SAINT LOUIS UNIVERSITY.

Program Assessment Plan

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Program: Pediatric Primary Care Masters NP and Pediatric Primary Care Post Masters Certificate NP

Department: Nursing

College/School: School of Nursing

Date: September 6, 2017; revised January 30, 2018

Primary Assessment Contact: Joanne Thanavaro

#	Program Learning Outcomes What do the program faculty expect all students to know, or be able to do, as a result of completing this program? ▪ *Note: These should be measurable, and manageable in number (typically 4-6 are sufficient).*	Assessment Mapping From what specific courses (or other educational/professional experiences) will artifacts of student learning be analyzed to demonstrate achievement of the outcome? Include courses taught at the Madrid campus and/or online as applicable.	Assessment Methods What specific artifacts of student learning will be analyzed? How, and by whom, will they be analyzed? ▪ *Note: the majority should provide direct, rather than indirect, evidence of achievement.* Please note if a rubric is used and, if so, include it as an appendix to this plan.	Use of Assessment Data How and when will analyzed data be used by faculty to make changes in pedagogy, curriculum design, and/or assessment work? How and when will the program evaluate the impact of assessment-informed changes *made in previous years*?
1	Implement collaborative strategies to provide ethical, high quality, safe, effective, patient-centered care.	**Didactic courses:** NURS 5040 Role Acquisition NURS 5110 Advanced Health Assessment	**Direct Measure for didactic courses:** 1. NURS 5040 Role Acquisition- 80% of all students will achieve a grade of B or better on a paper summarizing an interview with a primary care Pediatric Nurse Practitioner. (Appendix A- NURS 5040 Role Acquisition Interview) 2. NURS 5110 Advanced Health Assessment – 80% of all students will achieve a grade of	Aggregate results on the appropriate assignment in each didactic course will be analyzed and compared with trends from previous course offerings. If aggregate results indicate that less than 80% of students achieve a grade of B on the assignment, results and analysis with recommendations will be shared at a dedicated advanced nursing practice program committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body

			B or higher on a videotaped history and physical exam video performed on a simulated patient. (Appendix B – NURS 5110 Health Assessment Video Rubric)	members. Recommended changes will be implemented into the curriculum the following and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting.
		NURS 5140 Health Promotion	3. NURS 5140 Health Promotion – 80% of all students will achieve a grade of B or higher on a health promotion paper focusing on collaborative strategies to ensure ethical, safe and patient centered care. (Appendix C – NURS 5140 Health Promotion Paper Rubric)	
		NURS 5160 Principles of Practice Management.	4. NURS 5160 Principles of Practice Management – 90% of all students will achieve a grade of B or better on a paper focusing on a student selected issue relevant to Pediatric Nurse Practitioner primary care advanced nursing practice. (Appendix D – NURS 5160 Health Policy & Leadership Paper Rubric)	
		Clinical courses: NURS 5110 Advanced Health Assessment NURS 5320 PNP Clinical Studies 1 NURS 5330 PNP Clinical Studies 2 NURS 5810 PNP Nursing Practicum	**Direct Measure for Clinical Courses**: Direct observation of student clinical performance and therapeutic planning are conducted by NP faculty and preceptors in simulated scenarios, case conferences, and supervised clinical practicum.	Course faculty will aggregate results of all clinical practicum evaluations. Results will be analyzed and compared with trends from previous clinical courses including NURS 5110, NURS 5320, NURS 5330 and NURS 5810. If aggregate results are less than 90% of students

			1. 90% of all students achieve a satisfactory clinical evaluation for NURS 5110, NURS 5320, NURS 5330, and NURS 5810 based on direct preceptor or faculty observation. (Appendix E – PNP Student Clinical Evaluation) **Indirect Measures:** Skyfactor exit surveys are administered yearly to graduates assess student satisfaction on a wide variety of program specific benchmarks. 1. Skyfactor 11, Interprofessional teamwork; rating of 5.5 or higher on a 7-point scale on exit surveys. 2. Skyfactor 18, Patient care; rating 5.5 on a 7-point scale on exit surveys.	achieving a satisfactory clinical evaluation, then student performance will be compared with relevant assignments from previous courses. The results, analysis and recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. On an annual basis, student exit ratings on Skyfactor item measures 11 and 18 will be incorporated in the analysis. If ratings are < 5.5, they will be compared to previous years to identify trends in and associations with exit ratings and student performance in NURS 5320, NURS 5330, and NURS 5810.

2	Use scholarly inquiry including evidence-based practice and research application to improve decision-making and health outcomes.	**Didactic courses:** NURS 5200 General Research Methods NURS 5140 Advanced Health Promotion.	**Direct Measure:** 1. NURS 5200 General Research Methods - 80% of all students will achieve a grade 4 out of 5 points on the graded weekly discussion assignment. (Appendix F – NURS 5200 Research Discussion Rubric). 2. NURS 5140 Advanced Health Promotion – 80% of all students will achieve a grade of B or higher on a written evidence-based research assignment. (Appendix C – Health Promotion Paper Rubric). **Indirect Measures:** 1. Skyfactor 8, Research; rating of 5.5 on a 7-point scale on exit surveys. 2. Skyfactor 13, Evidence based knowledge; rating of 5.5 on a 7-point scale on exit surveys.	Aggregate results on the appropriate assignments will be analyzed and compared with trends from previous course offerings. If aggregate results indicate that less than 80% of students achieve a grade of B on the assignment, results and analysis with recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. On an annual basis, student exit ratings on Skyfactor item measures 8 and 13 will be incorporated in the analysis. If ratings are < 5.5, they will be compared to previous years to identify trends in associations with exit ratings and performance in NURS 5200 and NURS 5140.

