes insipidus, cancer, gastrointestinal disease; vomiting, diarrhea.

Grade: History:	**30 pts _____**
PE:	**30 pts_____**
Diagnoses	**15 pts _____**
Treatment	**25 pts _____**

Total: _____

Student Name _____ CASE # 4

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

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History : 30pts

(1pt)	Confirm chief complaint	
(9pt)	HPI: Onset	
	progression	
	Symptoms: (target organs: Heart—DOE, SOB, Orthopnea, PND) Brain: vision, speech, weakness of extremity Kidney—any history Eyes—exams, any retinal changes	
	Secondary HTN: symptoms r/t 1. Cushings Disease 2. Kidney and renal 3. BCP and/or other meds 4. Aldosteronisins 5. Pheochromocytoma 6. Hyper or hypothyroid 7. ?? or aorta 8. Connective tissue disease 9. Polycythemia	
	Thirst--Diabetes mellitus 1. onset 2. duration	
	Demonstrates cultural sensitivity while establishing rapport	
8pt	**Past Medical History**	
	Demonstrates cultural sensitivity during history gathering	
	Medication	
	Allergies	
	Previous illness	
	Hospitalizations	
	Trauma	
	Surgeries	
	Chronic illness	
	Health maintenance	
2pt	**Family History**	
	Parents	
	Grandparents	
8pt	**Social & Personal History**	
	Home environment, Friends	
	Work	
	Exercise	
	Smoking, ETOH, drugs	
	Diet	
	Self-breast exam	
2pt	**Review of Systems:**	
	Negative except thirst	

Instructor Checklist: Physical assessment (30pts)

Pts	System	Rationale	Findings
		Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	Baseline information	170/96 LA (sitting and standing, large cuff) 166/94 RA (sitting) HR: 72 R: 18 T: 97.8 F Height: 5'6" Weight: 190#
	Facies and general appearance	With HTN, want to r/o Cushing's, hyperthyroidism, SLE	Pleasant appearing, obese middle-aged female with normal fascies and general appearance. No facial changes characteristic of Cushing's, hyperthyroidism, nor SLE. No truncal obesity or abnormal fat distribution over spine.
	Skin, lip color	Good indicator of adequate oxygenation	Skin color good, lips pink
	HEENT	Especially important to look for xanthomas and signs of retinal hemorrhage and AV nicking as patient may have a long-standing problem with HTN	Normocephalic, no xanthomas. PEERLA. EOMS intact. Fundoscopic: Red flex present, not nicking or AV hemorrhage. TM intact bilaterally. Pharynx: swallows without difficulty, no erythema Neck: nonpalpable thyroid, no carotid burit, no lymphadenopathy.
	Lungs	With patient's cat allergy, look for any signs of external supraclavicular or intercostals retractions, wheezing. With history of HTN, look for rales.	No supraclavicular nor intercostals retractions; AP/lateral diameter WNL; chest expansion WNL; inspiratory/expiratory ratio at trachea WNL. Lungs clear to auscultation and percussion; no wheezing, rales, no rhonchi.
	Heart	With HTN, be especially alert for increased heart size, arrhythmias, gallops murmurs	Apex at 5th ICS at MCL. RRR; S1 greater than S2 apex. No murmurs or gallop rhythm noted.
	Abdomen	With HTN, look especially for hepatomegaly and examine for abdominal aorta and renal aorta bruits and/or pulsating masses	Obese abdomen. No masses noted. BS present in all four quadrants. No abdominal/renal bruits. No organomegaly.
	Kidney	With HTN, important to palpate size of kidney. Also, check for flank tenderness.	Unable to palpate kidneys due to obesity. No flank tenderness.
	Extremities, including feet	With HTN, check for peripheral edema and also check leg circulation. Especially, check color of toes and feet. Check distribution of hair. Check posterior popliteal, posterior tibius, and dorsalis pedis pulses. Check feet in the event that the patient does turn out to have diabetes.	No peripheral edema. Color of toes and feet good. Capillary return WNL. Posterior popliteal, posterior tibius, and dorsalis pedis present and equal bilaterally at 3+. Skin on feet and between all digits intact. No calluses. Nails in good repair
	Rectal/pelvic	Deferred.	See exam of two months ago

	Neurologic	Important in HTN to detect any deficit and to obtain a baseline.	Alert, oriented x3, exhibits coordinated gait. Romberg negative. Perceives light touch and pain in all extremities, bilaterally. Vibratory sense intact. Brachial, radial, patellar, and Achilles DTRs 2+. No apparent neuro defet.

Differential Diagnosis *Post* H & P

Stage 2 HTN

Probable not secondary HTN
No signs of Cushing's renal disease, renal artery stenosis, or connective tissue disease on history and physical. Still need to check CBC, U/A, BUN, and creatinine.

Essential HTN

No family history of diabetes but has signs and symptoms of diabetes.
Patient is overweight and eats a high fat diet. Does little exercise.
BP over 120/80-

Final Diagnoses

Essential HTN
Adult Onset DM
Obesity
Other:
In need of tetanus booster
Uninsured
Sexual activity

Grade: Pre-exam 5pts _____

Post-exam 10pts_____

Management Plan

Instructor check off	(25points)	Comments
	Accurate treatment decisions (15pts)	
	Diagnostic tests: see below	
	Pharmacology: **HTN** - HCTZ or Ace Inhibitor **AODM** Metformin 500 mg.	
	Therapeutic Communication(15 pts)	
	Explanations easily understandable and culturally appropriate	
	Professional approach	
	Explained findings & diagnosis clearly	
	Importance of follow up (6weeks)	
	Patient education addresses health promotion:	
	Supportive therapies: Diet,Exercise Eye exam, Microalbuminuria or urine protein, Feet exam, Skin care, Sick days Card in wallet	

Test	Rationale
CBC	R/o polycythemia. Results: Hb 13; Hct 40; WBC 6.8 RCB 4.5; Platelets 300.
FBS	R/p diabetes mellitus. Results: 208
Lipid panel (Obtain now as patient is obese and has dietary pattern not conducive to normal lipids).	Obtain baseline reading; look especially at total values and at HDL and LDL. Results: Cholesterol 200: HDL 55; LDL; 100
Electrolytes (obtain now as thiazide is most cost-effective drug available to client; although a cardioselective beta blocker would work, but they are more expensive; calcium channel blockers are too expensive)	Obtain baseline, especially if thiazide diuretic is to be prescribed. Sodium 142; Potassium 4.0; Carbon dioxide 24; Phosphate 3.5.
BUN/creatinine/Uric Acid/urinalysis (obtain now)	Obtain baseline. Look for signs of renal problems as etiology of or as indicator of end-organ damage. BUN 11; Creatinine 0.8; Uric Acid 5.3; Urinalysis WNL
ECG (obtain now)	Obtain baseline. Examine for end organ damage. WNL

Script for the Patient (Instructor copy):
You are a 41 year old white female who has been asked to return to the clinic because of high BP readings. You had originally gone to the BCCCP project for breast and cervical cancer screening because you have no insurance. Two weeks ago your BP was 164/94 with no orthostatic changes. Since then you have returned twice to the clinic and your BP was 172/98 and then one week ago: 166/96. You have come to consult with the NP today about your BP.

