Program-Level Assessment: Annual Report

Program: Pediatric Nurse Practitioner and Post Masters PNP Certificate Program	Department: Nursing
Degree or Certificate Level: MSN/PNP	College/School: Trudy Busch Valentine School of Nursing
Date (Month/Year): 5-2022	Primary Assessment Contact: Joanne Thanavaro/ Michelle Papachrisanthou

In what year was the data upon which this report is based collected? 4-2022

In what year was the program's assessment plan most recently reviewed/updated? Program outcome #3 was last reviewed in 2017

1. Student Learning Outcomes

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

#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.

Students were observed during their mandatory on-site residency at the Saint Louis University Campus, which was held April 13-14, 2022, while taking courses NURS 5330-22 and NURS 5900.

NURS 5330-22 is an online course with 3 theory credits and 1 clinical credit (75 clinical hours) that is taken during the spring semester. The students must also register for NURS 5900 (0 credits) when they register for NURS 5330. NURS 5900 is the mandatory on-site residency course.

During the mandatory on-site residency students were directly observed by the PNP program coordinator and one other PNP faculty while performing patient simulation. Each student randomly selected their case from different color-coded cases and were given their case immediately before their simulation started. They were expected to obtain a detailed history, perform a thorough physical examination, state the diagnosis(es), order any treatments/laboratories, and develop a plan of care (see appendix A). Additionally, local students were directly observed by the PNP program coordinator or PNP clinical faculty while performing direct patient care in the primary care clinical setting during their clinical hours or the PNP program coordinator spoke with the preceptor by phone regarding the student's progress (see appendix B).

To assess for cultural sensitivity each student was given a case during residency, and they had to report if the provider in that case handled the situation with cultural sensitivity, if anything could have been communicated/performed differently, and time to reflect for future improvements in care (see appendix C). Once the student reported their case findings, the case was opened to the class for discussion.

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.

During residency an evaluation tool was used that scored each student in the following areas differential diagnoses

(5 points), history (30 points), physical examination (20 points), diagnosis(es) (15 points), and treatment (30 points). Each section is further broken down with specific expectations (see appendix D).

Once the student completes the simulation, it is scored by the faculty and the scoring breakdown is as follows: 1) Advanced (91-100 points) student performs/demonstrates at a superior level with no verbal cues or prompting, 2) Proficient (80-90 points) student performs/demonstrates at the expected level with minimal verbal cues or prompting, 3) Not Proficient (79 or below points) student performs/demonstrates below minimally competent level requiring frequent verbal cues/prompting and requires remediation.

The cultural sensitivity cases are not scored but rather discussed in detail with the entire group of students after each student presented their case. If a student is challenged by their case, then they will be expected to perform another culturally sensitive case.

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)?

Residency case simulation results are as follows:
LB = 89/100 points (Proficient – Case 4 – 1 attempt)
BD = 90/100 points (Proficient – Case 1 & Case 3 were averaged (80 + 100) – 2 attempts)
LE = 94/100 points (Advanced – Case 1 – 1 attempt via Zoom due to healthcare issue)
EM = 91/100 points (Advanced – Case 1 – 1 attempt)
AS = 92/100 points (Advanced – Case 4 – 1 attempt)
JS = 87/100 points (Proficient – Case 5 – 1 attempt)
EW = 92/100 points (Advanced – Case 3 – 1 attempt)

Skyfactor 23 which assesses overall learning on the MSN exit survey for 2021 reveals an N of 28 with a mean of 6.29 out of 7 which exceeded the goal of 5.5 or greater.

Each student performed their cultural sensitivity case without needing any verbal prompting cues and no students were required to do an additional cultural sensitivity case.

5. Findings: Interpretations & Conclusions

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

Cases were reviewed for relevant content for the pediatric setting. All students in the PNP program scored in the advanced or proficient categories and no PNP students were scored as not proficient. These scores align with the scores seen in the Family Nurse Practitioner residency program that was held 2 days prior to the PNP residency.

Student evaluations (see appendix F) were obtained at the end of residency and all students scored the simulation section as “yes” for question 6 “The clinical patient simulation cases allowed me to demonstrate my clinical reasoning skills” and all “yes” for question 7 “A summary of my performance on the clinical patient simulation session was communicated to me.” Additionally, all students scored the cultural case section “yes” for question 5 “The session on cultural cases contributed to my learning.”

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 met at their monthly coordinators meeting on May 11, 2022, at 10:00am to review the findings of each program. Each case, grading rubric, & results were summarized and discussed by the MSN coordinators and the Associate Dean for Graduate Education. Findings were then presented at the monthly ANPPC meeting on May 11, 2022, at 1:00pm. All graduate faculty and student representatives were given the opportunity to review, discuss, ask questions, and make recommendations.

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.

Discussions with the students revealed that they would like more time during the case simulation, specifically the time from receiving the case to entering the examination room to obtain the health history. Students stated they were nervous and needed additional time to gather their thoughts and not forget to ask any pertinent history questions. Moving forward, students will be given 5+ minutes outside of the examination room to review the case and write down any important information they do not want to forget. The PNP faculty will monitor the time and let the student know when it is time to begin the case simulation. The PNP faculty also noticed that some history information was difficult to find for the student playing the patient (see Appendix E). Therefore, all the cases will be reviewed and updated for ease of flow. Additionally, all cases will be reviewed by the PNP program coordinator for the most current evidence-based practice guidelines and updated accordingly.

If no changes are being made, please explain why.

Changes are being made and discussed in prior section.

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?

Incorporating a more detailed rubric when scoring the residency simulation cases

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

Through use of the rubric for 2 years and with student evaluations.

C. What were the findings of the assessment?

The PNP faculty stated this was an easy scoring tool to use during residency to determine proficiency and student evaluations were all positive of the simulation experience.

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

I will continue with use of the scoring rubric making updates as needed or as recommended by the PNP faculty and by using student evaluations as my means of gathering input/data for any additional future recommendations/changes.

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

Appendix A

(Student Form)

Saint Louis University School of Nursing
Case 1 - Casey

Information for the Student:

Chief Complaint:
22-month-old female Casey has come to the office with her mother, Mrs. Smith. The chief complaint is runny nose x 1 week that is starting to dry up, fever to touch x 2 days, and fussiness.

Vital Signs:
- Temp - 100.0 ax
- HR – 110
- RR – 20
- Wt. 24 lb. 8 oz (40%)
- Ht. -32" (50%)

Immunization Record:
- Up-to-Date

Problem List:
- Gastritis – 11months old
- Bilateral Otitis Media – 15 months (Resolved with Amoxicillin x10days)

Last Visit:
- 18 month – well child visit

Task:
You have 30 minutes to:
1. State the possible differential diagnoses **at the onset** after reviewing the case sheet.
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list of differential diagnoses
5. State your final diagnosis
6. Develop a therapeutic plan including following as appropriate:
    a. pharmacologic
    b. lab/diagnostics if relevant
    c. nursing/supportive therapies
    d. health promotion
    e. health education
    f. follow-up

(Student Form)

Saint Louis University School of Nursing
Case 2 – Alisha

Information for the Student:

Chief complaint:

10-month-old female is here with her mother who reports a chief complaint of coughing, trouble eating, and "sounds congested in the lungs" X 1 day.