3	Integrate advanced competencies, skills, theories, and cultural sensitivity in relationships with patients and professionals.	**Didactic courses:** NURS 5080 Advanced Pharmacology NURS 5170 Advanced Pathophysiology NURS 5550 Family and Child Development	**Direct Measure for didactic courses:** 1. NURS 5080 Advanced Pharmacology - 90% of students will achieve an overall grade of B or higher on a variety of case study discussions focusing on pharmacological principles and their impact on health. (Appendix G –Pharmacology Case Studies) 2. NURS 5170 Advanced Pathophysiology - 90% of students will achieve an overall grade of B or higher on a variety of case study discussions focused on pathophysiological principles and their impact on health. (Appendix H – Patho-physiology Discussion Board Grading Rubric) 3. NURS 5550 Family & Child Development - 90% of all students will achieve a grade of B or higher on the Family Assessment paper using the Calgary Family Assessment Model. (Appendix I – Family Assessment Rubric)	Aggregate results on the appropriate assignment will be analyzed and compared with trends from previous course offerings. If aggregate results are less than 80% of students achieve a grade of B on the assignments, results and analysis with recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting.

		Clinical courses: NURS 5110 Health Assessment & Clinical Decision Making NURS 5320 PNP Clinical Studies 1 NURS 5330 PNP Clinical Studies 2	**Direct Measure for clinical courses:** Integrated content from NURS 5110, NURS 5320, NURS 5330 is directly measured by NP faculty and preceptors through supervised clinical practicum and simulation cases during residency 1. 90% of all students achieve a satisfactory clinical evaluation based on direct preceptor or faculty observation (Appendix E- Student Clinical Evaluation) 2. 90% of students will receive a proficient or advanced proficient rating on a variety of pediatric primary care cases with simulated patients during residency. (Appendix J – Residency Simulation Cases-Grading Rubric) **Indirect Measures:** 1. Skyfactor, Overall Learning; rating of 5.5 or higher on a 7-point scale.	Course faculty will aggregate results of all clinical practicum evaluations. Results will be analyzed and compared with trends from previous clinical courses. If aggregate results are less than 90 % of students achieving a satisfactory clinical evaluation, then student performance will be compared with performance from previous courses. The results, analysis and recommendations for improvement will be shared bi-annually at a dedicated Advanced Nursing Practice Program (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. On an annual basis, student exit ratings on Skyfactor, Overall Learning measures will be incorporated in the analysis. If ratings are < 5.5, they will be compared to previous years to identify trends in associations with exit ratings and performance in previous clinical courses (NURS 5320 and NURS 5330).

			2. National Pediatric Nurse Practitioner Board Certification pass rate of 90% or higher.	Board certification pass rates are analyzed annually for trends. If pass rates fall below 90%, aggregate data will be reviewed for areas of weakness and possible curricular or methodological revisions.
4	Design culturally sensitive patient care that includes health promotion and disease prevention.	**Didactic courses:** NURS 5140 Health Promotion **Clinical Courses:** NURS 5110 Health Assessment & Clinical Decision Making NURS 5320 PNP Clinical Studies 1	**Direct Measure for Didactic Course** 1. NURS 5140 – Health Promotion - 90% of students achieve a grade of B or higher on a written health promotion assignment that incorporates culturally sensitive care (Appendix C – Health Promotion Paper Rubric). **Direct Measure for Clinical Courses** 1. 90 % of all students achieve a satisfactory clinical evaluation based on direct preceptor or faculty	Aggregate results on the Health Promotion assignment will be analyzed and compared with trends from previous course offerings. If aggregate results indicate that < 80% of students achieve a grade of B on the assignment, results and analysis with recommendations will be shared at a dedicated ANPPC curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. Course faculty will aggregate results of all clinical practicum evaluations. Results will be analyzed and compared with trends from previous clinical