PMH: Tubal ligation at age 30.

Two vaginal deliveries with no complications. No other hospitalizations.

Sprained ankle at age 32. No MVA.

You had whooping cough and chicken pox as a child. You have had no serious adult illnesses.

Last eye exam one year ago. You have had trouble reading but were advised to get OTC reading glasses at Walmart.

Yearly flu shot from the Health department. Your last tetanus shot was 12 years ago, when you cut your hand cleaning out a sewer drain on your farm.

No seasonal allergies, but every time you visit your daughter your eyes itch,you get a stuffy nose, and your chest gets a little tight. Your daughter has 2 cats. It goes away within an hour or so after you leave. So now your daughter visits you instead of you visiting her.

No prescription medications. Occasionally you take Tylenol for aches.

FH: Mother: CVA at age 63 and died about 2 years later, having never fully recovered. Your only sibling, a brother, died at age 60 of a heart attack. Your father is still alive at age 70, but he had CABG about 5 years ago. There is no family history of DM. Your mat. Grandmother died of breast cancer. All other grandparents died of old age.

Social & Personal Hx: your husband died 3years ago and you live with your 20 year old son who attends school at the local junior college. Your daughter lives nearby and visits frequently. You are active in your church group. No ETOH, tobacco, nor illegal drugs. You work as a clerk at a hardware store, 38 hours/week.

ROS:
Head: no headaches, no history of seizures, fainting, or dizzy spells

Your last eye exam shows one year ago. You have no trouble reading with the glasses your eye doctor said to buy OTC at Walmart.

No sinus problems, no teeth/mouth/throat problems
Neck is fine and it moves well as do all your joints

Your lungs are fine. You have no shortness of breath, walk up hills and stairs fine, have never awakened at night short of breath. You do not smoke.

Neither with exercise or at rest have you ever had any chest pressure or pain, no left shoulder or arm pain, no left index finger pain, no throat, neck or jaw pain. You have never had high blood pressure before.

You have no difficulty eating. You have no abdominal pain or discomfort. You are not constipated nor do you get diarrhea – just normal stools, usually once/day.

You have never had a kidney or bladder infection.

Your pregnancies were all normal, no complications. (Your other female exam information was taken at the last visit and there is no need to repeat it here).

Your joints are fine. You walk, OK. You do not experience leg cramps when walking, nor do you have abnormal tingling or other sensations in your hands or feet.

You never had a thyroid problem. You do have thirst but you do have excess hunger. You are getting up more often once during the night to void and you only use the bathroom at work during a coffee break and at lunch. You would like to lose about 15 pounds. Your 24 hour diet recall is:

Breakfast: two eggs, toast, coffee
Lunch: Diet coke, Hardy's cheeseburger, fries
Supper: Pork chop, mashed potatoes, cake
TV snack: Popcorn

You have never been depressed, except after your husband died- but you think that was grief. You eventually felt better and each day you try to be upbeat. You do not feel stressed. You sleep fine, about 7 hours/night. You have noticed no change in weight or eating habits. You feel good about life. You have a boyfriend, a truck driver.

Physical Exam (Student Copy)

System	Findings
Vital signs, height, weight	170/96 LA (sitting and standing, large cuff) 166/94 RA (sitting) HR: 72 R: 18 T: 97.8 F Height: 5'6" Weight: 190#
Facies and general appearance	Pleasant appearing, obese middle-aged female with normal fascies and general appearance. No facial changes characteristic of Cushing's, hyperthyroidism, nor SLE. No truncal obesity or abnormal fat distribution over spine.
Skin, lip color	Skin color good, lips pink
HEENT	Normocephalic, no xanthomas. PEERLA. EOMS intact. Fundoscopic: Red flex present, not nicking or AV hemorrhage. TM intact bilaterally. Pharynx: swallows without difficulty, no erythema Neck: nonpalpable thyroid, no carotid burit, no lymphadenopathy.
Lungs	No supraclavicular nor intercostals retractions; AP/lateral diameter WNL; chest expansion WNL; inspiratory/expiratory ratio at trachea WNL. Lungs clear to auscultation and percussion; no wheezing, rales, no rhonchi.
Heart	Apex at 5th ICS at MCL. RRR; S1 greater than S2 apex. No murmurs or gallop rhythm noted.
Abdomen	Obese abdomen. No masses noted. BS present in all four quadrants. No abdominal/renal bruits. No organomegaly.
Kidney	Unable to palpate kidneys due to obesity. No flank tenderness.
Extremities, including feet	No peripheral edema. Color of toes and feet good. Capillary return WNL. Posterior popliteal, posterior tibius, and dorsalis pedis present and equal bilaterally at 3+. Skin on feet and between all digits intact. No calluses. Nails in good repair
Rectal/pelvic	See exam of two months ago (no concerns)
Neurologic	Alert, oriented x3, exhibits coordinated gait. Romberg negative. Perceives light touch and pain in all extremities, bilaterally. Vibratory sense intact. Brachial, radial, patellar, and Achilles DTRs 2+. No apparent neuro defect.

Script for the Patient (Student copy):
You are a 41 year old white female who has been asked to return to the clinic because of high BP readings. You had originally gone to the BCCCP project for breast and cervical cancer screening because you have no insurance. Two weeks ago your BP was 164/94 with no orthostatic changes. Since then you have returned twice to the clinic and your BP was 172/98 and then one week ago: 166/96. You have come to consult with the NP today about your BP.

PMH: Tubal ligation

Three vaginal deliveries with no complications. No other hospitalizations.

Sprained ankle at age 32. No MVA.

You had whooping cough and chicken pox as a child. You have had no serious adult illnesses.