Vital Signs:

- Temp: 101.8 ax
- HR: 132
- RR: 54
- Wt.: 20 lb. (50%)
- Ht.: 28" (50%)
- O2 Sats: 92% (Room Air)

Immunization Record: HepBx3, DTaPx3, Hibx3, IPVx3, PCV13x3, & RVx2
Influenza #1 7m/o

Problem List:

- 3 m/o: GER (Treated with Zantac/ranitidine x3 months). History of spitting up frequently & fussiness when feeding. Resolved at 6m/o & Zantac/ranitidine stopped.
- 7m/o: URI, slight intermittent, expiratory wheeze, no meds

Last Visit: 7 m/o: Acute visit (URI, wheeze) & FLU#1 vaccine given

Task: You have 30 minutes to:

1. State the possible differential diagnoses **at the onset** after reviewing the case sheet.
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list of differential diagnoses
5. State your final diagnosis
6. Develop a therapeutic plan including following as appropriate:
    a. pharmacologic
    b. lab/diagnostics if relevant
    c. nursing/supportive therapies
    d. health promotion
    e. health education
    f. follow-up

(Student Form)

Saint Louis University School of Nursing
Case 3 – Kelton

Information for the Student:

Chief Complaint:
8-year-old Kelton has come to the office with his mother. The chief complaint is cough and cold for 2 weeks.

Vital Signs:
- Temp: 101.6 orally
- HR: 90
- RR: 28
- BP: 90/66
- Wt.: 60 lbs. (75%)
- Ht.: 50" (50%)
- BMI: 16.9 (75%)
- O2 Sats: 98% (Room Air)

Immunization Record:
- UTD for age; except no influenza vaccine for the last 3 years.

Problem List:
- 3y/o: BOM
- 4y/o: Strep Pharyngitis

Last Visit: 5y/o well child visit

Task: You have 30 minutes to:

1. State the possible differential diagnoses **at the onset** after reviewing the case sheet.
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list of differential diagnoses
5. State your final diagnosis
6. Develop a therapeutic plan including following as appropriate:
    a. pharmacologic
    b. lab/diagnostics if relevant
    c. nursing/supportive therapies
    d. health promotion
    e. health education
    f. follow-up

(Student Form)

Saint Louis University School of Nursing
Case 4 – Brittany

Information for the Student:

Chief Complaint:
11-year-old, AA, Brittney is at the office with her mother. The chief complaint is frequent cough and wheezing in gym class. Needs a refill on her inhaler.

Vital Signs:
- Temp: 99.0ax.
- HR: 80
- RR: 14
- BP: 110/70 (50%+/50%+)
- Wt.: 130lbs. (>95%)
- Ht.: 60" (90%)
- BMI: 25.4 (>100%)
- O2 Sats: 94% (Room Air)

Immunization Record:
- UTD, except needs annual influenza vaccine

Problem List:
- 8y/o: Intermittent asthma started, no hospitalizations.

Last Visit:
- 10y/o well child visit

Task:
You have 30 minutes to:
1. State the possible differential diagnoses **at the onset** after reviewing the case sheet.
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list of differential diagnoses
5. State your final diagnosis
6. Develop a therapeutic plan including following as appropriate:
    a. pharmacologic
    b. lab/diagnostics if relevant
    c. nursing/supportive therapies
    d. health promotion
    e. health education
    f. follow-up

(Student Form)

Saint Louis University School of Nursing
Case 5 – Anna Marie

Information for the Student:

Chief Complaint:
15y/o female here with her mother with complaints of painful urination x2 days.

Vital Signs:
- Temp: 99.6 oral
- HR: 80
- RR: 14
- BP: 118/78 (50%/90%)
- Wt: 120 lbs. (60%)
- Ht.: 65" (75%)
- BMI: 20.0 (50%)

Immunization Record:
- UTD for age

Problem List:
- 5y/o: Influenza A
- 7y/o: Sinusitis

Last Visit:
- 14y/o: Well child visit

Task:

You have 30 minutes to:

1. State the possible differential diagnoses **at the onset** after reviewing the case sheet.
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list of differential diagnoses
5. State your final diagnosis
6. Develop a therapeutic plan including following as appropriate:
    a. pharmacologic
    b. lab/diagnostics if relevant
    c. nursing/supportive therapies
    d. health promotion
    e. health education
    f. follow-up

(Student Form)

Saint Louis University School of Nursing
Case 6 – Tia

Information for the Student:

Chief Complaint:
11-year-old Tia has come to the office with her mother. The chief complaint is runny nose and headache. Also, my rash will not go away.

Vital Signs:
- Temp: 99.0 ax.
- HR: 88
- RR: 21
- BP: 110/70 (50%/50%)
- Wt.: 80lbs. (45%)
- Ht.: 60" (75%)
- BMI: 15.6 (20%)

Immunization Record:
- UTD at age 10y/o.

Problem List:
- 24m/o: BOM
- 5y/o & 7y/o: Strep Pharyngitis

Last Visit:
- 10y/o: Well child visit

Task:
You have 30 minutes to:
1. State the possible differential diagnoses **at the onset** after reviewing the case sheet.
2. Obtain a focused history
3. Perform a focused physical assessment
4. Re-examine the list of differential diagnoses
5. State your final diagnosis
6. Develop a therapeutic plan including following as appropriate:
    a. pharmacologic
    b. lab/diagnostics if relevant
    c. nursing/supportive therapies
    d. health promotion
    e. health education
    f. follow-up

Appendix B
Saint Louis University
School of Nursing

☐ Telephone Conversation

☐ On Site Visit

Student Name:_____

Clinical Site:_____

Preceptor:_____

Date:_____

Faculty Completing Form:_____

Evaluation Form for Clinical Site

A. The Student

Professional behaviors of a NP exhibited: includes being punctual and timely	
Gives patient adequate amount of time for interview and exam	
Asks appropriate questions during HPI and exam – Develops appropriate history	
Formulates appropriate differentials	
Communicates data with preceptor in a logical, systematic fashion	
Formulates appropriate plan with rationale appropriate to dx	
Identifies appropriate diagnostic measures for problem/diagnoses	
Identifies therapeutic measures: Pharmacologic therapy, supportive nursing, health promotion/education	
Student is able to present appropriate follow-up in treatment plan	

B. Clinical Site

Clinical setting appropriate to course goals	
Population of patients is appropriate for goals of course	
Patients present with a variety of diagnoses	
The clinical site is available during a	

variety of hours	
The student has adequate access to patient charts and information needed to evaluate and provide care	
The clinical site is supplied with adequate equipment needed for student practice	
The clinical site has adequate support staff	

C. Preceptor

Preceptor is aware that course is taught online and has received preceptor information for course	
Preceptor has clear expectation of his/her role	
Does the preceptor know how to get hold of faculty?	
Is the preceptor willing to precept other SLU NP students	
Students work reflects preceptor's guidance to use clinical guidelines, current standards, up to date interventions	
Does the preceptor follow his/her scope of practice?	
Does the preceptor provide feedback to the student consistently?	