		NURS 5330 PNP Clinical Studies 2 NURS 5810 PNP Nursing Practicum	observation. (Appendix E – Student Clinical Evaluation). 2. 90% of students will receive a proficient or advanced proficient rating on a variety of pediatric primary care cases during residency. (Appendix K- Pediatric Cultural Sensitivity Cases) **Indirect Measure:** Skyfactor 12, Prevention and Population Care; rating of 5.5 or higher on a 7-point scale.	courses. If aggregate results are less than 90% of students achieving a satisfactory clinical evaluation, student performance will be compared from previous courses. The results, analysis and recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. On an annual basis, student exit ratings on Skyfactor item measures 12 will be incorporated in the analysis. If ratings are < 5.5, they will be compared to previous years to identify trends in associations with exit ratings and performance in previous clinical courses (NURS 5320 and NURS 5330).
5	Facilitate the improvement of health care through leadership within health care systems and communities.	**Didactic courses:** NURS 5160 Principles of Practice Management	**Direct Measure:** 90% of students will achieve a grade of B or higher on a written assignment that	Aggregate results on the written assignment will be analyzed and compared with trends from previous course offerings. If aggregate results indicate that <

			incorporates analysis of leadership strategies to affect healthcare policy change. (Appendix D- NURS 5160 Health Policy Issues Paper Rubric) **Indirect Measure:** Skyfactor 6, Leadership Skills; rating of 5.5 on a 7-point scale.	90% of students achieve a grade of B on the assignment, results and analysis with recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. On an annual basis, student exit rating on Skyfactor 6 item measures will be incorporated in the analysis. If ratings are less than 5.5, they will be compared to previous years to identify trends in and associations with exit ratings.
6	Demonstrate competence in a specialized area of advanced practice nursing that builds on foundational nursing knowledge.	NURS 5810 PNP Nursing Practicum	**Direct Measure:** 90% of all students achieve a satisfactory clinical evaluation on their final practicum (NURS 5810) based on direct preceptor or faculty observation. (See Appendix A).	Course faulty will aggregate results of all clinical practicum evaluations and comprehensive exit examinations. Students not receiving a satisfactory clinical evaluation and/or DRT comprehensive exam score will receive remediation. Results will be analyzed and compared with

			2. 90% of all students will achieve a satisfactory score on the DRT PNP Comprehensive Examination. **Indirect Measures:** Skyfactor, Overall Learning; rating of 5.5 on a 7-point scale. Skyfactor, Overall Effectiveness; rating of 5.5 on a 7-point scale.	trends from previous clinical courses. If aggregate results are less than 90% of students achieving a satisfactory clinical evaluation and/or DRT comprehensive exam score, student performance will be compared with relevant assignments from previous courses. The results, analysis and recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting. On an annual basis, student exit rating on Skyfactor Overall Learning and Skyfactor Overall Effectiveness item measures will be incorporated in the analysis. If ratings are less than 5.5, they will be compared to previous years to identify trends in and associations with exit ratings.

			National Specialty Board Certification pass rates: First-time pass rate 90% or higher.	Board certification pass rates are analyzed annually for trends. If pass rates fall below 90%, aggregate data will be reviewed for areas of weakness and possible curricular or methodological revisions.
7	Utilize health care informatics and technologies to support practice.	**Clinical Courses:** NURS 5320 PNP Clinical Studies I NURS 5330 PNP Clinical Studies II NURS 5810 PNP Nursing Practicum	**Direct Measure:** 1. 90% of students achieve a satisfactory or greater score on their clinical evaluation for use of electronic resources for evidence-based care. (Appendix E – Student Clinical Evaluation). b. 90% of students will achieve a grade of B or higher on Typhon notes graded by faculty in clinical courses. (Appendix L – Typhon Grading Rubric). c. 90% of students demonstrate competency with electronic health records by creating and downloading a comprehensive summary of all patient encounters using the available software system. (Appendix M – Typhon Summary Report Rubric)	Course faulty will aggregate results of all clinical practicum evaluations, Typhon log grades, and comprehensive report of patient encounters. Results will be analyzed and compared with trends from previous clinical courses. If aggregate results are less than 90% of students achieving a satisfactory score on any of the three direct measures, student performance will be compared with relevant assignments from previous courses. The results, analysis and recommendations for improvement will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting.

			Indirect Measure: Skyfactor 9, Healthcare Technologies; rating of 5.5 on a 7-point scale.	b. On an annual basis, student exit rating on Skyfactor 9 measures will be incorporated in the analysis. If ratings are less than 5.5, they will be compared to previous years to identify trends in and associations with exit ratings.
8	Advocate for policies that improve the health of the public and the profession of nursing	NURS 5160 Principles of Practice Management	**Direct Measure:** 90% of students will achieve a grade of B or higher on a written assignment focusing on analysis of a healthcare policy or issue of their choosing. (Appendix D-NURS 5160 Issues Paper Rubric	Aggregate results on the health care policy paper will be analyzed and compared with trends from previous course offerings. If aggregate results indicate that < 90% of students achieve a grade of B on the assignment, results and analysis with recommendations will be shared at a dedicated Advanced Nursing Practice Program Committee (ANPPC) curriculum meeting with all graduate nursing faculty and representative student body members. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting.
			Indirect Measure: Skyfactor 10, Policy and Advocacy; rating of 5.5 on a 7-point scale.	On an annual basis, student exit rating on Skyfactor 10 will be incorporated in the analysis. If ratings are less than 5.5, they will be compared to previous years to identify trends in and associations with exit ratings.