Last eye exam one year ago. You have had trouble reading but were advised to get OTC reading glasses at Walmart.

Yearly flu shot from the Health department. Your last tetanus shot was 12 years ago, when you cut your hand cleaning out a sewer drain on your farm.

No seasonal allergies, but every time you visit your daughter your eyes itch,you get a stuffy nose, and your chest gets a little tight. Your daughter has 2 cats. It goes away within an hour or so after you leave. So now your daughter visits you instead of you visiting her.

No prescription medications. Occasionally you take Tylenol for aches.

FH: Mother: CVA at age 63 and died about 2 years later, having never fully recovered. Your only sibling, a brother, died at age 60 of a heart attack. Your father is still alive at age 80, but he had CABG about 5 years ago. There is no family history of DM. Your mat. Grandmother died of breast cancer. All other grandparents died of old age.

Social & Personal Hx: your husband died 3years ago and you live with your 20 year old son who attends school at the local junior college. Your daughter lives nearby and visits frequently. You are active in your church group. No ETOH, tobacco, nor illegal drugs. You work as a clerk at a hardware store, 38 hours/week. You have a boyfriend, a truck driver.

ROS—next page

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You have never had a kidney or bladder infection.

Your pregnancies were all normal, no complications. (Your other female exam information was taken at the last visit and there is no need to repeat it here).

Your joints are fine. You walk, OK. You do not experience leg cramps when walking, nor do you have abnormal tingling or other sensations in your hands or feet.

You never had a thyroid problem. You do have thirst but you do have excess hunger. You are getting up more often once during the night to void and you only use the bathroom at work during a coffee break and at lunch. You would like to lose about 15 pounds. Your 24 hour diet recall is:

Breakfast: two eggs, toast, coffee
Lunch: Diet coke, Hardy's cheeseburger, fries
Supper: Pork chop, mashed potatoes, cake
TV snack: Popcorn

You have never been depressed, except after your husband died- but you think that was grief. You eventually felt better and each day you try to be upbeat. You do not feel stressed. You sleep fine, about 7 hours/night. You have noticed no change in weight or eating habits. You feel good about life. You have a boyfriend, a truck driver.

Case: 5
Annetta
Instructions to the Student:

Chief Complaint: weakness and fatigue more than usual over the last 2 months

HPI: Annetta, a 56year-old African American female, was in good health until about 2 months ago when she began to feel weak and tired more rapidly then usual. She also noticed she was getting up several times a night to urinate. Whenever she sis get up she was thirsty and would drink a glass of water and go back to bed. This was occurring 2-3 times a night so she thought she was maybe just not getting enough sleep. She felt like she wasn't as productive at work and just did not feel like going everyday.

Vital signs, height, weight	Female: Height: 5'7" Weight: 202 lbs Temp : 98.4 Pulse =76 BP 142/78

Task

You have 30 minutes to:

7. State the possible differential diagnoses at the onset
8. Obtain a focused history
9. Perform a focused physical assessment
10. Re-examine the list differential diagnoses
11. State your diagnosis
12. Develop a therapeutic plan include, all of the following if appropriate: pharmacological, nursing/supportive therapies health promotion and health education, and follow-up.

Student Name _____ CASE # 3

Instructor _____

Date _____-

Instructor solicited information
Pre-examination diagnoses before seeing the patient

Fatigue: Anémia
Thyroid
Diabetes
Chronic Fatigue Syndrome
Depression
Sleep disorder
UTI

Grade: History:		**30 pts _____**
PE:		**30 pts_____**
Diagnoses		**15 pts _____**
Treatment		**25 pts _____**

Total: _____

Student Name _____ CASE # 5

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

Definitions:

Advanced: Performs/demonstrates at a superior level with no verbal cues or prompting (91-100)

Proficient: Performs/demonstrates at the expected level with minimal verbal cues or prompting (80-90)

Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

History : 30pts

(2pt)	Confirm chief complaints	
(10pt)	**HPI:** onset :2 months ago	
	Progression of symptoms:	
	Activities that make it worse or better	
	Associated Symptoms: need to explore the following:	
	Polydipsia, Polyuria, Polyphagia	
	Weight loss	
	Visual changes	
	Infections	
	Poor wound healing	
	Dry skin	
	Numbness tingling	
	Headaches	
	Palpitations, chest pain, SOB	
	Sleep patterns	
	Should screen for depression/ lack of motivation	
	Alleviating factors : none	
	Demonstrates cultural sensitivity while establishing rapport	
5pt	**Past Medical History**	
	Demonstrates cultural sensitivity during history gathering	
	Previous Hospitalizations/ illnesses: G3P3, should ask about pregnancies , weight, and health - No chronic illness, ? Menses? menopause	
	Surgeries/ trauma: Appendectomy 1972, no injuries or disabilities	
	Childhood Illnesses: had usual illnesses with no complications	
	Previous health care: sees dr when needed, goes to local clinic always sees someone different	
	Recent Exams: (had everything when turned 50) Mammogram 6 years ago Eye exam 3 years ago Dental 6 years ago Never DEXA Never colonoscopy	

	Immunizations: Can't remember last tetanus, doesn't think she needs flu shot	
	Medication: No prescription meds, takes OTC Ibuprofen for headaches PRN, no herbal	
	Allergies: none	
	Health maintenance: self-breast exam monthly, never EKG, TM, or Xray (rest below)	
2pt	**Family History**	
	Parents: father died 69y/o massive stroke Mother : died 62 ESRD, DM , amp foot Should ask about hx migraines	
	Youngest of 4 children weight 10lb 2 oz at birth both parents and bro and sisters all overweight 2 have DM	
8pt	**Social & Personal History**	
	Home environment,	
	Military service	
	Work	
	Education	
	Exercise	
	Risk taking (Smoking, ETOH, drugs, seat belt use)	
	Diet	
3pt	**Review of Systems: negative**	
	-Skin hair nails: skin dry flakey always, uses olive oil, nails unchanged, feet have dry skin and calluses -Head and Neck, gums bl after tooth brush, rare headaches late in day relieved with Ibuprofen -eyes, blurry vision, especially as day goes on, getting worse, wears glasses for astigmatism, near sighted, has not seen eye dr 3 yr. -ENT, seasonal allergies, fine right now, takes OTC meds for it -Chest/ lung, denies sob, -Heart, denies chest pain, palpitations	

