**Washburn University**

**School of Nursing**

**NU 608 Health Care Practicum III- Specialty (Family)**

 **Clinical Performance Tool**

**(Completed by Student and Faculty)**

Student: Stephanie M. Kimbrel Semester Fall 2012

Agency: Sprint On-site Health Center Instructor: Jane Brown

Clinical performance is based on Universal Outcomes, End of Program Outcomes and National Organization of Nurse Practitioner Faculty Core Competencies of Nurse Practitioner Practice (2011). Nurse Practitioners must demonstrate care that is effective, patient-centered, efficient, timely, and equitable for the treatment of health problems and promotion of wellness.

**Universal Outcomes: Evaluating Behavior**

Universal Outcomes must be met in order to pass the course. Failure to meet any of the three Universal Outcomes will result in a grade of F. If an F is earned, the Core Competencies will not be considered

**Universal Outcomes**

Demonstrates honesty and integrity by submitting original work Met Not met

on assignments and accepting responsibility for own actions

taken/omitted

Prioritizes patient safety as the primary consideration in all care Met Not met

Maintains professional boundaries with patients, family and Met Not met

staff. Maintains confidentiality at all times

**Nurse Practitioner Core Competencies**

Students must achieve an **80%** on the final clinical evaluation tool to be successful in the course. These outcomes are only evaluated if the three Universal Outcomes are met. Students who do not meet the competencies within the required practicum hours may be required to successfully complete additional hours before a final grade will be awarded. Points are assigned as follows:

**Please rate your own performance using the descriptors listed below:**

0 = no opportunity to experience

1 = defined as not meeting expectations; failing to initiate learning experiences; arriving late and unprepared; failure to effectively communicate with the patient, family, preceptor, staff and faculty

2 = defined as inconsistently meeting expectations; requires much faculty/preceptor guidance in learning experience/support

3 = defined as routinely meeting expectations yet requires more faculty/preceptor direction in learning experiences

4 = defined as routinely meeting expectations with minimal support from faculty/preceptor

5 = defined as consistently meeting expectations with little guidance; proficient; can perform independently; initiates learning experiences; is well prepared for learning experiences.

**Competency Narrative**

The overall goal of the Clinical Performance Tool (CPT) is to assess the student’s progress throughout the practicum using a narrative description of each competency. To provide a description of the total progress, the student is expected to maintain a cumulative narrative of their performance.

With **each** competency and **each** submission, the student is expected to assign themselves a score from 0-5 (It is not expected that a student will have many scores of 4 or 5 with the first submission). Within the narrative, students are expected to briefly address the following 4 items:.

1. What does this competency mean? What challenges/strengths related to mastery of this competency are present at this point in time?
2. Give 2-3 examples from this practicum experience that best illustrate how you are preforming the selected competency and which support the score you assigned yourself?
3. What do I need to gain additional skills to master this competency?
4. What references/clinical guidelines/point of care tools (if appropriate) have been helpful in achieving this competency?

**Grading**

The Clinical Performance Tool is completed and submitted by the student at the completion of 80 clinical hours, 160 clinical hours, and 225 for a total of three submissions. **The first submission must address items 1-13. The second and final submission must address items 1-28. The final submission is graded.**

NONPF competencies addressed in this course include Independent Practice, Leadership, Quality, Technology/Information Literacy, and Ethics. Competencies are founded on an understanding of pathophysiology, patient presentation, differential diagnosis, patient management, surgical principles, health promotion, and disease prevention. Utilization of communication strategies, principles of quality care, information technology/literacy and ethical principles are expected. NP students are expected to demonstrate an investigatory and analytic thinking approach to clinical situations, professional behavior, effective communication, and a sensitivity and responsiveness to patient culture, age, gender, sexual orientation and ability.

NP students are expected to:

 0 1 2 3 4 5

1. Develop individualized health promotion, disease □ □ □ □ □ . .□

 prevention and health protection services for patients

 across the life span

A) A human being is unique, from their individual cell make up to all the life experiences that have created the unique person they are. When treating an individual, you are not just treating them physically; the treatment plan must include all that makes up the individual. The various dynamics that make an individual are unique to that individual, thus their health care should be unique and individualized as well.