Additional Questions

1. On what schedule/cycle will faculty assess each of the above-noted program learning outcomes? *(It is not recommended to try to assess every outcome every year.)*

Assessment Plan Cycle: 2016-2017: Outcomes # 3 and # 4 2017-2018: Outcomes # 1 and # 7 2018-2019: Outcomes # 2, #5, # 6, and # 8

2. Describe how, and the extent to which, program faculty contributed to the development of this plan.

In October 2016, a meeting was held with the advanced nursing practice committee (ANPPC) to determine the cycle for this assessment plan. The outcomes were all reviewed and decisions were made on the best approach to evaluating each outcome. Specifically, outcomes that could best be measured in specific courses were selected to be reviewed according to when those courses were offered in the curriculum. All faculty members were given a complete copy of the assessment plan and suggestions for revisions were discussed and implemented if there was a majority vote to make a change. Coordinators of each specialty track in the NP program were utilized as expert content for their respective curriculums. In January, 2018, the graduate faculty reviewed the Assessment Plan and additional revisions were made.

3. On what schedule/cycle will faculty review and, if needed, modify this assessment plan?

At the beginning of every academic year, the ANPPC committee will review the outcomes that have been selected for review. Any changes in the planned approach will be discussed and revisions will be made for the upcoming academic year. The assessment cycle has been developed to allow one outcome to be assessed in the fall and spring semesters. Evaluation of outcomes will be discussed in the November-December ANPPC meeting for the fall semester and the April-May ANPPC meeting for the spring semester. Recommended changes will be implemented into the curriculum the following academic year and changes will be evaluated at the next annual dedicated ANPPC curriculum meeting.

IMPORTANT: Please remember to submit any assessment rubrics (as noted above) along with this report.

APPENDIX A

NURS 5040: NP Interview - Grading Rubric		
Topic	**Points Possible**	**Points Achieved**
Interviewee Credentials & Personal History ▪ **Education, progression** ▪ **Current Job** ▪ **Marketing**	**30**	
Current Practice ▪ **Job Description** ▪ **Negotiation** ▪ **Typical Day** ▪ **Setting** ▪ **Organizational Structure** ▪ **Evaluation**	**30**	
Reflection of the Interview on your anticipated Practice ▪ **Job Choice** **Setting Choice** **Pearls** **Scope of Practice**	30	
Clarity of Paper (includes spelling, grammar, sequencing and presentation of information)	10	
Grade	**100**	
Comments:		

APPENDIX B

NURS 5110 – Advanced Health Assessment
Complete History & Physical Exam Faculty Grading Rubric

Complete History Component	Possible Points	Earned points
Chief Complaint	2. 5	
Hx Present Illness	**5**	
Past Medical Hx	**10**	
Family Hx **Genogram**	**5** **2.5**	
Personal/ Social Hx	**5**	
Review of Systems	**10**	
Cultural Hx	**5**	
Functional Hx	**5**	
VS and Constitutional	**2.5**	
Skin, Hair , Nails	**5**	
Head, Face, Neck	**5**	
Eye, Ear, Nose, Throat **Mouth**	**5**	
Lymph, Breast, Axilla	**5**	
Chest , Lungs	**5**	
Cardiovascular	**5**	
Gastrointestinal, Genitourinary	**5**	
Musculoskeletal	**5**	
Neurological	**5**	
Psychological, Mental	**2.5**	
Complete History Component	**Possible Points**	
TOTAL		

Comments:

- Students must receive a grade of B to successfully complete this assignment
- See Course Grading Scale

APPENDIX C

NURS 5140 – Health Promotion Research Paper
Faculty Grading Rubric

Paper Component	Possible Points	Student Points
Introduction: Detailed Intro (3 points) Level of Prevention Stated (1 point) Purpose Statement Provided (1 point)	5	
Background Data: Detailed Significance (15 points) Epidemiology Incidence & Prevalence Risk Factors Cultural Implications Outcomes	15	
Case Finding/Screening: Problem Identification (15 points) Screenings Diagnostics History & Physical Other Measures	15	
Interventions: Including collaborative strategies to provide high quality, safe, patient centered care. 3-4 Specific Interventions (10 points) Barriers to Interventions (5 points)	15	
Health Behavior Theory: 1 Health Behavior Theory/Model Discussed to include ethical implications to care (7 points) Evidence-based Research to Support Theory/Model use in practice (3 points)	10	
Conclusion: Concise Closure (8 points) New Ideas for what is Needed Next (2 points)	10	
APA Format: Strictly Followed (10 points)	10	
Writing Style: 10-12 Pages Typed Text (5 points) No Grammar, Spelling, Punctuation Mistakes (2 points) Easy to Read with No Quotes used (3 points)	10	
References: 10-12 Evidence-based Research Articles (3 points) References <5 years old (2 points)	5	
Resources: 8-10 Community/Professional Resources Provided (5 points)	5	
TOTAL POINTS	100	