Approval Body: Advanced Practice Program Committee
Approved: September 15, 2014

Appendix C

Culturally Sensitive Cases 2022

Case 1

A 3y/o female presents to the clinic with her mother for left sided ear pain. After a thorough history and physical, she is diagnosed with LOM and prescribed Amoxicillin. When the provider looks at the chart to determine her allergy status the provider notices the family is self-pay. The provider asks the mother if they have insurance, and she states "No". The provider proceeds to ask if she is aware of Medicaid. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been communicated differently? If so, what?

Case 2

The provider enters the examination room for a 4m/o well visit. The mother is holding her infant while sitting in the examination room chair. The visit starts with telling the mother how the infant is growing and showing the mother the infant's growth on the CDC growth charts. The infant becomes fussy and the mother states that the infant is hungry. The provider proceeds to tell the mother she may feed the infant while the provider finishes up with questions/education before the provider is ready to examine the infant. The mother becomes hesitant & demonstrates uncomfortable facial changes since the baby breast feeds. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? If so, what?

Case 3

A 17y/o Muslim female patient is at the office to be seen for a dry, itchy rash in her scalp. The patient is wearing a headdress and appears to be reserved and nervous. After obtaining the history, the provider asks the patient to remove her headdress so the rash can be examined. The provider waits in the room while the patient removes her headdress. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? If so, what?

Case 4

A 12y/o Greek male comes into the office for lower back pain. After obtaining the history, a physical examination is performed that reveals approximately six different 2-inch-wide circular areas of redness that appear in various stages of bruising that are non-raised to the lower back. The provider gives the parent a strange look and asks who has been abusing this child. The mother grabs the child, and they leave. The provider hotlines the case and Child and Family Services get involved. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? If so, what?

Case 5

A Hispanic mother brings her 2y/o son in for what appears to be a cough, runny nose, and fever. The mother speaks no English, the provider does not speak Spanish, and there is no interpreter available within the primary care setting. The provider uses the translate app on their iPhone to ask additional history questions. Examination reveals that the child has a RUL pneumonia. Amoxicillin is prescribed & the translate app is used to tell the mother to go to the pharmacy to get the medication. Mother leaves the office with the child. They return to the office 2 days later because the child is worse. The mother brought a friend who knows how to speak Spanish and English. It was discovered that the mother did not give the medication because she was unsure if she should rub it on his chest or give it in his mouth. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? If so, what?

Case 6

A 15y/o female patient & her mother presents to the office with concerns of being pregnant. After a thorough history, physical examination, and urine pregnancy test, the provider discloses to the patient that she is pregnant. Together they tell the mother she is pregnant. The provider is a devote Catholic and begins to discuss education regarding prenatal care with the patient and her mother. The mother interrupts the provider and states that they would like information on abortion. The provider gives them a strange look, crosses their arms & legs, & states not having that type of information. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? If so, what?

Case 7

A 16y/o female patient presents to the office for a sports physical. During the history it is noted that the patient is sexually active. The provider begins to educate on condom use but the patient does not seem engaged in the discussion. The provider continues with the education despite the reaction from the patient. What the provider fails to realize is the patient was seen about 1 month ago for depression and during that office visit the patient disclosed that she was in a same sex relationship. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? If so, what?

Case 8

A 17 y/o female patient presents to the clinic with reports of urinary frequency, vaginal itching, and drainage. She is new to the clinic practice and is accompanied by her adult aunt. The patient is very quiet and has some mild bruising visible on her neck. After a brief family & past medical history, you ask the aunt to step out of the room so you can conduct the physical exam. The aunt

states that she is like a mother to the patient, and she wants to stay in the room. The girl looks frightened. You reply: That it's office policy to allow the teenager privacy during the physical exam and that the aunt can return shortly. You will ask the office nurse to come in during the exam. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently? Is this youth at increased risk?

Case 9

A 9-year-old boy is at the office with his mother for an annual exam. He is healthy and makes good grades in school. The mother expresses concern that he has not yet outgrown his preference for "girly" things. He prefers girl movies, refuses to sign up for team sports, and wants to be called by a girl name. You reply that it sounds like a phase he is going through and that he should speak with a school counselor about school issues. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently?

Case 10

You are conducting a well child exam of a 5-year-old boy. His BMI has increased to the 95th percentile. His behavior is age appropriate, and his history and physical exam is unremarkable. When asked about his breakfast, he replies that he had juice and donuts. You reply to the mother that donuts should be limited and what else does he get for breakfast. The mother replies that they have been living in a shelter for the past two weeks, but they hope to be placed in an apartment soon. Did the provider handle this case with cultural sensitivity? Why or why not? Could things have been done differently?

Appendix D

(Instructor Grade Rubric Case 1)

Student Name: _____

Instructor: _____

Date: _____

Case 1: Casey 22-month-old

Instructor solicited information

Pre examination differential diagnoses before seeing the client

1. Upper respiratory infection
2. Otitis Media
3. Other viral illness with fever
4. Teething

Grade:

- **Differential Diagnoses (5 points)_____**
- **History (30 points)_____**
- **PE: (20 points)_____**
- **Dx: (15 points)_____**
- **Treatment: (30 points)_____**

Total: (100 points)_____

(Instructor Grade Rubric Case 1)

Differential Diagnoses (5 points):

Points	Category	Student Expectations	Student Performance
5	Differential Diagnoses	List 3-4 differential diagnoses	1.
			2.
			3.
			4.

History (30 Points):

Points	Category	Student Expectations	Student Performance
20	History of Present Illness	Confirm chief complaint	
		Onset	
		Progression of symptoms	
		Alleviating factors	
		Aggravating factors	
		Medications	
		Changes in activity	
		Changes in diet	
		Habits (bottle/cup bed)	
		Smoking	
		Childcare	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies (meds/food)	
		ED visits/Hospitalizations	
5	Family History	Mother, father, siblings, grandparents	

Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Well nourished, well developed, alert, playing with toys on mother's lap, responsive & cooperative.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor.	
2	Head/Neck	H – normocephalic, fontanelles closed N – supple neck, no lymphadenopathy.	
2	Eyes	PERRLA, EOM's, conjunctiva without redness or drainage, bilateral red reflex present.	
2	Ears	Canals clear with slight cerumen; left TM, clear with visible landmarks; right TM full, red, no landmarks, no light reflex, resisting right ear exam.	
2	Nose	Dried clear mucus in both nares with mild congestion; resisting nasal exam.	
2	Mouth/ Throat	M – moist, 2 upper molars erupting T – pink, tonsils 2+, no exudate	
2	Heart	S1 and S2, RRR, no murmur, pulses 2+ & equal to upper & lower extremities, HR 110	
2	Lungs	Lung CTA, no wheezing, good aeration, RR 20	
2	Abdomen	Soft, nontender, no masses, no organomegaly, BS present in all 4 quadrants.	

Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
7.5	Diagnosis 1	Right Otitis Media	
7.5	Diagnosis 2	URI	

Treatment (30 points):

Points	Category	Student Expectations	Student Performance
30	ROM URI	Amoxicillin (400mg/5mL) 6mL BID x10days or Augmentin (600mg/5mL) 4mL BID x10days.	
		WASP script.	
		Ibuprofen (100mg/5mL) 1 tsp Q6-8 hours PRN.	

		Tylenol (160mg/5mL) 1 tsp Q4-6 hours PRN.	
		Heating pad/warm towel to right ear PRN pain.	
		Cool mist humidifier at naptime and bedtime.	
		NS and bulb suction PRN.	
		Elevate HOB.	
		1tsp honey Q4 hours PRN cough.	
		Avoid second-hand smoke.	
		Take all prescribed antibiotic	
		Follow-up 2 weeks for ear recheck and well visit.	

(Instructor Grade Rubric Case 2)

Student Name: _____

Instructor: _____

Date: _____

Case 2: Alisha 10-month-old

Instructor solicited information

Pre examination differential diagnoses before seeing the client

1. Upper respiratory infection
2. Wheezing
3. Bronchiolitis
4. Pneumonia
5. GERD
6. Foreign body Aspiration

Grade:

- **Differential Diagnoses (5 points)_____**
- **History (30 points)_____**
- **PE: (20 points)_____**
- **Dx: (15 points)_____**
- **Treatment: (30 points)_____**

Total: (100 points)_____

(Instructor Grade Rubric Case 2)

Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Well nourished, well developed, alert, resting quietly in mother's arms. Momentarily interested in a toy, refused bottle of formula.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor.	
2	Head/Neck	H – normocephalic, ½ cm anterior fontanelle that is soft & flat, posterior fontanelle closed. N – supple neck, no lymphadenopathy.	
2	Eyes	PERRLA, EOM's, conjunctiva without redness or drainage, bilateral red reflex present.	
2	Ears	Canals clear with slight cerumen; left & right TMs both pearly gray, +light reflex, visible landmarks, & good mobility.	
2	Nose	Dried clear mucus with scant clear nasal discharge from both nares present with congestion.	
2	Mouth/ Throat	M – moist, 8 teeth present T – pink, tonsils 2+, no exudate	
2	Heart	S1 and S2, RRR, no murmur, pulses 2+ & equal to upper & lower extremities, HR 132	
2	Lungs**	Slight subcostal retractions, wheezing on expiration & intermittently on inspiration in all lobes, unable to appreciate any crackles due to the wheezing, fair aeration, O2 sats 92%, RR 54. No stridor, sporadic dry cough in office.	
2	Abdomen	Soft, nontender, no masses, no organomegaly, BS present in all 4 quadrants.	

**** (IF STUDENTS DECIDES):**

After Albuterol nebulizer treatment: O2 Sats: 97%, HR: 154, RR: 40. No retractions, good aeration, intermittent faint wheezing on expiration, no crackles.

If student elects to get CXR: negative, except for slight hyperaeration.

If student elects to get RSV, COVID-19, & FLU testing: negative.

Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
5	Diagnosis 1	Wheezing, R/O RSV, COVID-19, FLU A&B	
5	Diagnosis 2	URI/Bronchiolitis	
5	Diagnosis 3	Immunization Update	

Treatment (30 points):

Points	Category	Student Expectations	Student Performance
20	In Office Tx	Give Albuterol treatment in office?	
		Reassess lungs & O2 sats after Albuterol treatment that was given in office?	
		Perform RSV, COVID-19, &/or Influenza testing in office?	
	Home Tx	Albuterol 0.083% 1 ampule Q4-6 hours PRN cough/wheeze per nebulizer	
		Albuterol inhaler 2 puffs Q4-6 hours PRN cough/wheeze/SOB	
		Ibuprofen (100mg/5mL) 3/4 tsp Q6-8 hours PRN fever.	
		Tylenol (160mg/5mL) 3/4 tsp Q4-6 hours PRN fever.	
		Cool mist humidifier at naptime and bedtime.	
		NS and bulb suction PRN.	
		Elevate HOB by placing pillow/beach towel under mattress & not directly under child.	
		Avoid second-hand smoke.	

		Encourage formula, Pedialyte, no bottle in bed.	
		Follow-up 1 week to reassess lungs – sooner for any acute changes. Needs 9m/o well child check-up, FLU#2, Hgb, lead level.	
		Return to office/ED if develops: RR > 60 with difficulty breathing, retractions, or will not drink fluids, no urine output q 6-8 hours, dry eyes, dry mouth.	
10	Immunization Update	Give Influenza#2 today or hold until follow-up visit when well.	

(Instructor Grade Rubric Case 3)

Student Name: _____

Instructor: _____

Date: _____

Case 3: Kelton 8-years-old

Instructor solicited information

Pre examination differential diagnoses before seeing the client

1. Upper respiratory infection
2. Sinusitis
3. Seasonal Allergies
4. Pneumonia

Grade:

- **Differential Diagnoses (5 points)_____**
- **History (30 points)_____**
- **PE: (20 points)_____**
- **Dx: (15 points)_____**
- **Treatment: (30 points)_____**

Total: (100 points)_____

(Instructor Grade Rubric Case 3)

Differential Diagnoses (5 points):

Points	Category	Student Expectations	Student Performance
5	Differential Diagnoses	List 3-4 differential diagnoses	1.
			2.
			3.
			4.

History (30 Points):

Points	Category	Student Expectations	Student Performance
20	History of Present Illness	Confirm chief complaint	
		Onset	
		Progression of symptoms	
		Alleviating factors	
		Aggravating factors	
		Medications	
		Changes in activity	
		Changes in diet	
		Smoking	
		School	
		Sports	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies (meds/food)	
		ED visits/Hospitalizations	
5	Family History	Mother, father, siblings, grandparents	

Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Well nourished, well developed, alert, awake & sitting next to mother with his head against her shoulder, looks tired but not toxic.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor. Skin just proximal to the eyes with slightly darkened circular area.	
2	Head/Neck	H – normocephalic, even hair. N – supple neck, palpable posterior cervical nodes bilaterally that are ½ cm, mobile, nontender, & soft.	
2	Eyes	PERRLA, EOM's, conjunctiva without redness or drainage, bilateral red reflex present. No tenderness with palpation of forehead or maxillary region.	
2	Ears	Canals clear with slight cerumen; left & right TMs both pearly gray, +light reflex, visible landmarks, & good mobility.	
2	Nose	Dried crusty mucus with reddened turbinates to both nares.	
2	Mouth/ Throat	M – moist, no lesions. T – pink, tonsils 2+, no exudate, scant clear post-nasal drip, +cobblestone.	
2	Heart	S1 and S2, RRR, no murmur HR 90	
2	Lungs**	Clear breath sounds in upper lobes, faint crackles on inspiration on right base, good aeration. RR 28, O2 Sats 98%.	
2	Abdomen	Soft, nontender, no masses, no organomegaly, BS present in all 4 quadrants.	