	-Abd, denies indigestion, regular BM no blood. Diet should be ? if not previous -Female gyn, menses age 11, menopause 52, occ yeast infections treated with OTC meds -Neuro, numbness tingling, wakes at night, several years, moving or changing positions helps _all other systems unremarkable	

Client – Script for Physical Assessment

Instructor check-off (30pts)	System	Findings
	Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	Female: Height: 5'7" Weight: 202 BMI 31; Waist 40 " Temp: 98.4 Pulse 76 BP 142/78
	General Appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant, obese
	Skin	Warm, dry, no cuts or bruises, normal female hair distribution, consistent color, no rashes or lesions
	Eyes	PERRLA, EOMs intact vision corrected to 20/20 with glasses, fundi clear yellow, without pigment variations, disc margins sharp, no AV nicking, no retinopathy
	Ears	Auricles NT, symmetric, TMs pearly grey, landmarks visualized, hearing accurate
	Mouth & Pharynx	No lesions, dentition several repaired carries, uvula rises symmetrically, gag intact, pharynx clear without erythema or exudates
	Neck	Neck supple, full range of motion, no visible deformity, thyroid non-palpable
	Heart/Peripheral vascular	RRR without murmur or gallop, S1 and S2 within normal limits, all pulses present equal and strong, Femoral, popliteal, dorsalis pedis 2 + bilaterally, no carotid bruits or thrills appreciated. PMI 5th ICS, Left MCL. No edema, capillary refill rapid.
	Lungs	Clear to auscultation A and P bilaterally, vesicular sounds throughout
	Abdomen	bulky, BS X 4, soft, no tenderness to light or deep palpation, no masses or bruits, no organomegaly
	Musculoskeletal (this does not need to be done)	Full Active ROM Upper Extremities, and lower Extremities. Opposition intact, symmetric strength 5/5
	Neurological	Diminished vibratory sense to for foot, absent ankle reflex, All other DTR 2+ Monofilament sensed only above ankle Smooth rapid movement

		Strength all 5/5 Memory intact recent and past Smooth clear speech

Diagnoses: (15 points)

List of Differential Diagnoses

Diabetes, Type I
Diabetes, Type II
HTN
Obesity
Hypercholesterolemia (they may include this)

Final Diagnoses:

Diabètes, Type II
Obesity
Peripheral Neuropathy
Elevated Blood Pressure

Management Plan

Instructor check off	**(25 points)**	**Comments**
	Accurate treatment decisions	
	Diagnostic tests: Lab: (preferably fasting) CMP, CBC, Lipids, HgA1C, C-Peptide, UA. (CMP will have FBS) EKG, CXR, may want a TN before starting exercise program	
	Pharmacology: Because FBS >250 but < 400 need to start an oral med….single agent first. -Prefer Biguanide, Metformin 500 BID This may also help with weight loss -Could also chose sulfonylurea, Glipizide 5mg po qd, or glyburide 1.25 mg po qd (no renal impairment, liver ETOH, or sulfa allergy) May also mention Lyrica or something for the peripheral neuropathy, would be best to get glucose stable first	
	Diet, Weight loss, and Exercise education see below.	

	Therapeutic Communication	
	Explanations easily understandable and culturally appropriate - Pathology of Diabetes, - Signs and symptoms - Home glucose monitoring/ log - Target range for Blood glucose and what to do - Diet , Exercise, Weight loss - Complications of diabetes Explain effects of Obesity Explain effects of elevated BP	
	Professional approach	
	Explained findings & diagnosis clearly	
	Importance of follow up (1weeks)	
	Patient education addresses : (include spouse if possible) -Diet: balanced, Protein, carbs, fiber, fats ratio, 3 meals 3 snacks and regular timing, high glycemic foods, sweeteners, ETOH, NAS since slightly elevated BP -Long term weight loss, portion control, lose 10% weight, -Exercise, 30 min a day, decreases BS and utilizes insulin better ROM, warm up and cool down - Importance of meds, how they work, side effects, timing -BS testing at least each AM and prior to meals, or if symptomatic, keep log and bring to each visit -Foot care, socks, check daily, proper fitting shoes, larger toe box on shoes since callus -	

	BP check at each visit, NAS as mentioned above Smoking cessation, No alcohol for now Health Promotion: Seat belts, smoke detectors (older home), colonoscopy, flu shot, stress management and sleep hygiene, DEXA, Pelvic Pap _Annual eye exam, foot exam, dental BP checks	
	Help her to set personal goals for all education: Wt loss, Exercise, BS	
	Referral to: Diabetic Educator Dietitian Podiatrist Ophthalmologist Dental Local Support Group	

Lab Results

Complete Metabolic Panel		
	Results	**Norm**
Glucose	**352 mg/dl**	**65-109 mg/dl**
Creatinine	**1.0 mg/dl**	**0.5-1.4 mg/dl**
BUN	**18 mg/dl**	**7-30 mg/dl**
Na	**141 mg/dl**	**135-146 mg/dl**
K+	**4.3 mg/dl**	**3.5 – 5.3 mg/dl**
AST	**14 IU/L**	**0-40 IU/L**
ALT	**19 IU/L**	**5-40 IU/L**
Alk Phos	**56 IU/L**	**35 – 125 IU/L**
Random Blood Glucose	**456**	
Hg A1C	**13.3%**	
C-Peptide	**2.65 ng/ml**	**.51-2.7 g/ml**
CBC	**All within normal limits**	
Lipid Panel		
Total Chol	**162 mg/dl**	**<200**
HDL	**43 mg/dl**	**≥ 40**

LDL	**84 mg/dl**	**< 100**
Triglycerides	**177 mg/dl**	**< 150**
Chol: HDL ratio	**3.8**	**< 50**
Urinalysis		
Color	**Straw**	
PH	**6.0**	
SpG	**1.025**	
Protein	**Neg**	
Ketones	**Neg**	
Glucose	**4+**	
Blood	**Neg**	
Leucocytes	**Neg**	

CXR, clear

EKG, NSR (see attached)

Script for Patient (Instructor copy)

You are a 56 -year -old AA female administrative secretary who came in alone in no apparent distress

CC : I feel weak and tired more than usual over the last 2 months

History of Present Illness

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HPI: Annetta was in good health until about 2 months ago when she began to feel weak and tired more rapidly then usual. She also noticed she was getting up several times a night to urinate. Whenever she sis get up she was thirsty and would drink a glass of water and go back to bed. This was occurring 2-3 times a night so she thought she was maybe just not getting enough sleep. She felt like she wasn't as productive at work and just did not feel like going everyday.