APPENDIX D

NURS 5160: PRINCIPLES OF PRACTICE MANAGEMENT HEALTH POLICY AND LEADERSHIP PAPER - GRADING RUBRIC

Section	Points
A. What is the problem/ topic? Why is this important? What are the implications to practice, economy, and patient care? Who are the stakeholders that the policy affects and how?	30
B. What is the current legislation? What are the recent or proposed changes? What are the barriers to change? Who are the legislative stakeholders? Describe your leadership analysis and its impact on the recent/ proposed policy change	30
C. Your suggestions: What would be your suggestions for implementing change to the policy/ legislation? How would you accomplish this? (include specific persons that may need to be contacted, i.e. Representatives, congress persons, associations) Based upon your leadership analysis how would you recommend to impact recent/ proposed policy change?	30
D. APA format, critical thinking, spelling/ wording	10
TOTAL	
Comments: A 93-100 A- 91-92 B+ 89-90 B 85-88 B- 83-84 C+ 80-82 C 77-79 C- 75-76 D 70-74 F 69 and below • **Students must receive a grade of B to successfully complete this assignment**	

APPENDIX E

Student Clinical Evaluation
Pediatric Primary Care Nurse Practitioner Program

Student:_____ **Course: _____**

Preceptor:_____ **Date: _____**

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: _____

APPENDIX F

NURS 5200 GENERAL RESEARCH METHODS
DISCUSSION - GRADING RUBRIC

GRADED DOMAINS AND SCALE	GRADING SCHEME	
Content	**PASS**	**FAIL**
0 to 3 points possible	Contains all elements required and discussion of elements is in-depth, clear, and displays adequate attending to course content	One or more elements is under-developed, missing, unclear or displays minimal application to course content.
Response to Peers	**PASS**	**FAIL**
0 to 2 points possible	Contains all elements required and responses are in-depth, clear, based upon facts or logical synthesis, and displays adequate attending to course content.	Responses to peers is inconsistent with the original post, is lacking depth, is unclear, lacking thoughtful reflection or discourse, or is not contributory to the ongoing discussion.
Etiquette	**PASS**	**FAIL**
Maintaining appropriate etiquette is expected. Failure to maintain online etiquette may warrant vacating all points possible for a discussion thread.	All members of the class and their diverse views are treated with an attitude of respectfulness and dissenting views are conveyed and received with civility	One or more members of the class and/or their views are treated with disrespect and/or dissenting views are conveyed or received in manner inconsistent with civility

APPENDIX G

NURS 5080: ADVANCED PHARMACOLOGY
CASE STUDIES - FACULTY GRADING RUBRIC

Content	Possible Points	Points Earned	Comments
Demonstrate advanced competencies and skills when prescribing appropriate medications.	2		
Appropriate dose, frequency, and duration.	0.75 (each worth 0.25)		
Identify 5 possible side effects.	0.75		
Patient Education. Consider cultural sensitivities and theories in relation to pharmacotherapeutic prescribing.	1		
References	0.5		
Total	5		

APPENDIX H

NURS 5170: ADVANCED PATHOPHYSIOLOGY
RUBRIC FOR FACULTY GRADING OF DISCUSSION BOARD

OBJECTIVE	DEVELOPING (C)	ACCOMPLISHED (B)	EXEMPLARY (A)
Shared thoughts	Sometimes shared well-considered thoughts	Often shared well-considered thoughts	Consistently shared well-considered thoughts and introduced new ideas
Displayed critical thinking (application, analysis, synthesis & evaluation)	Satisfactory development of critical thinking skills	Very good display of critical thinking skills	Excellent, clear display of critical thinking skills
Discussion entered promptly	Sometimes entered discussion promptly; occasionally posted original insights; responses to classmates may be brief	Usually entered discussion promptly; posted original insights and responded appropriately to classmates; postings sometimes elicit classmate or instructor response	Always entered discussion promptly; posted original insights and responded appropriately to classmates; postings nearly always elicit classmate or instructor response

APPENDIX I

NURS 5550 Family Assessment: Description and Grading Criteria

1. The student will conduct a detailed family history and assessment of the family's strengths and problems with a family not well known to the student.
2. Review the readings for Week 2 in Wright & Leahy and required articles via E-Reserves. These readings include content on the Calgary Family Assessment Model (CFAM), Genogram, Ecogram (Family Attachment Diagram), and how to conduct a family assessment.
3. The focus of the interview and the paper should include the key components of the CFAM, Genogram, & Ecogram.
4. Interview as many family members as you can in your selected family to obtain different family member perspectives, including children. Observations of family behaviors and interactions should also be included.
5. The paper should include: a summary of your family assessment and the completed family Genogram & Ecogram.
6. Templates for the family genogram & ecogram are posted on BB.
7. The body of paper should have 6-8 pages (not including title page & references).

Grading Criteria and Required Subheadings	**Points**	**Student Score**
(a) Title page (use APA format)	5	
(b) Introduction	3	
(c) Rationale for referral	3	
(d) Pertinent History	9	
(e) Family Strengths & Problems	25	
(f) Summary of the Interview	15	
(g) Conclusions: Include proposed plan family goals and Psychosocial/educational interventions	10	
(h) References (APA format)	5	
(i) Family Composition Diagram(Genogram)	10	
(j) Family Attachment Diagram (Ecogram)	10	
(k) Clarity of writing, correct spelling & punctuation	5	
Total	100	

APPENDIX J

Residency SIMULATION CASES
FACULTY GRADING RUBRICS

Student Name _____

Instructor _____

Date _____

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 (79 or below)

Performance Summary Form used for all cases

Student Name: _____
Instructor: _____
Date: _____

Case #:
Instructor solicited information
Pre examination differential diagnoses before seeing the client
1.
2.
3.