The World Health Organization (WHO) defines health promotion as the process of enabling people to increase control over, and to improve, their health. This is done both at the micro level of the individual and their behaviors but also at the macro level through health promotion programs, policies, and legislation at the local, national, regional and global levels. These programs look to reduce the leading causes of premature death, disease and disabilities. “Many of today’s and tomorrow’s leading causes of death, disease and disability (cardiovascular disease, cancer, chronic lung diseases, depression, violence, substance abuse, injuries, nutritional deficiencies, HIV/AIDS/STI and helminthes infection) can be significantly reduced by preventing six interrelated categories of behavior: tobacco use, behavior that results in injury and violence, alcohol and substance use, dietary and hygienic practice that cause disease, sedentary lifestyle, and sexual behavior that causes unintended pregnancy and disease” (World Health Organization, 2012).

In order to promote an individuals health, assist them in preventing premature death, diseases, and disabilities, a health care provider must take into considerations all the various dynamics that make up the individual and the dynamics that can affect their health.

B) Every individual that presents to Sprint is screened for smoking, substance abuse, and seat belt use regardless the nature of the visit. Based on the chief complaint, the health care provider discusses specific behaviors not covered in triage during their evaluation. Based on their responses further health promotion and protection is offered. Individuals who currently smoke are then assessed for their willingness to quit, offered smoking cessation resources including both pharmalogical and non-pharmalogical assistance to encourage them to quit and referral to Sprint Alive, which is a health improvement program that compensates Sprint employees for successfully completing various programs such as smoking cessation. A 34-year-old Caucasian male presents to the Sprint clinic with complaints of an upper respiratory infections. Upon obtaining a social history it was found that he also smokes one and half packs of cigarettes a day. An assessment of his willingness to quit concluded that he was not interested at this time. I then encouraged him to decrease the amount of smoke he exposes himself to during treatment, educated him on how the smoke will irritate his airway and cause further illness and suffering. I offered informational brochures on Sprint Alive’s smoking cessation program and reiterated that the clinic was available to assist him in quitting if he so choses.

Immunization status is also determined each visit. Vaccines are offered free of charge to the employee through Sprint. Tetanus and influenza are the main immunizations screened for across the board regardless of age; however, Sprint offers multiple immunizations based on patient need. Sprint offers travel vaccinations due to the diverse population and increased international business travel by employees. These vaccinations are administered based on CDC’s recommendations for the area of travel. Each individual is counseled on travel information for that area, such as mosquito repellant, long sleeved clothes, not drinking anything that is not bottled, treatment for traveler’s diarrhea and how to administer medications supplied for travel such as Cipro and Imodium.

Upon evaluating a 63-year-old female for bilateral ear pain, she requested information of the shingles vaccine. Throughout the clinic there was debate whether varicella titer should be drawn if an individual does not recall having chickenpox. Every health care provider stated it should be given regardless, the nursing staff however stated that it is a live vaccine and we should draw titers or we would be giving them chicken pox. Upon CDC recommendations the only contraindications is an individual that is allergic to vaccine components, is immune-compromised, or pregnancy. “Patients do not need to be asked about their history of varicella or have serologic testing conducted to determine varicella immunity” (Centers for Disease Control and Prevention, 2012).

Routine health physicals are offered yearly to all Sprint employees. Labs are drawn prior to the physical that include CBC, lipid profile, and BMP, which are used to screen for lipid and cardiovascular disorders. With consent of the patients, HIV and hepatitis C virus screenings are done as well. Based on the individuals past medical history or current complaints, other screenings are done to identify possible common causes such as: thyroid disorders, vitamin D deficiencies, and diabetes. Lipid disorders area assessed using the ATP III Guidelines and the ATP risk calculator. Based on lipid levels and risk factors individuals are counseled on therapeutic lifestyle changes and if needed pharmalogic intervention. A 33-year-old Caucasian male presents to the clinic for a routine physical. Labs are all within normal limits, including HDL of 41, LDL 98 however his BMI was 32 and he is a smoker. He is at increased risk for CVD, high cholesterol, and diabetes (just to name a few) if he does not begin some therapeutic lifestyle changes. He was assessed for willingness to quit smoking and losing weight. Encouraged to eat a healthier diet and increase his daily exercising to 20-30 minutes five times a week. Different ideas were discussed to fulfill these goals and he was also referred to a dietician and Sprint Alive’s weight loss and smoking cessation program.