**** (IF STUDENTS DECIDES):**

CXR: patchy infiltration right lower lobe.

Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
5	Diagnosis 1	Pneumonia	
5	Diagnosis 2	URI	
5	Diagnosis 3	Allergic Rhinitis	

Treatment (30 points):

Points	Category	Student Expectations	Student Performance
20	Office Tx	CXR ordered?	
	Home Tx	Allergy to PCN!	
		Cefdinir (250mg/5mL) 4mL BID or 7.5mL QD x10days (caution since PCN allergy) OR Zithromax (200mg/5mL) 6.8mL day1 & 3.4mL days 2-5 (mycoplasma)	
		WASP	
		Zyrtec 10mg QD at HS or Claritin 10mg QD	
		Ibuprofen (100mg/5mL) 2.5 tsp Q6-8 hours PRN fever.	
		Tylenol (160mg/5mL) 2.5 tsp Q4-6 hours PRN fever.	
		Cool mist humidifier at naptime and bedtime.	
		Blow nose PRN to remove secretions. May also use NS PRN.	
		Elevate HOB by using extra pillow.	
		Avoid second-hand smoke.	
		Encourage fluids and rest.	
		Make sure to take all antibiotics.	
		No school until fever free x24 hours without antipyretic medication and feeling better.	
		Follow-up 1 week to reassess lungs & discuss possible allergic rhinitis. Needs to schedule well child visit.	
10	Immunization Update	Give Influenza today or hold until follow-up visit when well.	

(Instructor Grade Rubric Case 4)

Student Name: _____

Instructor: _____

Date: _____

Case 4: Brittany 11-years-old

Instructor solicited information

Pre examination differential diagnoses before seeing the client

1. Intermittent asthma
2. Exercise induced asthma
3. Allergic Rhinitis

Grade:

- **Differential Diagnoses (5 points)_____**
- **History (30 points)_____**
- **PE: (20 points)_____**
- **Dx: (15 points)_____**
- **Treatment: (30 points)_____**

Total: (100 points)_____

(Instructor Grade Rubric Case 4)

Differential Diagnoses (5 points):

Points	Category	Student Expectations	Student Performance
5	Differential Diagnoses	List 3-4 differential diagnoses	1.
			2.
			3.
			4.

History (30 Points):

Points	Category	Student Expectations	Student Performance
20	History of Present Illness	Confirm chief complaint	
		Onset	
		Progression of symptoms	
		Alleviating factors	
		Aggravating factors	
		Medications	
		Changes in activity	
		Changes in diet	
		Smoking	
		School	
		Sports	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies (meds/food)	
		ED visits/Hospitalizations	
5	Family History	Mother, father, siblings, grandparents	

Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Alert & cooperative, sitting on exam table, well nourished. Appears overweight with extra abdominal tissue.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor.	
2	Head/Neck	H – normocephalic, even hair. N – supple neck, no lymphadenopathy.	
2	Eyes	PERRLA, EOM's, conjunctiva without redness or drainage, bilateral red reflex present.	
2	Ears	Canals clear with slight cerumen; left & right TMs both pearly gray, +light reflex, visible landmarks, & good mobility.	
2	Nose	Turbinates slightly pale, scant amount of clear drainage noted to both nares.	
2	Mouth/ Throat	M – moist, no lesions. T – pink, tonsils 2+, no exudate, scant clear post-nasal drip.	
2	Heart	S1 and S2, RRR, no murmur HR 80	
2	Lungs**	Equal lung sounds, no wheezing, good aeration. RR 14, O2 Sats 94%.	
2	Abdomen	Soft, nontender, no masses, no organomegaly, BS present in all 4 quadrants.	

**** (IF STUDENTS DECIDES):**

Spirometry is normal.

Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
5	Diagnosis 1	Intermittent Asthma	
5	Diagnosis 2	Allergic Rhinitis	
5	Diagnosis 3	Obesity	

Treatment (30 points):

Points	Category	Student Expectations	Student Performance
20	Office Tx	Spirometry ordered?	
	Home Tx	Albuterol Inhaler 2puffs Q4-6 hours PRN cough/wheeze (#2 home/school). Use with aerochamber.	
		Take 2 puffs of Albuterol 10-15 minutes prior to gym class or any activities.	
		Loratadine 10mg 1 tablet QD or Zyrtec 10mg 1tablet QD at HS.	
		May need to add inhaled corticosteroid or Singulair.	
		Avoid second-hand smoke.	
		Keep track of possible asthma triggers.	
		Administer Influenza vaccine today.	
10	Obesity	Encourage healthy diet and drinks.	
		Increase exercise to 5-6 days per week for 60 minutes.	
		Reduce TV/computer/tablet/phone/games to <2 hours per day	
		Obtain universal lipid testing since she is 11y/o.	
		Follow-up 3-6 months to recheck weight and BP.	
		Follow-up phone with lipid results.	

(Instructor Grade Rubric Case 5)

Student Name: _____

Instructor: _____

Date: _____

Case 5: Anna Marie 15-years-old

Instructor solicited information
Pre examination differential diagnoses before seeing the client

1. Urinary Tract Infection
2. Urethritis/vaginitis
3. Sexually transmitted disease

Grade:

- **Differential Diagnoses (5 points)_____**
- **History (30 points)_____**
- **PE: (20 points)_____**
- **Dx: (15 points)_____**
- **Treatment: (30 points)_____**

Total: (100 points)_____

(Instructor Grade Rubric Case 5)

Differential Diagnoses (5 points):

Points	Category	Student Expectations	Student Performance
5	Differential Diagnoses	List 3-4 differential diagnoses	1.
			2.
			3.
			4.

History (30 Points):

Points	Category	Student Expectations	Student Performance
20	History of Present Illness	Confirm chief complaint	
		Onset	
		Progression of symptoms	
		Alleviating factors	
		Aggravating factors	
		Medications	
		Changes in activity	
		Changes in diet	
		Smoking	
		School	
		Sports	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies (meds/food)	
		ED visits/Hospitalizations	
5	Family History	Mother, father, siblings, grandparents	

Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Alert & cooperative, sitting on exam table. Well nourished & well developed.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor.	
2	Head/Neck	H – normocephalic, even hair. N – supple neck, no lymphadenopathy.	
1	Eyes	PERRLA, EOM's, conjunctiva without redness or drainage, bilateral red reflex present.	
1	Ears	Canals clear with slight cerumen; left & right TMs both pearly gray, +light reflex, visible landmarks, & good mobility.	
1	Nose	Pink turbinates, no drainage.	
1	Mouth/ Throat	M – moist, no lesions. T – pink, tonsils 2+, no exudate.	
2	Heart	S1 and S2, RRR, no murmur HR 80	
2	Lungs	Lungs CTA, no wheezing, good aeration. RR 14.	
2	Abdomen	Soft, nontender, no masses, no organomegaly, BS present in all 4 quadrants. Mild suprapubic tenderness.	
2	Perineal**	No rashes & no lesions present to vagina or anus, vagina moist & pink, no vaginal or anal discharge.	
2	Back/Gait	No flank tenderness. Gait steady & walks easy without pain to abdomen or extremities.	