Final Grade:

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

Total: (100 points)_____

(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, 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:
- DTaP, IPV, Hib, PCV13, HepB, RV – Up-to-Date
- HepA, MMR, Varicella, Influenza – Refused at 12 month visit

Problem List:
- GI Bug – 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.

(You may step out of the room to write down your diagnosis and plan if desired)

(Instructor Form)

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	
		Child care	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies	
		ED visits	
5	Family History	Mother, father, siblings, grandparents	

Case 1 - Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Well nourished, well developed, alert, playing with toy's on mother's lap, responsive, & cooperative.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor.	
2	Head/Neck	H – normocephalic, fontanel closed N – supple neck, no lymphadenopathy.	
2	Eyes	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, resists right ear exam.	
2	Nose	Dried mucus in both nares; resists 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 HR 120	
2	Lungs	Equal lung sounds, 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
5	Diagnosis 1	Right Otitis Media	
5	Diagnosis 2	URI	
5	Diagnosis 3	Immunization Delay	

Case 1 – Management/Treatment (30 points):

Points	Category	Student Expectations	Student Performance
20	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.	
10	Vaccine Hesitancy	Appropriate counseling of needed vaccines.	

(Instructor & Parent Form)

Case 1 – Casey - Background - Script
(Try not to volunteer excess info but answer the questions as a parent would.)

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 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 whiney and crying more easily the last couple of days. She is still drinking but eating less.

Previous Illness visits:
- 11 months of age for GI bug
- 15 months – double ear infection, Resolved with amoxicillin x10 days

Allergies: None to medications

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.
f. **Cough:** Yes, she's had a little cough with the runny nose but it's not too bad.
g. **Urination:** Yes, she is having about 5-6 wet diapers per day.
h. **Sleeping:** Yes, she woke up crying twice last night and I finally put her in bed with us.
i. **GI:** No vomiting or diarrhea.
j. **Rash:** No.

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

Social Hx:
- She attends a 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: Mother refused HepA, MMR, Varicella, & Influenza vaccines at 12 months. Mother is afraid of those vaccines.
Screenings: Lead and CBC were never done.

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

Saint Louis University School of Nursing (Student Form)
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: 140
- RR: 64
- Wt.: 20 lb. (50%)
- Ht.: 28" (50%)
- O2 Sats: 92%

Immunization Record: HepB, DTaP, Hib, IPV, PCV13, & RV: Up-to-Date
Influenza #1: Given at 6m/o

Problem List:

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

Last Visit: 7m/o: Acute visit (URI, wheeze)

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.

(You may step out of the room to write down your diagnosis and plan if desired)

(Instructor & Parent Form)

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 102F yesterday and I gave her some baby Motrin and fever came down.
- Last night, she started breathing faster and hard. Her chest looked funny.

Allergies – None to medications

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 Tmax 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.
- **Urination:** 4 wet diapers yesterday. Wet diaper this am. No diarrhea.
- **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 but no one ever said she wheezed before.
- **Feeding/appetite**: She acts hungry but then after an ounce or so of formula she stops because she looks like she is having trouble breathing. She took 4 ounces of apple juice this morning.
- **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 numerous other 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 can't help out much.
- Dad smokes a lot indoors.

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

Instructor Form

Case 2 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	
		Child care	
		Immunizations	
		ROS (general, resp., eye, nose, ear, GI, skin)	
5	Past Medical History	Previous illnesses	
		Allergies	
		ED visits	
5	Family History	Mother, father, siblings, grandparents	

Case 2 - Physical Examination (20 points): (Instructor)

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 milk.	
2	Skin	Warm, dry, no lesions, no rash, rapid capillary refill, & good turgor.	
2	Head/Neck	H – normocephalic, ½ cm anterior fontanel that is soft & flat. N – supple neck, no lymphadenopathy.	
2	Eyes	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.	
2	Mouth/ Throat	M – moist, 8 teeth present T – pink, tonsils 2+, no exudate	
2	Heart	S1 and S2, RRR, no murmur HR 140	
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 64.	
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: 44. 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 & FLU testing: negative.

Case 2 - Diagnoses (15 points):

Points	Category	Student Expectations	Student Performance
5	Diagnosis 1	Wheezing, R/O RSV	
5	Diagnosis 2	URI/Bronchiolitis	
5	Diagnosis 3	Immunization Update	

Management/ 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 &/or Influenza testing in office?	
		Albuterol Inhaler 2 puffs Q4-6 hours PRN cough/wheeze with spacer.	
	Home Tx	Albuterol 0.083% 1 ampule Q4-6 hours PRN cough/wheeze per nebulizer	
		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.	
10	Immunization Update	Give Influenza#2 today or hold until follow-up visit when well.	

(Student Form)

Saint Louis University School of Nursing
Case 3 – Kevin

Information for the Student:

Chief Complaint:
8 year-old Kevin 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 (50%/50-90%)
- Wt.: 60 lbs. (75%)
- Ht.: 50" (50%)
- BMI: 16.9 (75%)
- O2 Sats: 98%

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.