Her weight was always average through high school, she was a cheerleader and very active in school events, but gradually over the years she put on pounds. Her appetite had remained excellent though she admits she does love breads and pasta and thinks that is what contributed most to her weight gain, though in the last 2 months without trying she has lost about 15 pounds and had begun to feel weak and tired

She does also note some pain in her feet that is worse at night, sometimes it even keeps her awake. She describes it as a burning pain, sometimes her toes feel numb. She has also noticed some numbness and tingling in her fingers that sometimes causes her some problems at work when she is typing on the computer, or placing paperclips on reports. She noticed she is frequently dropping small items and has difficulty with some fine motor movement.

Her vision is blurry at times especially as the day goes on, afternoon, but she thinks she just needs to get her glasses checked, it has been a while.

She denies any palpitations, headaches, shortness of breath.

Past Medical History
No chronic illness, You have enjoyed good physical health in the past, so you usually do not see a doctor on a regular basis. G3 P3. uncomplicated pregnancies. Menses at age 11, Menopause at age 51

surgeries or trauma, Appendectomy 1972

normal childhood illnesses

No known allergies.

No prescription medications, takes OTC Ibuprofen for aches and pains sometimes

Immunizations, can't remember last tetanus, has never had the flu shot because "she is healthy", does do self breast exam, she has a friend and they remind each other, last mammogram was at the age of 50. Last eye exam was about 3 years ago, last dental visit 6 years ago when she chipped a tooth on a nut
she drinks several cups of coffee at work each day, quit smoking several times the last time was 6 months ago…she only smokes ½ ppd. Started when she was 16, "it was the cool thing to do", quit when she was pregnant with her first child. Started smoking again about a year later. Has started and stopped on and off through the years when she was pregnant when her kids were in their teens, when she and her husband were having trouble for a while. Thinking about quitting again because cigarettes are just getting too expensive.

Family Hx: Both parents are deceased father died at the age of 69 from a massive stroke mother died at 62 from end stage kidney disease., she had been diagnosis with Diabetes at the age of 42 and had had numerous complications including partial amputation of her right foot. She was on dialysis for 3 years before she died….Annetta was very involved in her mothers care, giving her shots 2 times a day and transporting her to dialysis and MD visits.

Annetta is the youngest of 4 children and weighed 10 lbs 2 oz at birth. Both parents are overweight as are the siblings 2 of which have been dx as diabetes.

Personal and Social History

Happily married, lives at home that they have owned for 30 years. She has 3 grown children, 2 girls and 1 boy, 2 grand children. All live in the area. She smokes as previously noted, has an occasional drink (wine) after work with her friends and on special occasions. She is in the choir at her church, and enjoys reading and sewing, but it has been difficult to do these things lately. She knows she should exercise but it never quite fits into her schedule.

She enjoys her job as an Administrative Executive Secretary, where she has worked for the same boss for the last 26 years…they have been promoted in the company together. In this position there are lots of deadlines and reports and she feels that all things need to be done perfectly.

She is a high school graduate, then completed Ms Hickey's Secretarial School. She was the top in her class.

Neither she nor her husband have ever been in the military
Diet: Eats a lot of bread and pasta. Normal dinner is 2 cps cooked pasta with homemade sauce, 3-4 slices of Italian bread (sometime with cheese and garlic) During the day she has a sandwich with lunch meat, usually puts butter on the bread to keep it moist. She also eats about 6 pieces of fruit a day at meals and as snacks, She prefers chicken and fish when she goes out but likes when it has a cream sauce on it best!

ROS: (in addition to what has already been given)

-Skin hair nails: skin dry flakey always, uses olive oil, nails unchanged, feet have dry skin and calluses

-Head and Neck, gums bleed after tooth brush, rare headaches late in day relieved with Ibuprofen

-eyes, blurry vision, especially as day goes on, getting worse, wears glasses for astigmatism, near sighted, has not seen eye dr 3 yr.

-ENT, seasonal allergies, fine right now, takes OTC meds for it

-Chest/ lung, denies sob,

-Heart, denies chest pain, palpitations

-Abd, denies indigestion, regular BM no blood. Diet should be ? if not previous

-Female gyn, menses age 11, menopause 52, occ yeast infections treated with OTC meds

-Neuro, numbness tingling, wakes at night, several years, moving or changing positions helps

_all other systems unremarkable

Physical Exam: Things are a little blurry and you need to wear your glasses
You have numb toes/ feet (nothing else abnormal you need to act out)

Treatment Plan: You are very motivated, want to be well so that you can do good at work and enjoy children, and grandchildren. Think your husband will be supportive and could benefit from this plan as well…you want to do it together. You will do what ever you need to do.

Student copy of physical findings

System	Findings
Vital signs, height, weight	Female: Height: 5'7" Weight: 202 BMI 31; Waist 40 " Temp: 98.4 Pulse 76 BP 142/78
General Appearance	Well nourished, well developed, alert and oriented X3, appropriate, pleasant, obese
Skin	Warm, dry, no cuts or bruises, normal female hair distribution, consistent color, no rashes or lesions
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Script for Patient (Student copy)

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Her weight was always average through high school, she was a cheerleader and very active in school events, but gradually over the years she put on pounds. Her appetite had remained excellent though she admits she does love breads and pasta and thinks that is what contributed most to her weight gain, though in the last 2 months without trying she has lost about 15 pounds and had begun to feel weak and tired

She does also note some pain in her feet that is worse at night, sometimes it even keeps her awake. She describes it as a burning pain, sometimes her toes feel numb. She has also noticed some numbness and tingling in her fingers that sometimes causes her some problems at work when she is typing on the computer, or placing paperclips on reports. She noticed she is frequently dropping small items and has difficulty with some fine motor movement.

Her vision is blurry at times especially as the day goes on, afternoon, but she thinks she just needs to get her glasses checked, it has been a while.

She denies any palpitations, headaches, shortness of breath.

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normal childhood illnesses

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Immunizations, can't remember last tetanus, has never had the flu shot because "she is healthy",
does do self breast exam, she has a friend and they remind each other, last mammogram was at the age of 50. Last eye exam was about 3 years ago, last dental visit 6 years ago when she chipped a tooth on a nut
she drinks several cups of coffee at work each day, quit smoking several times the last time was 6 months ago…she only smokes ½ ppd. Started when she was 16, "it was the cool thing to do", quit when she was pregnant with her first child. Started smoking again about a year later. Has started and stopped on and off through the years when she was pregnant when her kids were in their teens, when she and her husband were having trouble for a while. Thinking about quitting again because cigarettes are just getting too expensive.