****IF STUDENT ASKS:**

UA: PH 8; glucose negative; bilirubin negative; SG 1.020; Leukocytes 3+; Nitrates +; RBCs 2+

Urine Pregnancy: Negative

Urine CT/GC: Will take a few hours for results (negative)

Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
5	Diagnosis 1	UTI	
5	Diagnosis 2	Vulvovaginitis	
5	Diagnosis 3	R/O Pregnancy R/O STI	

Treatment (30 points):

Points	Category	Student Expectations	Student Performance
30	Office Tx	UA ordered? Pregnancy test ordered? STI testing ordered?	
	Home Tx	Bactrim DS (800mg/160mg) 1 tablet BID x3-10 days Cefdinir 300mg 1 tablet BID or 2 tablets QD for 7-10days.	
		Send UA for C&S, CT/GC.	
		Discuss testing for other STIs such as HIV & syphilis if in high prevalent area	
		Wear cotton underwear. Avoid thong underwear & leggings.	
		Use condoms with all sexual encounters. Use oral barriers such as dam when performing oral sex.	
		Shower daily and keep vaginal area clean. Avoid bubble baths or soapy water sitting.	
		Avoid douching.	
		Urinate after sexual encounters.	
		Wipe front-to-back.	
		Ibuprofen (200mg) 2-3 tablets Q6-8 hours PRN pain.	
		Tylenol (500mg) 1-2 tablets Q4-6 hours PRN pain.	
		Discuss sexual identity & refer if needed.	
		Follow-up 2 weeks to retest urine and discuss results of STI testing. Or, call if no better in 2-3 days. Get private phone # for F/U with STD lab tests.	

(Instructor Grade Rubric Case 6)

Student Name: _____

Instructor: _____

Date: _____

Case 6: Tia 11-years-old

Instructor solicited information

Pre examination differential diagnoses before seeing the client

1. Upper Respiratory Infection
2. Sinusitis
3. Allergic Rhinitis

Grade:

- **Differential Diagnoses (5 points)_____**
- **History (30 points)_____**
- **PE: (20 points)_____**
- **Dx: (15 points)_____**
- **Treatment: (30 points)_____**

Total: (100 points)_____

(Instructor Grade Rubric Case 6)

Differential Diagnoses (5 points):

Points	Category	Student Expectations	Student Performance
5	Differential Diagnoses	List 3-4 differential diagnoses	1.
			2.
			3.
			4.

History (30 Points):

Points	Category	Student Expectations	Student Performance
20	History of Present Illness	Confirm chief complaint	
		Onset	
		Progression of symptoms	
		Alleviating factors	
		Aggravating factors	
		Medications	
		Changes in activity	
		Changes in diet	
		Smoking	
		School	
		Sports	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies (medications/food)	
		ED visits/Hospitalizations	
5	Family History	Mother, father, siblings, grandparents	

Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Alert & cooperative, sitting on exam table. Well nourished & well developed.	
2	Skin	Light brown skin with pink undertones. 3x4cm dry, thick, hyperpigmented, lichenified patches bilaterally on antecubital spaces. Dry tiny pale papules on abdomen.	
2	Head/Neck	H – normocephalic, even hair. N – supple neck, no lymphadenopathy.	
2	Eyes	PERRLA, EOM's, conjunctiva without redness or drainage, bilateral red reflex present. No sinus pressure/pain upon palpation to frontal or maxillary sinuses.	
2	Ears	Canals clear with slight cerumen; left & right TMs both pearly gray, +light reflex, visible landmarks, & good mobility.	
2	Nose	Pale, boggy turbinates, scant amount of clear drainage, right nostril almost occluded by swollen turbinate, +congestion, +allergic salute.	
2	Mouth/ Throat	M – moist, no lesions. T – pink, tonsils 2+, no exudate, +cobblestone and clear post-nasal drip.	
2	Heart	S1 and S2, RRR, no murmur HR 88	
2	Lungs	Equal lung sounds, no wheezing, good aeration. RR 21	
2	Abdomen	Soft, nontender, no masses, no organomegaly, BS present in all 4 quadrants.	

Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
5	Diagnosis 1	URI	
5	Diagnosis 2	Allergic Rhinitis	
5	Diagnosis 3	Atopic Dermatitis/ Eczema	

Treatment (30 points):

Points	Category	Student Expectations	Student Performance
15	URI/AR	Loratadine 10mg 1 tablet QD or Zyrtec 10mg 1 tablet QD at HS	
		Singulair 5mg 1 chewable HS	
		Flonase (or other steroid nasal spray), 1-2 squirts to both nostrils QD.	
		Keep window shut. Use AC. Shower after playing outside.	
		Keep cat out of room that you sleep in.	
		Vacuum carpets in home once a week.	
		Blow nose frequently to remove mucous and congestion. May use nasal saline.	
		Cool mist humidifier at HS.	
		1tsp honey or honey cough product or cough drops Q4-6 hours PRN cough.	
		Elevate HOB/ add a pillow.	
		Avoid second-hand smoke.	
15	Eczema	Use unscented soap and lotion.	
		Apply Vaseline to affected areas TID-QID.	
		Leave skin moist after bathing and apply moisturizer.	
		Wear loose fitting clothing. No wool clothing.	
		May use 1% hydrocortisone ointment BID to affected areas for 2 weeks then bid prn.	
		Avoid scratching. Keep nails trimmed short.	
		Follow-up in 1 week for recheck, well visit, & immunization update.	

Appendix E

(Instructor/Patient Background Script)

Case 1 – Casey - Background - Script

Casey S. - 22-month-old Casey has come to the office with her parent, Mrs. Smith. The chief complaint is runny nose, fever, and fussiness x1week. Temp at office is 100.0 ax.

Hx of Present Illness:
She started with a clear runny nose a week ago and then the last 2 days she acted like she didn't feel well and she felt hot yesterday and today. Last night she was rubbing at her right ear. She's been irritable the last couple of days. She is still drinking but eating less.

Previous Illness visits:

- 11 months of age for gastritis
- 15 months – bilateral ear infection that resolved with amoxicillin x10 days

Allergies: None to medications/food

Review of systems:

a. **General:** Laying around more today and fussy.
b. **Fever:** Hot to touch yesterday and today. (Unsure where thermometer is).
c. **Eyes:** No drainage.
d. **Ears:** Pulling at both ears but rubbing right ear more.
e. **Nose:** Drainage started off clear, then yellow and thick, but now it's drying up, scant congestion.
f. **Throat:** No soreness, still drinking, but appetite decreased.
g. **Cough:** Yes, she's had a little dry cough but it's not too bad, no wheezing, no SOB.
h. **Urination:** Yes, she is having about 5-6 wet diapers per day.
i. **Sleeping:** Yes, she woke up crying twice last night and I finally put her in bed with us.
j. **GI:** No vomiting or diarrhea.
k. **Rash:** No.

Family Hx: Parents & 3-year-old brother are healthy. Both parents' work. MGM has HTN and T2DM.