(You may step out of the room to write down your diagnosis and plan if desired)

(Instructor/ Patient Form)

Case 3 – Kevin – Background Script
(Try not to volunteer excess info but answer the questions as a parent or child would)

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 is remains drinking fluids and urinating. Kevin'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).

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.
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.
f. **Throat:** Kevin 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).
h. **Urination:** Yes, he went just before we left for the clinic.
i. **Sleeping:** Kevin has been sleeping more but the coughing wakes him up at night.
j. **GI:** No vomiting or diarrhea.
k. **Rash:** No.
l. **Appetite:** He has lost his appetite. He just eats a tiny amount. He's drinking only water and juice.

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

Social Hx:
- Kevin lives at home with his mother, father, and 3 older brothers (10y/o, 12y/o, & 15y/o).
- Kevin is in 3rd grade & likes school. Has many friends.
- No second hand smoke 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 Form)

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	
		ED visits	
5	Family History	Mother, father, siblings, grandparents	

Case 3 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	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.	
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.

Case 3 Diagnoses (15 points):

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

Case 3 Management/Treatment (30 points):

Points	Category	Student Expectations	Student Performance
20	Office Tx	CXR ordered?	
	Home Tx	Allergy to PCN!	
		Zithromax (200mg/5mL) 6.8mL day1 & 3.4mL days 2-5. (mycoplasma)	
		WASP	
		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 placing pillow/beach towel under mattress & not directly under child.	
		Avoid second hand smoke.	
		Encourage fluids and rest.	
		Make sure to take all antibiotics.	
		No school until fever free x24 hours 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.	

(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
- Wt.: 130lbs. (>95%)
- Ht.: 60" (90%)
- BMI: 25.4 (>100%)
- O2 Sats: 94%

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.

(You may step out of the room to write down your diagnosis and plan if desired)

(Instructor Form)

Case 4 – Brittany – Background Script
(Try not to volunteer excess info but answer the questions as a parent or child would)

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 can't 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 mos ago).

Allergies: None to medications.

Review of Systems:

a. **General:**
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:**
e. **Nose:** Mom says I suffer from nasal allergies that happens in the spring time. 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've been coughing a lot in the morning & sometimes at night my cough is waking me up.
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.
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.

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

- Coughs in AM & has used her inhaler the last 5 mornings. Night time coughing – woke up 1 time and had to use inhaler the last week.
- We have to run a mile in gym class and I have to stop after a couple of laps since I'm short of breath and need my inhaler.
- I don't pre-treat or use my inhaler before gym class.

Family Hx: Mother & 9y/o brother are healthy. Father suffers from hay fever. 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 Form)

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	
		ED visits	
5	Family History	Mother, father, siblings, grandparents	

Case 4 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	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	

Case 4 Management/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.	

(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 x2days.
Vital Signs:

- Temp: 99.6 oral HR: 80 RR: 12 BP: 118/78 (50-90%/50-90%)
- Wt: 120 lbs. (60%) Ht.: 65" (75%) BMI: 20.0 (50%)

Immunization Record: Up-to-Date for age
Problem List:

- 5y/o: Influenza B
- 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 as appropriate

(Instructor Form)

Case 5 – Anna Marie – Background Script
(Try not to volunteer excess info but answer the questions as a teen would.)

Anna Marie T. 15y/o female here with mother with complaint of painful urination x2days.
Hx of Present Illness:
For the last couple of days it has hurt to pee and it really hurts now. I have to 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.
Review of Systems:

a. **General:** Feels more tired the last 2 days.
b. **Fever:** I don't 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 have to go to the bathroom below my belly button.
i. **Back:** Denies back pain.
j. **Urination:** I have to 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. **Rash:** No.
n. **Appetite:** I don't want to drink much since it only makes me go to the bathroom. I've been eating a little bit.
o. **Activity:** I didn't go to school today. My favorite activity is to go to mall/ hang out with friends.
p. **Hygiene:** Doesn't use bubble bath, uses Dove soap, has thought about douching.
q. **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.

l. Last Menstrual Period: Couple of weeks ago, no problems, flow was 5 days, no cramping, uses tampons.
m. 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: **N**one.

(Instructor Form)

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	
		ED visits	
5	Family History	Mother, father, siblings, grandparents	

Case 5 Physical Examination (20 points):

Points	Category	Student Expectations	Student Performance
2	General appearance	Alert & cooperative, sitting on exam table. Well nourished & well developmed.	
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	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	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. 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:

Case 5 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	

Management/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 x3-14 days	
		Send UA for C&S, CT/GC.	
		Discuss testing for other STIs such as HIV & syphilis.	
		Wear cotton underwear. Avoid thong underwear.	
		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.	