C) I feel very comfortable promoting healthy choices and lifestyles along with educating individuals on prevention. I continue to improve my communication style and interviewing techniques so that my message is delivered in a confident, caring and knowledgeable way with out expressing judgment. I do this by re-evaluating my interviews and interactions with patients, deciding what I did well or what I could of done better. I ask for constructive criticism from my preceptors, which one of the number one things is “sometimes less is more, when you start seeing their eyes glaze over you have lost them, bullet points. Give them the most information for their buck, short and sweet.”

 Upon completion of this semester I feel my delivery and my ability to pull the bullet points out has greatly improved. I continue to work on reading individuals for information overload.

D) Center for Disease Control

 ATP III Guidelines

 Epocrates phone application

 AHRQ phone application

2. Develop individualized anticipatory guidance and □ □ □ □ □ . . □

 health counseling for patients across the life span

A) Anticipatory guidance is providing individuals and families with information and counseling on what to expect with the upcoming developmental milestones and changes in both health and illness states. The greatest challenge for me with this competency is knowing the various developmental milestones, especially infancy and early childhood, and not comparing the patient to others I have came into contact with or have previous experiences such as my own child.

B) When providing a sports physical for a 12-year-old female I made sure that anticipatory guidance was provided regarding safety. Discussion of wearing her seat belt every time she is in an automobile and wearing a helmet when riding anything with wheels was done along with assessing her personal safety, feeling safe at home, school, or at friends homes. What happens if she does not feel safe? We discussed media use and I encouraged increase activity levels. We discussed personal hygiene, knowledge of expected changes that her body is or will be going through. With my patient’s mother, I also discussed these changes her daughter will be going through as well. Normal behavior includes withdrawing from responsibilities, significant relationships are with her peers, she will begin to test the waters and become much more independent through the next few years (Harder, 2012). Though this is a difficult time for them as they explore and experiment in attempts at finding themselves it is important to provide structure and safety through love, understanding and guidance. Advised the parents to discuss risky behaviors, limit media use, however use media as teaching moments, emphasize alternative activities.

Sexually transmitted infections or possible exposure allows for extensive health counseling for various individuals at Sprint. For example, a 31-year-old male presented to the clinic for concerns that he had been exposed to sexually transmitted infections. The patient disclosed that he had protected sexual intercourse with a female that he later found out to have multiple previous sexual partners. He was visibly upset and wanted all tests done to make sure that he did not have any infections. He was empirically treated with Rocephin 250mg IM, Zithromax 1 gram and Flagyl 2 grams by mouth. He was screened for chlamydia and gonorrhea with a urethral swab; blood was drawn to screen for HIV, hepatitis, HSV and syphilis. Patient was counseled on risky sexual behaviors, having safer sex, and follow up testing. To date the patient has been negative for all initial and 6 week screenings.

A 32-year-old Caucasian male presented to the clinic requesting an STD screening due to a new girlfriend request of him. He reported multiple previous unprotected sexual activities; however when screening for urethral swabs were suggested, he declined, after discussion a urine g/c and chlamydia was obtained due to the reduced invasiveness. Blood was also obtained to screen for HIV, hepatitis, HSV, and syphilis. I educated patient on STD prevention and pending results and their meanings.

C) I am currently increasing my skills in motivational interviewing and assessing willingness to change. I want my patients to feel autonomous and for myself not to appear paternalistic. In my attempts to increase these skills I have been studying motivational interviewing along with dialoguing with an individual who trains other parole officers on how to do motivational interviewing.

 Upon completion of this semester, I continue to improve my motivational interviewing skills through experiences and using information regarding motivational interviewing from others such as my fellow colleagues, preceptors and individuals that use these skills daily.

D) Harder, 2012

 CDC

 Piagets stages of cognitive development

 Erickson’s psychosocial development stages

 Developmental milestones

3. Prioritize differential diagnoses based on etiologies, □ □ □ □ . □ □

 risk factors, underlying pathologic processes and

 epidemiology for medical conditions

A) Selecting appropriate possible diagnoses formulated from general knowledge of etiologies, risk factors, underlying pathologic processes, epidemiology, signs and symptoms for medical conditions. Some of the challenges related to this competency is knowing when to chase a zebra.

