**Rubric Formative Simulation Center Observation**

**NGR 6002C Advanced Health Assessment**

**Semester \_\_\_\_\_\_\_\_\_ Year\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SP Case 2**

1.

2.

3.

4.

 \* = critical element

This is a checklist for observing students during Simulation Center encounters with the Standardized Patients. Support your scoring with Feedback.

**Student: Faculty Observer:**

| **Elements and Samples of Behavior** | **Poss****Pts** | **S**  | **U** | **Comments** |
| --- | --- | --- | --- | --- |
|  |
| **Must verify patient’s name and DOB** |  **1** |  | **All or nothing** |
|  |
| **Total for Name/DOB section** | **1** |  |  |  |
| **History** |
| *Chief Complaint**HPI (Presenting Illness)* OLDCARTS  | **1****2** |  |  |  |
| *Allergies*  Meds, Food, Latex, Environmental*Medications* (Duration, frequency, reason) Prescription, OTC, Supplements/Herbals, Illicit substances | **1****1** |  |  | **NO SPECIFIC INSTRUCTIONS TO SP - THEY MAY GIVE OWN HX OR FABRICATE - must address each section below**Allergies: Prescription: OTC: Supplemental/herbal |
| *Biographic:*  Past History- Medical -Surgical  Family HistoryRelevant medical history of first degree relatives addressed  | **1****1** |  |  | **must address each section below****PMHx****PSHx:*** Medical conditions:
* Surgeries/Hospitalizations:

**Family Hx:*** Parents
* Mother
* Father
* Siblings
* Children
 |
| *Social History*1. Occupational history—exposures, current work status/responsibilities/deployment
2. Nutrition-eating history/disorders
3. Tobacco Use-quantity, duration
4. Alcohol use—CAGE, AUDIT-C
5. Social support system-family, friends, partners, relationships
6. Recent Travel
7. Sleep Pattern
8. Spirituality
9. Physical Activity –type, frequency
10. Other (caffeine, etc)
 | **2** |  |  | **must address each section below**1. Occupational history -
2. Nutrition
3. Tobacco Use
4. Alcohol use
5. Social support system-family, friends, partners, relationships
6. Recent Travel
7. Sleep Pattern
8. Spirituality -
9. Physical Activity
10. Other
 |
| *Sexual/Reproductive History (if applicable)*1. OB Hx
2. Partners
3. Practices
4. Female: LNMP

*Health Promotion/Immunizations History (if applicable)*1. Immunizations
2. Last dental and eye exams
3. Last PE and age appropriate screenings
 | **1** |  |  | **NO SPECIFIC INSTRUCTIONS TO SP - THEY MAY GIVE OWN HX OR FABRICATE - must address each section below*** Sexual history
* Male: NA LMP: LMP
* Partners/Practices:
* Emotional status/psychiatric history
* Immunizations
* Health promotion:
 |
| *Review Of Systems (in context of complaint)* Constitutional Skin Eyes ENT/Mouth CV Respiratory Breasts GI GU Musculoskeletal Neuro Psychiatric Endocrine Hemo/lymph | **3** |  |  | **Must address appropriate systems with at least 3 questions in each section** |
| **Total for History section** | **13** |  |  |  |
| **Physical Exam** |
| **Washes hands before beginning examination**Vital Signs (VS) addressed with patient  Temp, Pulse, Respiration, BP, Pain, BMI | **1** |  |  | **VS must be reviewed with patient** |
| ***PE of Affected System and Relevant Systems (in context of complaint)*** |  |  |  |  |
| *Circle Systems Assessed*Skin* Inspection, Palpation

Head* Inspection, Palpation

Eyes* Vision, Funduscopic, EOM, Pupil, Visual Fields

ENT/Mouth* Hearing, Otoscopic, Sinus, Nose and Mouth

Neck* ROM, Lymph nodes, Thyroid, JVP, Carotid

Cardiac/Vascular* Inspection, Palpation, Auscultation, Peripheral Pulses X4 limbs, Capillary refill,

Peripheral edemaRespiratory* Percussion, Palpation, Auscultation

~~Breasts (as indicated)~~* ~~Inspection, Palpation Breasts and Axillary nodes~~

GI* Inspection, Auscultation, Percussion, Palpation

~~GU (as indicated)~~* ~~Per GTA~~

Musculoskeletal* Inspection, Active/Passive ROM, Strength testing, joint above and joint below

Neurologic* Cranial nerves, DTR, Gait, Romberg, Sensitivity

Lymphatic* Palpate Cervical and axillary nodes

~~Mental Health/Cognitive~~* ~~MMSE, Mental Status, Administration of MH tools~~
 | **9** |  |  | **Selects Appropriate Systems.****Expected:** |
| **Total for Physical section** | **10** |  |  |  |
| **Assessment/Plan** 1. Discusses differential diagnoses and rationale for actual diagnosis with patient
	1. Accurate diagnosis based on H&P and case scenario
	2. Uses shared decision-making to develop diagnostic, treatment and follow-up options with patient
 | **3** |  |  | **(1 point for generally appropriate differential diagnoses, 1 point for rationale for the actual diagnosis(es), 1 point for shared decision-making, and 1 point for an appropriate follow-up time and plan with patient)****Differential Dx:** |
| 2. Develops a complete plan of care appropriate for the actual diagnosis and baseline medical conditions | **2** |  |  | **Diagnosis & Interventions** |
| 3. Education/Anticipatory Guidance | **2** |  |  | Education |
| **Total for Assessment/Plan Section** |  |  |  |  |
| **Points Possible** | **24** |  |  | **Student Score** **Goal >18 points = passing** |

**General Comments:**

**Opportunities for growth:**

Faculty Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_