Social Hx:

- She attends an in-home day care 3 days a week while parents are at work. Gets along ok with the children there. Someone is usually sick at day care.
- Grandfather smokes but he usually goes outside when she is there. We only visit them on the weekend.

Nutrition: Drinks from cup. Takes pacifier when she goes down for a nap and bedtime.
Developmental: No concerns.
Speech: She is saying many words, but some things are unclear.

Hearing: Seems to hear ok.
Immunizations: UTD.
Screenings: Normal at 9m/o and 18m/o.

Do you have any other concerns about her?
She doesn't seem interested in toilet training yet. I put her on the potty, and she just laughs. She does pull off her wet diapers when we are home.

(Instructor/Patient Background Script)

Case 2 – Alisha – Background Script:

Alisha M. 10-month-old female here with her mother who gives a chief complaint of coughing, trouble eating, and "sounds congested in the lungs" x1 day**.** Temp at office is 101.8 ax.

Hx of Present Illness:

- Cold for 3 days then her cough got worse yesterday – she's coughing a lot.
- Sounds congested and sometimes she vomits when she coughs. She has vomited at least 2 times a day – it's clear with some milky mucus stuff. This is different from the reflux that she used to have. That was milk spit up.
- Temp was 102 F yesterday and I gave her some Children's Motrin 3/4tsp and fever came down.
- Last night, she started breathing faster and hard. Her chest looked funny.

Allergies – None to medications/foods

Review of Systems:

- **General:** Laying around more yesterday and today. She's crying more than usual but I can usually get her settled down.
- **Fever:** Day#2 with T max of 102F yesterday.
- **Eyes:** No drainage or redness.
- **Ear:** No ear pulling or drainage present. Seems to hear well.
- **Nose:** Occasional clear discharge or crusty discharge with congestion present.
- **Cough:** She's coughing a lot. Sometimes she coughs so hard she vomits up this clear, slimy mucus. She has done this 2x/day for the last 2 days. Most of the time it sounds dry.
- **Urination/Stool:** 4 wet diapers yesterday. Wet diaper this am. No diarrhea. 1 stool yesterday, soft, brown, no blood/mucus.
- **Rash:** No.
- **Sleeping:** She couldn't sleep very well last night. She kept coughing and waking up. She would cry and not settle down unless I held her.
- **Choking Episode:** I don't think she choked on anything**.**
- **Wheezed Before?: S**he often sounds kind of congested especially with a cold & wheezed at 7m/o with a cold that was treated with supportive treatment & 1 nebulizer treatment in the office.
- **Feeding/appetite**: She acts hungry but then after an ounce or so of Enfamil Infant formula she stops because she looks like she is having trouble breathing. She took 4 ounces of apple juice this morning. Baseline feeding is 6oz of formula 3-5x/day and baby food 2-3x/day and cereal 1x/day.
- **Bulb syringe** – Can I still use that? I don't know where mine is.

Family Hx: Mother, father, & siblings are healthy. Maternal Aunt (mother's sister) has asthma.

Social Hx:

- She attends daycare full time at a licensed facility with 9 other children in her room. They called me yesterday about her coughing. There are many children sick in her room right now.
- Mother is divorced; 2 siblings, a girl who is 2 ½ and a 4-year-old brother.
- Family lives in an apartment. Mother is a department manager at Wal-Mart.
- Dad works a lot and cannot help much.
- Dad smokes a lot indoors.

Developmental: She is sitting by self, pulling up, taking steps holding onto furniture, babbling mama & dada.

(Instructor/Patient Background Script)

Case 3 – Kelton – Background Script

Kevin T. 8y/o male is at the office with his mother with the chief complaint of cough and cold x 2 weeks.

Hx of Present Illness:
He started with a clear runny nose about 2 weeks ago that changed to green mucous after 1 week but is now drying up. I thought he was getting better but now he seems worse. His fever started 2 days ago with a Tmax of 102F this morning. About 3 days ago he started with a cough, and it seems to be worse at night. It is productive and he is coughing up greenish-yellow phlegm. His appetite is decreased but he remains drinking fluids and urinating. Kelton's brothers have all had this cold but they "shook it off" after 5-7 days.

Previous Illness Visit:
- 3y/o: BOM
- 4y/o: Strep Pharyngitis

Allergies: Amoxicillin (Hives – Broke out on 3rd day while taking for strep throat at 4y/o). No food allergies.

Review of Systems:
a. **General:** Laying around more the last 3 days & unable to go to school yesterday & today.
b. **Fever:** For the past 2 days he has had a fever of 101-102F. It goes down after Tylenol then back up at the 4-hour mark.
c. **Eyes:** He has some circles under his eyes. No eye drainage. No eye redness.
d. **Ears:** No complaint of ear pain or discharge.
e. **Nose:** At first it was clear runny drainage that changed to green and now it is drying up with mild congestion.
f. **Throat:** Kelton has not complained of his throat hurting.
g. **Cough:** He's been coughing a lot the last 3 nights and some during the day. Coughing up green-yellow phlegm (especially the last 2 mornings). No SOB, no chest pain, no difficulty breathing, no wheezing.
h. **Urination:** Yes, he went just before we left for the clinic. Pale yellow with no odor.
i. **Sleeping:** Kelton has been sleeping more but the coughing wakes him up at night.
j. **GI:** No vomiting or diarrhea. No abdominal pain.
k. **Rash:** No.
l. **Appetite:** He has lost his appetite. He just eats a tiny amount. He is drinking only water and juice.

Family Hx: Mother, father, & 3 older brothers are all in good health. PGF has T2DM.

Social Hx:
- Kelton lives at home with his mother, father, and 3 older brothers (10y/o, 12y/o, & 15y/o).

- Kelton is in 3rd grade & likes school. Has many friends.
- No second-hand smoke exposure. No travel, no COVID exposure.
- 2 indoor dogs

Other Concerns: I was wondering if he could have allergies to pollen or something? He frequently has a clear runny nose and sneezes a lot in the spring.

(Instructor/Patient Background Script)

Case 4 – Brittany – Background Script

Brittany A. 11-year-old Brittney has come to the office with her mother, Ms. Allen. The chief complaint is frequent cough and wheezing in gym class. (Mom is going to let Brittney answer the questions).

Hx of Previous Illness:
I have had a history of asthma for the last 3 years that seems to act up when I am sick or a change in the weather. For the last month I am having trouble running and feel like I cannot catch my breath in gym class.
I will cough with exercise and sometimes throughout the night. My appetite is good, and I do not have any vomiting or diarrhea.

Previous Illness visits: 8y/o: Intermittent asthma diagnosed. (Last visit asthma – 6 months ago).

Allergies: none to medications/food.