B) For example 21-year-old female presents to the clinic with sore throat for two days. Posterior oropharynx is erythematous with exudate; rest of physical exam is negative. Patient was empirically treated for streptococcal pharyngitis with amoxicillin. Patient return to clinic three days later, symptoms have not resolve, worsened, now unable to swallow. Posterior oropharynx has multiple lesions with exudate, extending into the soft and hard palate, along with petechial on the soft palate. Vesicular lesions noted to upper lip and gums now. Differentials include streptococcal pharyngitis, mono, viral pharyngitis. When discussing the care plan for this patient with the provider they reminded me to assess the risk factors for possible oral STI such as HSV or gonococci pharyngitis. I had not considered this etiology, which based on her age and her sexual behaviors could increase her risk for HSV or gonococci being the causative agent.

 In children febrile illnesses are not rare, however when assessing infants, toddlers, and young children thought processes to diagnostically rule in or rule out is different. With female patients it is key if no other outward signs of infection are present a urine sample should be evaluated. 3-year old black female presents with fever and vomiting. Upon exam, patient is a well-developed, alert and appropriate healthy 3-year old. A urine sample was obtained; a UTI was found and treated with Keflex. Evidence shows that girls have a 2- to 4-fold higher incidence of UTI than a circumcised boy.

 A female presenting with abdominal pain to the ER requires a thorough history, HPI, physical evaluation and risk assessment to reduce the sheer number of possible diagnosis. A 38-year-old Caucasian female presented to the emergency with acute onset of RUQ and epigastric pain with nausea and vomiting. She had no significant medical, surgical, or social history, currently taking no daily medications. The pain began suddenly at approximately 2200. She reports having pain like this a few times before, but it usually resolves itself within a short time period, and has never had the vomiting with it. Denies recent illnesses or fevers, vital signs are within normal limits. ROS negative other than what discussed in HPI. Upon physical exam patient does not have an acute abdomen, minimally tender to the RUQ and has a positive Murphy’s sign, otherwise abdomen is soft, non-tender with active bowel sounds. Initially the diagnosis’s could include as many as ten, after exam the differentials were prioritized to the top four. In the ER you must rule out the bad, but also consider the common. Blood work was obtained that ruled out acute infections, pancreatic, liver, or kidney involvement. Her nausea and pain was treated with Zofran and morphine. Hydrated with normal saline due to vomiting, electrolytes were normal. Her pain and nausea resolved with treatment, patient declined ultrasound to screen for cholilithiasis with possible biliary duct blockage. She wanted to follow up with her PCP. Due to the resolution of her pain and the bad ruled out (acute abdomen or infection), after discussing possible treatment plans, she was discharged to home to follow up with her PCP.

C) Through continued learning and accessing resources such as textbooks, phone applications, internet (previous two reliable sources of course), and continued mentorship with knowledgeable providers will help to enhance and refine this competency. Last night at the ER, I pull out a book to look up information about c-spine evaluations and the Nexus c-spine criteria, another physician told me very kindly, “Stephanie you do know that you will never know it all.” This coming from a physician who has been practicing for thirty plus years in both internal and emergency medicine, demonstrates how health care is ever evolving, it is your job as a provider to continue learning and also stay up to date on current medical advancements, research and evidence.

 Upon completion of the semester I fell that I have become much more profieient at prioritizing my differential diagnoses and separting zebras from horses. This is shown in my ability to communicate both written and orally, my methodology of my evaluations and treatment plans, to my preceptors without having to be redirected or need to simplify the information provided, allowing me to be more precise.

1. Textbooks including: The Washington Manual of Medical Therapeutics, Pathophysiology, Fitzpatricks Clinical Dermatology

Internet and phone applications including: CDC, Epocrates, UptoDate, Medscape

Handheld resources: Sanford microbiology, Pharmacopia

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4. Perform comprehensive health history and physical exam □ □ □ □ . □ □ for patients across the life span

A) During the past two years my knowledge base of detecting signs of disease, recognizing risk factors, and identifying normal healthy individuals has expanded greatly. I am able to perform a comprehensive health history and physical exam with little difficulty. Processing this information continues to seem slower than it should be. When performing this competency I continue to struggle with time management. I continue to work on the flow of my exams so that they are thorough along with being efficient. I am continually seeking more opportunities to do all generalized physical exam that presents to Sprint while I am present.