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Anetta is the youngest of 4 children and weighed 10 lbs 2 oz at birth. Both parents are overweight as are the siblings 2 of which have been dx as diabetes.

Personal and Social History

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Diet: Eats a lot of bread and pasta. Normal dinner is 2 cps cooked pasta with homemade sauce, 3-4 slices of Italian bread (sometime with cheese and garlic) During the day she has a sandwich with lunch meat, usually puts butter on the bread to keep it moist. She also eats about 6 pieces of fruit a day at meals and as snacks, She prefers chicken and fish when she goes out but likes when it has a cream sauce on it best!

ROS: (in addition to what has already been given)
-Skin hair nails: skin dry flakey always, uses olive oil, nails unchanged; feet have dry skin and calluses

-Head and Neck, gums bleed after tooth brush, rare headaches late in day relieved with Ibuprofen

-eyes, blurry vision, especially as day goes on, getting worse, wears glasses for astigmatism, near sighted, has not seen eye dr 3 yr.

-ENT, seasonal allergies, fine right now, takes OTC meds for it

-Chest/ lung, denies sob,

-Heart, denies chest pain, palpitations

-Abd, denies indigestion, regular BM no blood. Diet should be ? if not previous

-Female gyn, menses age 11, menopause 52, occ yeast infections treated with OTC meds

-Neuro, numbness tingling, wakes at night, several years, moving or changing positions helps

_all other systems unremarkable

Physical Exam: Things are a little blurry and you need to wear your glasses
You have numb toes/ feet (nothing else abnormal you need to act out)

Treatment Plan: You are very motivated, want to be well so that you can do well at work and enjoy children, and grandchildren. Think your husband will be supportive and could benefit from this plan as well…you want to do it together. You will do what ever you need to do.

Case: 6

John

Instructions to the Student

Chief Complaint: John is a 62-year-old auto mechanic who is requesting a routine checkup. He has a history of hypertension. He has not seen a health care provider since he lost his health care insurance about one year ago. He recently started a new job and is requesting a check-up. He takes Hydrochlorothiazide for high blood pressure. He feels he eats a healthy diet .His only complaints are occasional fatigue, blurred vision, and urinary frequency with dribbling after he urinates. He has to get up several times a night to void.

Vital Signs, height Weight	Male: Height: 70 inches: Weight 225 lbs. Temp: 98 F HR= 80, regular

Task

You have 30 minutes to:

1. State the possible differential diagnoses at the onset.
2. Obtain a focused history.
3. Perform a focused physical assessment.
4. Re-examine the list of differential diagnoses.
5. State your final working diagnosis.
6. Develop a therapeutic plan including all of the following if appropriate:
    a. Pharmacologic
    b. Nursing/supportive therapies
    c. Health promotion
    d. Health education
    e. Follow-up.

Student Name _____

Instructor _____

Date _____

Instructor solicited information
Pre-examination diagnoses before seeing the client.

1. Essential hypertension.
2. BPH
3. Obesity
4. Eye problems such as presbyopia, cataract, glaucoma.

Grade: History:	**30 pts _____**
PE:	**30 pts_____**
Diagnoses	**15 pts _____**
Treatment	**25 pts _____**

Total: _____

Student Name _____ CASE # 6

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

Definitions:

Advanced: Performs/demonstrates at a superior level with no verbal cues or prompting (91-100)

Proficient: Performs/demonstrates at the expected level with minimal verbal cues or prompting (80-90)

Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

(2 pts)	Confirm chief complaints	
(10 pts)	**HPI: (HTN)** onset: 5 years ago	
	Progression: getting worse since he ran out of medicine	
	Associated symptoms: occasional chest pain discomfort, no SOB, palpitations or headache.	
	(Urinary Symptoms)	
	Onset: uncertain, but at least the last six months	
	Progression:	
	Alleviating factors:	
	Aggravating factors	
	Associated symptoms	
	Demonstrates cultural sensitivity while establishing rapport	
5 pts	**Past Medical History**	
	Demonstrates cultural sensitivity during history gathering	
	Medication	
	Allergies	
	Previous Illness	
	Hospitalizations, surgeries, trauma (none)	
	Health Maintenance	
2 pts	**Family History**	
	Parents: Father had HTN Should ask about DM, CAD	
8 pts	**Social & Personal History**	
	Exercise	
	Diet	
	Work environment	
3 pts	**Review of Systems**	
	Student should ask particularly about obstructive and irritative symptoms. Because of HTN student should ask about chest pain, SOB and palpitations.	

Symptoms that Cumulatively Support the Diagnosis of BPH:

1. Obstructive Complaints:
   Hesitancy
   Decreased force & caliber of stream
   Sensation of incomplete bladder emptying
   Double voiding (urinating a second time within 2 hours)
   Straining to urinate,
   Post-void dribbling.

2. Irritative Complaints:
   Urgency
   Frequency
   Nocturia.

American Urological Association Symptom Index.
Single most important tool used in the evaluation of patients with BPH.
Should be calculated for all patients before starting therapy.
Likert scale 0 (not at all) to 5 (almost always)

1. Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?
2. Over the past month, how often have you had to urinate again less than 2 hours after you finished urinating?
3. Over the past month, how often have you found that you stopped & started again several times when you urinated?
4. Over the past month, how often have you found it difficult to postpone urination?
5. Over the past month, how often have you had to push or strain to begin urination?
6. Over the past month, how many times did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?

*** Answers quantitate the severity of obstructive or irritative complaints. Score can range from 0-35, in increasing severity of symptoms.**

Clues to Differential Diagnoses

1. Other obstructive conditions (urethral stricture, bladder neck contracture, bladder stone or carcinoma of the prostate) should be considered when evaluating men with presumptive BPH.
2. Prior history of urethral instrumentation, urethritis, or trauma should be elucidated to exclude urethral stricture or bladder neck contracture.
3. Hematuria & pain are commonly associated with bladder stones.
4. CA of the prostate may be detected by abnormalities on DRE or elevated PSA.
5. UTI may mimic irritative symptoms of BPH.
6. CA of the bladder may present with irritative voiding complaints.