(Student Form)

Saint Louis University School of Nursing
Case 6 – Tiffany

Information for the Student:

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

Vital Signs:
- Temp: 99.0 ax.
- HR: 88
- RR: 21
- BP: 110/70 (50-90%/50-90%)
- Wt.: 80lbs. (45%)
- Ht.: 60" (75%)
- BMI: 15.6 (20%)

Immunization Record:
- Up-to-Date 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 as appropriate

(You may step out of the room to write down your diagnosis and plan if desired)

Case 6 – Tiffany – Background Script (Instructor Form)

(Try not to volunteer excess info but answer the questions as a parent or child would)

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

Hx of Present Illness:
I have this runny nose that doesn't ever go away. Sometimes I feel stuffy and my head starts to hurt. I also have a rash that won't 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

Review of Systems:
- **a. General:** Tired the last 2 days. I've 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:**
- **e. Nose:** Mom says it started with spring time. 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've been coughing a little bit. No breathing problems.
- **h. Urination:** No problem with this.
- i. **Sleeping:** I sleep good.
- **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.
- Does sleep with windows open when the weather is nice.

Case 6 Differential Diagnoses (5 points): (Instructor Form)

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	
		ED visits	
5	Family History	Mother, father, siblings, grandparents	

Case 6 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	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.	
2	Mouth/ Throat	M – moist, no lesions. T – pink, tonsils 2+, no exudate.	
2	Heart	S1 and S2, RRR, no murmur HR 86	
2	Lungs	Equal lung sounds, no wheezing, good aeration. RR 24	
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	Eczema	

Case 6 Management/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 1-2 squirts to both nostrils QD	
		Keep window shut.	
		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 Q4-6 hours PRN cough	
		Elevate HOB.	
		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 14 days out of 30.	
		Avoid scratching. Keep nails trimmed short.	
		Follow-up in 1 week for recheck, well visit, & immunization update.	

APPENDIX K

Pediatric Cultural Sensitivity Cases & Rubric

Grading Rubric for use during Residency Discussion Session

Advanced: Student articulated various approaches to incorporate culturally sensitive and competent care and contributed to cases presented by other students.

Proficient: Student identified culturally sensitivity issues and 1 alternative care approach.

Not Proficient: Student was unable to articulate any cultural sensitivity concerns and had difficulty offering an alternative approach to assigned case.

Student	Case #	Student Outcome	Comments; Faculty

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 her with left otitis media and prescribed Amoxicillin. When the provider reviews 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 then asks if she is aware of Medicaid. Did the provider handle this case with cultural sensitivity? Why or why not? Could anything 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 the NP discussing the infant's growth and showing the mother the infant's progress on the growth charts. The infant becomes fussy and the mother states that the infant is hungry. The NP tells 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 anything 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 anything have been done differently? If so, what?

Appendix K (Cont.)

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 anything have been done differently? If so, what?

Case 5
A Hispanic mother brings her 2y/o son in for a chief complaint of 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. 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 anything 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 anything 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 anything have been done differently? If so, what?

APPENDIX L

PEDIATRIC PRIMARY CARE
TYPHON LOG - GRADING RUBRIC

1. The following must be included in the Typhon clinical log: Date, age, gender, race, student participation, and chief complaint or reason for visit and ICD code (diagnosis).

2. Under clinical notes, include the chief complaint, brief description of the history, health promotion focus, and management plan including medications, and 3 elements of anticipatory guidance or education for well child visits. Provide the dosing for any antibiotics prescribed. You must describe any abnormal physical exam findings and treatment plan (labs/testing, health promotion, immunizations, follow-up). For well child visits, document at least 8 areas of the PE even if all are normal. For sick child visits, document at least 6 areas of the PE even though most may be normal.

Grading Criteria for Typhon Logs

Log entries should include: well defined chief complaint & relevant past medical history; list of current medications and allergies; pertinent review of systems; pertinent exam findings; differential diagnoses if relevant; treatment plan (labs/testing/ meds, health promotion, immunizations, follow-up).

100%	Log entries were entered on-time. Notes were complete and all categories of required content were included.
95%	Log entries were entered on-time. Minor prompting by faculty was required to clarify an encounter or to remind student to include a content area. Student responded promptly to any questions from instructor.
90%	Most log entries were entered on-time. Occasional prompting by faculty was required for clarification. Occasionally, logs were not concise or were missing information or were similar to previous postings. Student responded promptly to questions from instructor.
85%	Often, logs were late or incomplete or plan was not consistent with history and assessment. Student did not respond readily to faculty questions.
80%	Log entries were very late. Notes were incomplete. Student had minimal response communication with faculty. No logs were entered by midterm.

A student may receive a grade in-between the above categories based upon log entries or if improved with feedback. Students are expected to respond to faculty suggestions and feedback on logs.

APPENDIX M

COMPREHENSIVE REPORT SUMMARY LOG
GRADING RUBRIC

Students will download and submit an electronic report of all student clinical log encounters from the Typhon database at the end of the fall N5810 (final course).

Expected level of achievement: ≥ 90 % of students will submit a complete report.

Complete report: 7/7 items completed.

Rubric includes 7 elements: Course Number, Date, Age, Gender, Diagnosis, Clinical Notes, and Student Participation)

Report Elements	***Included***	***Not Included***
Course Number		
Date		
Age		
Gender		
Student Participation		
Diagnosis (ICD 10 Codes)		
Clinical Notes		