B) A 28-year-old Caucasian female presented for general medical exam. Labs) vitamin d-14; glucose 80, total cholesterol- 140, HDL- 49, LDL- 115, TSH- 3.2. Based on ATP III guidelines that include determining presence of major risk factors: age, gender, tobacco use, BMI, family history, and hypertension. This patient was less than 10% of a 10-year risk of coronary heart disease. Unremarkable exam. She was treated for vitamin d deficiency based on vitamin d level <20. The reason I used this example is upon first reviewing these lab levels I was concerned with the LDL of 115, however with using the ATP III guidelines and the Framingham point score it was not of real concern at this time. We did discuss increased activity and healthy diet options. This entire exam took me approximately 45 minutes…way too long. (That does include time in room examining patient, researching, and charting)

 A 50-year-old Caucasian female presents to clinic for a general medical exam. Labs were unremarkable…health history unremarkable…physical exam unremarkable. I honestly have to say I felt stuck; whatever do you do with an actual healthy person. I encouraged patient to maintain health lifestyle choices, which led into a great session of anticipatory guidance: discussion of expected changes, screenings she needed to have including a colonoscopy and mammogram. A simple exam right…35 minutes in the room with the patient, this is not including research or charting.

 An 11-year-old Caucasian male presented to the clinic for a sports physical to play football. Mother denies any medial, surgical or social history. Family history is unremarkable, negative for heart disease, sudden death before the age of 50, or cancers. Immunizations are up-to-date. Mother and patient report no previous head injuries; however this will be the first year playing football. ROS is negative and the physical exam is unremarkable. He was cleared to play football, deemed healthy and fit for this type of physical activity. The reason I choose this example is the fact it is so important to do a comprehensive health history and physical exam so that as a provider you are able to screen for and possible prevent incidents of sudden death or disabilities in young athletes with cardiac anomalies or clearing them to return to physical activity after an injury. There are number of providers who farm school aged children’s sports physicals through their clinics missing key signs and symptoms.

C) Actions/steps I am taking to master this competency:

* Becoming more familiar with guidelines especially ATP (lipid), JNC7 (HTN), diabetes prevention, screening, and treatment, thyroid disorders without having to constantly reference them.
* Becoming aware of time: wearing a watch, working on flow and interviewing skills.

Upon completion of this semester I continue to increase my familiarity of various guidelines by reviewing them as time allows while at work and at leisure. My goal in being aware of time continues to elude me. I have begun to wear a watch more, but I attempt to be attentive to time regardless. My flow and interviewing continue to improve, as I gain more experiences I feel that I will master this as well.

D) ATP III guidelines

 JNC7 guidelines

 American Diabetes Association guidelines

 AHRQ phone ap

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5. Perform problem focused health history and physical exam □ □ □ □ □ . .□ for patients across the life span

1. Based on my background as an Emergency Room nurse I feel very comfortable and feel that I can complete a focused health history and physical exam proficiently. My challenge in this competency is to find the balance between minimalist and excessiveness. My goal is not to follow the rabbit down the rabbit hole.
2. I have found myself looking for more when assessing patients; for example: 45-year-old female chief complaint is ear pain, upon a review of systems and HPI; she states she is having ankle pain when asked about joint or muscle pain. Upon further investigation, the right ankle pain has been occurring for months and is non-contributory to the present illness. At the beginning of the semester I would dive into the ankle pain, where as now I am comfortable refocusing the exam to the ear pain. In another incident

I had an incidental finding an irregular heart beat in a 30-year-old male presenting for leg pain, which ended up being on overuse injury. Upon inquiring if he has always had an irregular heartbeat, he reported that approximately one year ago he was sent to the ER with palpitations with the symptoms of chest pain, dizziness, and diaphoresis. He was cleared at the ER, told to follow up with cardiology for further testing including a halter monitor. He reports that he did not follow up due to the expense. States he though he was fine because he has not had any symptoms since the initial incident one year ago. Due to the incidental finding we were able to refer him on to cardiology for further testing and had him return for a full physical with labs, which he had previously not done in more than five years.

1. I believe through continued experience and solid mentorship I will continue to refine my practice and attain a balance. By the end of clinical I was able to perform a focused exam health history and physical exam proficiently with confidence.

