1d. Assessment of and for student learning, assessment and data literacy, and use of data literacy, and use of data to inform practice

Nursing 137 Health Appraisal: Key Assignment

Physical Assessment Case Study

CLINICAL ACTIVITY ASSIGNMENTS (20 Points possible)

10 Clinical activities assigned to the different systems are outlined in the calendar. Each activity is tied to a slide presentation and readings assigned. Each one is in the workbook and a copy of the page can be scanned and sent via the link. **All 10 are due by 5 PM July 6**

OBSERVED ASSESSMENT SKILLS RETURN DEMONSTRATION (20 points possible)

Scheduled time will be set-aside for student to do an observed Hx / exam on an unknown problem. Working with the person you have done the history and practice physical activities and exam on during the course. At your assigned time, I will choose 1 of 5 potential problems from the Grading Criteria for Selected System page in this syllabus. You will then take appropriate Hx, do appropriate PE and briefly summarize findings. Your assigned time will be posted shortly after the enrollment is finalized after the first day of classes. This will be a ZOOM session for me to observe your skills and techniques.

WRITE-UP OF PHYSICAL ASSESSMENT (20 points possible)

1. Continue with the same person you used for your history.

2. Collect an interval history. (Any changes since your initial history, 1 page max)

3. Follow the guidelines on physical exam documentation that is in the Javis text, chapter 27, page 255-259 in the student manual.

Develop a short problem list based on the history and physical exam. Develop a preliminary plan for any current problems. A one sentence plan is sufficient for each problem identified. This write-up will be scanned and submitted via the link in Canvas by July 8.

ON-LINE CASE STUDIES (10 points possible)

2 case studies listed below and a summary of your decision process, following the prompts, will be required to be submitted on-line prior to the end of the course July 10.
Care Management Studies

1. What further subjective data is needed?
2. Give specific example of questions used to get further info
3. **What physical exam/ objective data is most valuable**?
4. What is your assessment?

5. Give a specific plan for today's interaction with family.

Case Study #1

16 year old Suzie is here today with both of her parents. You have seen Suzie two other times within the past year, once for allergic conjunctivitis, and once for a contact dermatitis. Her family moved to this area about two years ago. The pediatrician with whom you work has never met Suzie, though he may remember the mother from other family member visits. Suzie has two younger siblings who are very familiar to you because of chronic otitis media. The mother has had a history of following through with recommendations made for the siblings. You have not previously met Suzie's father.

Suzie is here because last week she was with a group of students who were found behind the gymnasium bleachers passing around a bottle of liquor. She was suspended by the school until she and her parents were seen by a physician. You are finding out today that this year Suzie has already been expelled from school twice; once because she was drunk on campus, and another time a bottle of alcohol fell from her locker just as a teacher passed by. The police have been involved, a court date has been set, but Suzie has yet to appear before a judge.

Suzie is silent. She is slumped in the chair avoiding eye contact. **PE is non-contributing today and appropriate for age.**

Suzie's father states concern for his daughter and states that he is very worried about her behavior. Her mother is tapping on the chair arm, obviously irritated. She states that she plans on suing the school for denying her daughter an education. Further, she states that this is usual teenage behavior, and that she and everyone she knew did the same thing in high school and "it was no big deal, just normal teenagers."

Case Study #2

Thirteen month old David is here today with his mother because David is cranky and his mother is suspicious that he has an earache. He was last well about 3-4 weeks ago. He has had cold symptoms for more than three weeks. These symptoms include running nose and cough which becomes worse when lying down. Triaminicol ¾ teaspoon at bedtime initially gave some relief, but not recently. Temperatures have not been taken but David hasn't felt warm. He has had no vomiting or diarrhea. There have been no skin rashes except currently he has a diaper rash which he has had for about two weeks. For his diaper rash David's mother has tried zinc oxide ointment without resolution.

PMH: You last saw David 6 months ago for an uncomplicated URI. Since then David's mother started a new job and she states that because of time conflict she has been taking David to an evening clinic at another medical facility. In the past two months David has been diagnosed as having four ear infections and one sinus infection. He last completed Suprax less than 2 weeks ago for left otitis media and sinus infection. David's mother states that she gave the Suprax as prescribed one time a day, and finished it on the ninth day of the prescription. She did not have it rechecked after completing the antibiotic. Prior to having Suprax David had had Amoxicillin twice and Duracef. Prior to this past six months, David has had only one ear infection. He has no other history of chronic illness, hospitalization, or surgery. David's last complete well child physical was 6 months ago where he completed his third OPV, second Hepatitis B, third HIB, and third DPT immunization. At that time his growth was consistent at

the 75th percentile for weight and OFC, and between the 75th and 90th percentiles for height. He is not allergic to any known medications. He routinely takes no medication except Tri-vi-flor 0.25 mg/1ml, 1ml daily.

Family history is positive for asthma for the father and 2 uncles, and positive for adult onset diabetes for both sets of grandparents.

Social History: David is the second of two children; the sibling is 28 months old. Both go to daycare 5 days per week in a private home where 5 children are cared for, David's father drives trucks long distances and has an erratic schedule. Davis' mother is a waitress.

Physical exam: Ht: 29 ½ inches Wt: 19lbs 14oz OFC: 18 1/2inches
Temp: 100.6 rectal Apical HR: 112 (crying) RR: 24 (crying)

O: Alert but fussy toddler, playing with rattle, then crying through much of the exam, responding appropriately to his mother.

HEENT: Ant. Fontanel closed
TMs: Right is hyperemic, translucent, normal position and normal landmarks though dull.
Left is erythematous, bulging, dull, and opaque
Eyes: PERRL, bilat = red reflex, conjunctiva bilat minimally injected without discharge, without periorbital edema or discoloration
Nose: Bilat mucopurulent discharge, without foul odor, bilat patent Nasal mucosa is bright, dark pink.
Tonsils 1+ slightly erythematous without exudates, pharynx is also slightly erythematous without exudates

Neck: Supple without adenopathy

Heart: Rhythm and rate regular, without murmur though crying, S1 and S2 sharp

Lungs: Excellent air exchange throughout, scattered coarse crackles, which clear somewhat with cough. Coughing is rare but moist.

Abdomen: Soft, no hepatosplenomegaly, no masses

Skin: Clear except macular pinpoint erythematous macular patches to anterior diaper area with papery edged border and satellite lesions

Neuro: DDST is normal for age