Client-Script for Physical Assessment

Instructor check off (20 pts)	System	Findings
	Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	162/96 HR 80 R18 T 98 Height 70 inches Weight 225 lbs.
	General Appearance	Well nourished, well developed, alert, NAD
	Skin	Warm, dry, without lesions
	Eyes	Red reflex intact. PERRLA, EOM's full. Optic disc margins well defined, no AV nicking or hemorrhages.
	Neck	Supple, no thyromegaly or bruits, no JVD.
	Lungs	CTA, AP/Lateral WNL.
	Heart	No lifts or heaves. PMI 5th ICS, MCL. S1 and S2 RRR. Faint + S4 heard best at the apex. Grade 2/6 systolic murmur.
	Abdomen	Obese. + normal BS. Soft, non-tender without masses, tenderness or bruits.
	Neurological	Alert & Oriented. Cooperative. Gait coordinated. Normal sensory, motor & vibratory sensatory bilaterally. DTR's + 2 throughout.
	Extremities	Pulses +2, skin warm & pink, no edema. Feet dry. No dermopathy. No open areas. Nails in good repair.
	Rectum	Anal sphincter and rectal vault wnl. Prostate boggy with symmetric lobes. No nodules, soft brown stool. Guiac negative.

List of Differential Diagnoses:

1. HTN
2. BPH
3. Possible Angina

Final Diagnosis

1. HTN (uncontrolled) Stage 2
2. BPH
3. Possible angina with 3+ cardiac risk factors

Management Plan

Instructor Check off 30 points	(30 points)	Comments
	Accurate treatment decisions (20 pts)	
	Diagnostic tests: BMP: normal TSH: normal Lipids: Total Chol=236 LDL=156 HDL= 28 U/A Urine C/S negative PSA: normal EKG: normal	
	Pharmacology**:**	
	Therapeutic Communication (10 pts)	
	Explanations easily understandable and culturally appropriate	
	Professional approach	
	Explained findings & diagnosis clearly	
	Importance of follow up (4 weeks)	
	Patient education addresses: HTN- importance of adherence to medications. Smoking-importance of smoking cessation & possible strategies. Obesity- BMI= Dyslipidemia-appropriate diet Chest discomfort- need for stress test to rule out CAD	
	Medical Therapies: Order Stress and 2D echo with color flow for multiple CAD risk factors	

Smoking: TTM: pre-contemplation. Bring up at each visit. Chantix/Zyban therapy if patient agrees.
HTN: Uncontrolled Stage 2. Student should consider which drug therapy to use. JNC-7 guidelines suggest 2 medications for this level of HTN. Student may choose one if she/he believes it's due to non-adherence to drug therapy.
BPH: alpha blockers good choice in light of HTN. 5a reductase inhibitors (Finasteride). Combination therapy (should start with monotherapy initially).
No imaging needed (no UTI or hematuria). Cysto not needed to determine tx (only if surgery indicated)
Dyslipidemia: Low fat, low cholesterol diet. Student should mention that statin therapy may be indicated if TLC doesn't bring down lipid levels. Patient needs weight reduction. No exercise program until stress test is reviewed.
Chest discomfort: Patient has numerous CAD risk factors (smoking, dyslipidemia, HTN, obesity)-Should have stress test and ECHO (patient has murmur).Order as atypical angina with multiple CAD risk factors.
Blurred vision: Schedule eye exam

Script for Patient (Instructor copy)

You are a 61-year-old auto mechanic and come in alone.
You are not in any immediate distress.

CC "I haven't been to a health care provider in a few years. I have high blood pressure but I'm really worried about having to urinate so much."

History of Present Illness
Identify yourself as someone who really tries to avoid seeing a health care provider. You work really hard as an auto mechanic and don't really have time for routine check-ups. You've been diagnosed with high blood pressure but you're really not concerned about this because you have no symptoms. You run out of your medication sometimes.

You're here today because you're constantly running to the bathroom to urinate. This interferes with your job and your sleep. You think you're so tired because you get up several times a night to go to the bathroom. You don't have any burning or pain with urinating. You have noticed that it's difficult to get your stream going and sometimes you have to urinate twice in one hour.

Past Medical History
No known allergies.
HCTZ 12.5 mg PO daily
No major illnesses.
Father had HTN.

Personal and Social History
You smoke 1 pack of cigarettes a day. You started smoking age 16. You have 1-2 beers every evening after dinner. You've been married for 40 years and have three children who are all married with kids. You don't have time to exercise. You feel you get plenty of exercise on the job.

ROS:
You do occasionally have some chest pressure but it's usually because you work so hard. It doesn't last very long (maybe 5 minutes). When you rest it goes away.

Physical Exam:
You really don't see the need for a physical examination today. You just want something to stop the constant urination. You really don't want to discuss your high blood pressure or your occasional chest discomfort.

Treatment Plan:
You want to know when you can stop taking your high blood pressure medicine. You are not interested in getting any testing done at this time.

Student copy of physical findings

System	Findings
Vital signs, height, weight	162/96 HR 80 R18 T 98 Height 70 inches Weight 225 lbs.
General Appearance	Well nourished, well developed, alert, NAD
Skin	Warm, dry, without lesions
Eyes	Red reflex intact. PERRLA, EOM's full. Optic disc margins well defined, no AV nicking or hemorrhages.
Neck	Supple, no thyromegaly or bruits, no JVD.
Lungs	CTA, AP/Lateral WNL.
Heart	No lifts or heaves. PMI 5th ICS, MCL. S1 and S2 RRR. Faint + S4 heard best at the apex. Grade 2/6 systolic murmur.
Abdomen	Obese. + Normal BS. Soft, non-tender without masses, tenderness or bruits.
Neurological	Alert & Oriented. Cooperative. Gait coordinated. Normal sensory, motor & vibratory sensatory bilaterally. DTR's + 2 throughout.
Extremities	Pulses +2 , skin warm & pink, no edema. Feet dry. No dermopathy. No open areas. Nails in good repair.
Rectum	Anal sphincter and rectal vault wnl. Prostate boggy with symmetric lobes. No nodules, soft brown stool. Guiac negative.

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ROS:
You do occasionally have some chest pressure but it's usually because you work so hard. It doesn't last very long (maybe 5 minutes). When you rest it goes away.

Physical Exam:
You really don't see the need for a physical examination today. You just want something to stop the constant urination. You really don't want to discuss your high blood pressure or your occasional chest discomfort.

Treatment Plan:
You want to know when you can stop taking your high blood pressure medicine. You are not interested in getting any testing done at this time.