1. Textbooks: Mosby’s Guide to Physical Examination

Handheld aids such as Clinical Coach for NP’s

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6. Apply diagnostic reasoning and critical thinking □ □ □ □ . .□ □

 in clinical decision-making and development of a

 treatment plan

1. In development of a treatment plan multiple variants must be taken into consideration requiring critical thinking skills. Diagnostic reasoning must be done to support your clinical decision-making. Challenges in mastering this competency include: not pigeon holing the diagnosis, letting the evidence guide you, not make the diagnosis and find the evidence. A health care provider must analyze the individual, their signs and symptoms to systematically develop probable hypotheses (Croskerry, 2009), decide how to rule out or in these hypotheses, then decide the proper treatment for this individual.
2. The patient mentioned in competency #3 who presented to the ER for re-evaluation for unresolved throat pain after 3 days on Amoxicillin. Diagnostic reasoning included formulating hypotheses based on her presenting signs and symptoms: increasing throat pain x5days, ulcerations in multiple areas of the mouth some with exudate, symptoms not resolving with antibiotic treatment. Also included in formulating the hypotheses include age and gender, 21-year-old, sexually active female. (Discussed due to r/o pregnancy) Differentials include: bacterial or viral pharyngitis, peritonsilar abscess, mononucleosis, or HSV. What I had not originally formulated was what type of bacterial pharyngitis could be the causative agent? Hence gonococcal would not respond to penicillin treatment.

Skin conditions are extremely difficult to diagnose. At both sites I saw multiple patients with various skin related skin complaints. The first step both Dr. Evers and Ann McDaneld, APRN do when looking at skin is to decide is the person sick not sick? Next step: how to treat. Anti-inflammatory topical or oral? Steroids? Pain/itch? For example a 9-year-old black male presents to the ER with a rash. He denies itching or any other constitutional symptoms. Mother reports papules and plaques to trunk, shoulders and upper legs. Herald patch present to left chest wall. Antihistamine and calamine lotion recommended. Education on what pityriasis rosea is and how to care for it at home was provided.

1. Through experience and solid mentorship I will continue to refine my practice and clinical decision-making. Continued education and research of current evidence and practice guidelines will also assist me in development of a treatment plan.

Upon completion of this semester I feel much more comfortable developing a treatment plan and having confidence in my diagnostic reasoning; however I will continue to improve my practice through experiences, mentorship, continued education and research of current evidence and practice guidelines.

1. UpToDate

Epocrates

NCBI

PubMed

Fitzpatrick’s Clinical Dermatology

7. Implement screenings appropriate to differential diagnoses □ □ □ □ . □ □

1. Screenings help to identify conditions before symptoms begin. For example blood pressure screenings to identify hypertension before symptoms begin to help to prevent end target organ damage.
2. Each patient when triaged is assessed for various risk factors as discussed earlier and their height and weight are measured and recorded. The EMR software Sprint uses automatically computes BMI. In the ER, a triage note cannot be completed with out height and weight. This allows for screening of every individual with increased body fat (BMI) that puts them at risk for type II diabetes, cardiovascular diseases, hypertension, and breathing problems. As discussed in competency #1 Sprint offers routine medical exams that screens for lipid disorders. The EMR software Sprint uses also allow for easy one view of all previous vital signs in order of date taken. For example a 44-year-old male presented to the clinic for routine medical exam so that we would fill his hypertension medication. Upon evaluation his BMI was 34, it has risen two points over the past two years. His hypertension is currently being controlled with lisinopril. Last three recorded blood pressures were in the 130’s systolicly. LDL was 105, HDL was 41, and total cholesterol 198. He is also a pack a day cigarette smoker. His 10-year risk calculation per Farmington Point Score is 8%. Fasting glucose was 99. HgbA1c was 5.1. If this gentleman continues with an inactive unhealthy lifestyle he will be on a crash course with Type II diabetes and CVD. We discussed in detail screening results and where he was headed. Therapeutic lifestyle changes, reasonable changes that could be made on a daily basis. He was referred to Sprint Alive and a dietician. Given written material on hypertension.

Screening for tobacco use affects diagnoses when considering lung conditions. For example a 33-old female presents to Sprint clinic with a three-day history of rhinorrhea, sore throat, non-productive cough worse in the morning, no fever. She does not have any contributing health history, this occasionally occurs with the change in weather. Does not take any daily medications. A 56-year-old male presents to the clinic for a 3-day history of similar complaints, rhinorrhea, sore throat, and productive cough with a history of 2.5 packs of cigarettes per day, no fever. History of sinusitis, bronchitis, and pneumonia. Currently taking no daily medications. For the female, symptom management was the treatment of choice. Due to the health history and current health status of the male, symptom management and Doxy were selected for treatment to cover/prophylactically treat both sinus and lung infection.