Review of Systems:

a. **General:** Alert and oriented.
b. **Fever:** No.
c. **Eyes:** I see ok. No drainage. Sometimes, they feel a little itchy, but I try not to rub them.
d. **Ears:** No pain or discharge.
e. **Nose:** Mom says I suffer from nasal allergies that happens in the springtime. The drainage is usually clear. Sometimes, I sniff a lot. Sometimes I sneeze a lot in the summer when grass is being cut. Sometimes my nose feels itchy. I think this happened last year too.
f. **Throat:** Sometimes I feel a tickle in the back of my throat but no wheezing.
g. **Cough:** I have been coughing a lot in the morning & sometimes at night my cough is waking me up. Dry cough.
h. **GI:** I am urinating fine with no pain, and I have no diarrhea or constipation. I usually poop 1x/day & it is easy to push out with no blood/mucus.
i. **Rash:** No.
j. **Sleeping:** I sleep ok except when I cough.
k. **Appetite:** I like to eat, especially chips, soda, & juice. I eat 3 meals per day plus snack.
l. **Activity:** I like to watch TV & I do go to the park on Saturdays to play tennis with my friends, does not play any other sports.

****IF ASKED (Cough)**:

- Coughs in AM & has used her inhaler the last 5 mornings. Nighttime coughing – woke up 3 times and had to use inhaler in the last week.
- We must run a mile in gym class, and I must stop after a couple of laps since I'm short of breath and need my inhaler.
- I do not pre-treat or use my inhaler before gym class.

Family Hx: Mother & 9y/o brother are healthy. Father suffers from seasonal allergies. MGM has T2DM.

Social Hx:

- Brittany is in the 6th grade & has 2 close friends. She makes A's and B's.
- Mother & father are separated. Brittany lives with her mother and 9y/o brother & lives with dad every other weekend.
- Pets: 1 inside dog that is 7y/o at mother's house.
- No smokers at mother or father's house.

(Instructor/Patient Background Script)

Case 5 – Anna Marie – Background Script

Anna Marie T. 15y/o female here with mother with complaint of painful urination x2 days.

Hx of Present Illness:
For the last couple of days, it has hurt to pee, and it really hurts now. I must go frequently. It kind of smells. I had to get up twice last night to go to the bathroom and I never do that.

Allergies: None to medications/food.

Review of Systems:

a. **General:** Feels more tired the last 2 days.
b. **Fever:** I do not think so.
c. **Eyes:** No drainage.
d. **Ears:** Denies pain or drainage.
e. **Nose:** Denies congestion or discharge.
f. **Throat:** Denies sore throat.
g. **Cough:** Denies cough or SOB.
h. **Abdomen:** Only hurts when I must go to the bathroom, pain is below my belly button.
i. **Back:** Denies back pain.
j. **Urination:** I must go almost every hour or 2 now. Denies blood in urine.
k. **Sleeping:** Denies any changes to sleep. Goes to sleep at 11pm and awakes at 6:30am.
l. **GI:** No vomiting or diarrhea.
m. **GU:** denies vaginal discharge.
n. **Rash:** No.
o. **Appetite:** I do not want to drink much since it will only make me go to the bathroom. I have been eating a little bit.
p. **Activity:** I did not go to school today. My favorite activity is to go to mall/ hang out with friends.
q. **Hygiene:** Does not use bubble bath, takes showers, uses Dove soap, has thought about douching.
r. **Sexual Activity:** Why are you asking? I have a boyfriend & we fooled around a little bit. Well, we had sex but had trouble figuring out the condom. Also, I had a girlfriend about 6 months ago that I fooled around with. We had oral sex.

r. Last Menstrual Period: Couple of weeks ago, no problems, flow was 5 days, no cramping. I use tampons.

s. Medications: None, but I started drinking some cranberry juice – a friend told me it may help.

Family Hx: Father, mother, and 2 sisters are healthy. MGM has HTN.
Social Hx:

- Lives at home with mother and 2 sisters (13y/o, 11y/o). Parents are divorced x5 years.
- Is in 10th grade, makes C's, has 3 close friends.

Other Concerns: None.

(Instructor/Patient Background Script)

Case 6 – Tia – Background Script

Tiffany J. 11-year-old Tia has come to the office with her mother, Ms. Jones. The chief complaint is runny nose and headache. Plus, her rash will not go away. (Mom is going to let Tia try to answer any questions).

Hx of Present Illness:
I have this runny nose that does not ever go away. Sometimes I feel stuffy, and my head starts to hurt. I also have a rash that will not go away on my belly and arms. It itches.

Previous Illness Visits:
- 24m/o: BOM
- 5y/o & 7y/o: Strep Pharyngitis

Allergies: None to medications/food

Review of Systems:
a. **General:** Tired the last 2 days. I have had a headache off & on for one week. When I have it, I feel it on my forehead. I can usually ignore it but sometimes I take a Tylenol. That usually makes it go away.
b. **Fever:** No.
c. **Eyes:** I see ok. No drainage. Sometimes, they feel a little itchy too, but I try not to rub them.
d. **Ears:** No pain or discharge.
e. **Nose:** Mom says it started with springtime. The drainage is usually clear. Sometimes, I sniff a lot. Sometimes I sneeze a lot in the summer when grass is being cut. Sometimes my nose feels itchy. I think this happened last year too.
f. **Throat:** Sometimes I feel something draining back there.
g. **Cough:** I have been coughing a little bit. No breathing problems.
h. **Urination:** No problem with this.
i. **Sleeping:** I sleep well.
j. **GI:** No vomiting or diarrhea.
k. **Rash:** Yes, for a week on her belly and arms. She has sensitive skin. She starts scratching her arms & it seemed to spread to her belly. Use whatever soap & lotion my mom buys.
l. **Appetite:** I like to eat.
m. **Activity:** I like to ride my bike and I like to play outside a lot.

Family Hx: Mother & brother are in good health. Dad has allergies to hay fever. Paternal: Uncle (dad's brother) with asthma.

Social Hx:
- Lives with father, mother, 7y/o brother.
- Is in 6th grade & makes B's & C's.
- No smokers in the home.
- 1 indoor cat that has been there for 3 years & sleeps in Tia's bedroom at night.

- Does sleep with windows open when the weather is nice.

Appendix F

N5330-22 PNP Residency Evaluation Spring 2022

1. The session/content on pediatric x-rays contributed to my learning.

- (●) Yes
- ( ) No
- ( ) Not applicable

2. The workshop on Suturing & Incision/Drainage contributed to my learning.

- ( ) Yes
- ( ) No
- ( ) Not applicable

3. The class on Common Pediatric Procedures contributed to my learning.

- ( ) Yes
- ( ) No
- ( ) Not applicable

4. The class on Pediatric ENT care contributed to my learning.

- ( ) Yes
- ( ) No
- ( ) Not applicable

5. The session on Cultural Cases contributed to my learning.

- ( ) Yes
- ( ) No
- ( ) Not applicable

6. he Clinical Patient Simulation Cases allowed me to demonstrate my clinical reasoning skills.

- ( ) Yes
- ( ) No
- ( ) Not applicable

7. A summary of my performance on the Clinical Patient Simulation session was communicated to me.

- ( ) Yes
- ( ) No
- ( ) Not applicable

8. The student presentations contributed to my learning.

- ( ) Yes

- No
- Not applicable

9. Overall evaluation of the Residency:

- Excellent
- Good
- Average
- Poor

10. Please provide any additional information that would improve future residencies.