Case: 7

Sally

Instructions to the Student

Chief Complaint: Sally is a 26 year old bar tender. She is here today because she is worried about shortness of breath which started one week ago. She also is worried about a non-productive cough that is worse at night when she gets into bed. She sometimes has some nasal congestion. Otherwise, she states she is in good health.

Vital Signs, height Weight	BP 110/76 HR 80 (regular) Temp 98.6 Height 5'5 Weight 120 lbs

Task

You have 30 minutes to:

1. State the possible differential diagnoses at the onset.
2. Obtain a focused history.
3. Perform a focused physical assessment.
4. Re-examine the list of differential diagnoses.
5. State your final working diagnosis.
6. Develop a therapeutic plan including all of the following if appropriate:
    a. Pharmacologic
    b. Nursing/supportive therapies
    c. Health promotion
    d. Health education
    e. Follow-up.

Student Name _____ Case #7

Instructor _____

Date _____

Instructor solicited information
Pre-examination diagnoses before seeing the client.

1. Upper Respiratory Infection
2. Seasonal Allergies
3. Asthma
4. Upper Airway Cough Syndrome

Grade: History:	**30 pts _____**
PE:	**30 pts_____**
Diagnoses	**15 pts _____**
Treatment	**25 pts _____**

Total: _____

Student Name _____ CASE # 7

Instructor _____

Date _____

During direct observations of a patient encounter or a given case simulation, score the student on the following program outcomes:

Program Learning Outcomes	Advanced	Proficient	Not Proficient
3A.The student integrates advanced competencies in relationships with patients/professionals.			
3B. The student integrates advanced theories in relationships with patients/professionals.			
3c. The student integrates cultural sensitivity in relationships with patients/professionals.			
4a. The student designs culturally sensitive patient care that includes health promotion and disease prevention.			

Definitions:

Advanced: Performs/demonstrates at a superior level with no verbal cues or prompting (91-100)

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Not Proficient: Performs/demonstrates below minimally competent level; requires frequent verb cues/prompting. Requires remediation. (79 or below)

(30 pts)	**History**	
	Confirm chief complaint	
	HPI: onset:	
	Progression of symptoms:	
	Associated symptoms:	
	Alleviating factors:	
	Aggravating factors	
	Demonstrates cultural sensitivity while establishing rapport	
	Past Medical History	
	Demonstrates cultural sensitivity during history gathering	
	Medication	
	Allergies	
	Previous Illness	
	Hospitalizations, surgeries, trauma (none)	
	Health Maintenance	
	Family History	
	Social History	
	Exercise & Diet	
	Smoking & ETOH	
	Work environment	
	Review of Systems	

Client-Script for Physical Assessment

PE: Instructor check off (30 pts)	System	Findings
	Demonstrates cultural sensitivity during physical examination	Ie. Draping, covering/uncovering, gender of provider/religious preferences observed
	Vital signs, height, weight	110/76 HR 80 R18 T 98.6 Height 5'5 Weight 120 lbs.
	General Appearance	Well nourished, well developed, alert, NAD
	Skin	Warm, dry, without lesions
	Eyes	Red reflex intact. PERRLA, EOM's full.
	Ears	Normal canals. TM normal. No bulging.
	Nose/ Mouth	Turbinates mildly boggy. Mouth- no lesion. No erythema or exudates
	Neck	No thyroid enlargement. No lymphadenopathy
	Heart	S1 & S2 RRR. No murmur.
	Lungs	Normal A-P diameter. No tactile fremitus. No dullness to percussion. Expiratory wheezing all lung fields.
	Extremities	No edema.

(15 pts)
Final Diagnoses: 1. Asthma
2. High risk sexual behavior
3. ETOH abuse

(25 pts) Management Plan

		Comments
	Diagnosis	
	Identifies all three final diagnoses Orders appropriate diagnostic tests: **PFT's** FEV1 1.9 (81% of predicted) FVC 3.3 (55%) of predicted Improves by 20% with bronchodilator HCG-negative Urine- Chlamydia/GC RPR, VRDL, HIV	
	Management Plan Pharmacology**: Orders medications consistent with Step 3 (moderate persistent asthma) care** Rescue Inhaler Low Dose ICS & LABA	
	Therapeutic Communication	
	Explanations easily understandable and culturally appropriate	
	Professional approach	
	Explained findings & diagnosis clearly	
	Importance of follow up (2-4 weeks)	
	Patient education addresses: **<u>Asthma</u>** Asthma Triggers Use of inhalers Orders PFM & Spacer Rinse mouth after using inhalers Written asthma plan **<u>High Risk Sexual Practices</u>** Safer sex practices Schedule follow up for WWE **<u>ETOH Use</u>** Explores perception of ETOH Use Discusses options for decreasing Use	
	Health Protection Immunizations: Influenza, Pneumonia, HPV	

Script for Patient (Instructor copy)

You are a 26-year old bartender.
You are very mildly SOB during this visit
CC "I'm having difficulty breathing.
History of Present Illness

You're here today because you've been a "little bit short of breath" for the last week. You think it started about one week ago after you took your dog for a walk. It's usually worse at night when you lay down to go to sleep. It's been getting a little worse every day. You notice it more when you exercise or go up a flight of steps.

You also are concerned about a cough which started about the same time that the breathing problems started. The cough is non-productive. You have no fever or chills. You have some nasal congestion, but you've had that for many years. You think you probably have allergies (especially in the spring) but it seems much worse this year.

Past Medical History
Unremarkable.
Take no meds.

Family History
Mom and Dad- Alive and well. No health care issues.
Brother (age 15). Diagnosed with asthma as a child.

Personal and Social History
You have never smoked. You are a bartender and drink 5-6 beers when you get off of work each night at 1 pm.

You use to have a boyfriend but broke up 10 months ago. Since then, you have been sexually active with several men. You don't use condoms. You have an IUD (Merena) for birth control. You really haven't thought about getting an STI. If asked, you have no vaginal symptoms.

Physical Exam:
You really don't see the need for a physical examination today. You have not had a WWE for 3 years (when your IUD was inserted).

Script for Patient (Student Copy)

You are a 26-year old bartender.
You are very mildly SOB during this visit
CC "I'm having difficulty breathing.
History of Present Illness

You're here today because you've been a "little bit short of breath" for the last week. You think it started about one week ago after you took your dog for a walk. It's usually worse at night when you lay down to go to sleep. It's been getting a little worse every day. You notice it more when you exercise or go up a flight of steps.

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