1. Continue to stay up to date on current screenings for individuals.
2. I currently use AHRQ USPSTF Preventative task force phone application for on the go screenings based on age, sexual activity, and tobacco use. I also like to use websites such as US Department of Health and Human Resources, PubMed, Medline, Up-to-date, and the National Clearing House.

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8. Initiate diagnostic strategies appropriate to differential □ □ □ □ . □ □

 diagnoses

1. Diagnostic strategies is the system/methodology used to guide providers to the appropriate diagnosis. Establishing diagnostic strategies will aid you in ruling in or ruling out diagnoses. Part of the strategy must include determining which diagnoses will be ruled out the easiest, and selecting diagnostic test that are appropriate. Challenges for mastering this clinical competency is the variables affecting diagnostic strategy, allowing not only for the providers knowledge and practice base but the individual, their health status: allergies, co-morbities, finances, insurance, knowledge level, and biases.
2. Example:

Patient presents to the ER with complaints of neck pain post motor vehicle accident 8 hours ago. Do we x-ray to clear the c-spine? Using the NEXUS (National Emergency X-ray Utilization Study) c-spine guidelines, history of present illness, and physical exam this individual was assessed to determine if an x-ray is needed to clear her c-spine. The NEXUS criteria: Are there any focal neurologic deficit present? Midline spinal tenderness present? Altered level of consciousness present? Intoxication present? Distracting injury present? Patient subjectively reports bilateral neck pain, increasing since the accident. Denies decrease ROM, numbness or tingling, loss of bowel or bladder, loss or altered level of consciousness, any other injury, or consumption of alcohol or illicit/narcotic drug use. Upon exam, patient has no point tenderness along the entire spine, head is a-traumatic normal-cephalic. Cranial nerves II-XII are grossly intact, no focal neurologic deficits appreciated. She is alert and oriented to person, place, time, and situation, able to recall events previous, during and immediately after the accident. No decrease in ROM in any muscle-skeletal region. Pain is elicited with palpation of the bilateral trapezius muscles. Based on the NEXUS criteria and exam the differential of a c-spine injury is ruled out without the need for an x-ray.

 In the ER we see individuals with kidney stones frequently, the question then

 become how often do you need to expose them to radiation such as a CT scan or KUB.

 The strategy used by Dr. Evers regarding this requires a comprehensive health history:

Is there a history of kidney stones? Renal disease? Renal agenesis or dyplasia? Nephrectomy? Ever had a kidney stone that needed interventions to pass? How often/or how many kidney stones has the person had? For example a 43-year-old male presented to the ER with acute left flank pain, history of multiple kidney stones. No history of renal disease or complications. He has needed lithrotripsy multiple times to help pass stones. Last kidney stone was eight months ago. A CT revealed a 6 mm stone. Once his pain was under control patient opted to go home with oral pain medication to follow up with urologist. A 36-year-old male presents to the ER with acute left sided flank pain with history of kidney stones, no history of needing lithrotripsy, renal disease or complications. This patient did not have health insurance and requested that we do as little as possible due to financial concerns. With this in mind a KUB was ordered that showed an approximate 6 mm stone. After pain was controlled, patient was discharge home with oral pain medications and follow with an urologist. (Given the BCBS metro area safety net clinic information to assist with proper follow-up)

C) To gain additional skills in mastering this competency include:

* Utilizing critical thinking skills with diagnostic reasoning.
* Staying up to date and studying current guidelines.
* Ask questions during clinical and work if I do not understand the reasoning/process behind a decision-making.
* Utilize mentorship

Upon completion of this semester and the completion of the program, I have learned that diagnostic strategies can very well depend on your resources or your patient’s financial situation. Having a firm understanding and ability to perform a thorough physical exam can assist you in forming differential diagnosis with little diagnostic information or performing unnecessary tests.

D) NCBI

 UpToDate

 PubMed

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9. Develop and evaluate the plan of care utilizing □ □ □ □ . □ □

evidence-based practice

1. Evidence-based practice is using the most up-to-date evidence to provide care to an individual by harmonizing clinical expertise with sufficient research that supports or rejects practice methods. Challenges to this competency include balancing evidence-based medicine, the providers intuition/experiences, and the patients expectations and satisfaction.
2. Examples:

\*44-year-old Caucasian male presents to the clinic with complaints of rhinorrhea, sinus congestion, headaches, and sore throat for three days, worse in the am. No current treatment. “I have a sinus infection, I get one every year, I need a z-pack and I will be good.” Top three differentials include: acute sinusitis, allergic rhinitis, or upper respiratory infection. The most common cause of acute sinusitis and upper respiratory infections is viral, allergic rhinitis is inflammation of the nasal cavity caused by environmental allergies. All three differentials treatment is very similar: symptom management- antihistamine, decongestant, pain relievers, saline rinses/sprays, increase humidity, both nasal and/or systemic steroids to decrease inflammation depending on the severity of symptoms. Symptoms typically resolve in seven to ten days. Acute bacterial sinusitis symptoms, which is rare and typically result of complications from viral infection, include: symptoms that have persisted for >10 days, fever, and facial pain. First line therapy for acute bacterial sinusitis is amoxicillin. (Up-to-date.com) For this patient, patient education of the disease process in language he could understand, both written and verbal care plan instructions for symptom management, follow up for persisting symptoms >10 days, high fever, changing or worsening of condition. This patient was initially unhappy with not receiving an antibiotic, after education of the disease process and reassurance that evidence supports this treatment plan patient verbalized understanding. Patient offered to just call if symptoms had not resolved within the next week. Upon follow-up call to patient 3 days post, patient reported symptom improvement.

\*In the ER we discussed the Centor guidelines in ruling in/out of diagnosis of bacterial pharyngitis in a patient suffering from a sore throat. 17-year old male patient presents to the ER for ear pain and sore throat. He scored a four on the Centor scale, any number above three you treat empirically. He was placed on a five-day course of 500 mg/ day of Zithromax due to a penicillin allergy.

C) To master this competency:

* Stay up to date on current evidence based research
* Continue efforts to improve communication and health literacy with patients
* Evidence based guidelines are recommendations; each individual must be assessed and treated uniquely.

D) Epocrates

Sanford

NCBI

 UpToDate

 PubMed

 National Clearing House Guidelines

 CDC

10. Prescribe medications based on cost, diagnoses, □ □ □ □ . □ □

efficacy, safety, and individual patient needs

1. When deciding on a treatment plan, the decision to prescribe medications must take in multiple variables into consideration, is the medication appropriate for the diagnosis? Areas of compliance must be contemplated, such as affordability of medications, based on the patient is the dosing able to be followed, are the side effects manageable? Challenges to this competency include balancing evidence-based medicine, the providers intuition/experiences, and the patients expectations and satisfaction.
2. Doing clinical’s at two different locations allowed me to see this competency from two different perspectives. Individuals at Sprint have private insurance, the goal of employee health is to keep them happy and healthy and out of expensive places like urgent cares and ER’s. These individuals are not concerned with cost of medications or diagnostic strategies in the clinic because of the benefits associated with the onsite health center and pharmacy. However, at Sprint, the clinic functions to save money for Sprint, so this must be taken into consideration when prescribing medications and various diagnostic tests. In the ER the patients financial situation is a huge consideration, can the individual afford to pay for medications? For example \*those individuals with chronic sinusitis with an acute infection, Augmentin is the first line medication, however Augmentin is extremely expensive. This must be a consideration when prescribing this medication. Alternative medication such as high dose amoxicillin. At Sprint Augmentin would be prescribed without a second thought, in the ER however alternative medications must be considered if the patient is unable to afford it when amoxicillin is on the $4 list at the majority of pharmacies.

\*18-year old Caucasian female presents to the ER with axillary abscess, same young lady that I had treated for folliculitis of the mons pubis within the last 7-10 days. Reports folliculitis on the mons pubis has resolved however she did not ever fill the prescription because she did not have the money to purchase, prescription was too expensive and her Medicaid is not valid at this time. I researched the cost of Bactrim, which in the generic form is $4.00 at Walmart. I discussed this with the patient, and supplied her with a prescription discount card.

\* An 18-year-old female presents to the ER with complaints of dysuria. She is diagnosed with UTI. She was concerned with the price of the antibiotic, Bactrim DS and pyridium based on being a student and uninsured. I researched prices reassuring her both are affordable and under $10, also provider her with a prescription savings care and information regarding prescription assistance and health insurance.

C) To master this competency:

* Stay up to date on current evidence based research
* Continue efforts to improve communication and health literacy with patients
* Evidence based guidelines are recommendations; each individual must be assessed and treated uniquely.

D) Epocrates

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11. Perform medical and surgical procedures as appropriate □ □ □ □ .. □ □

1. Medical procedures are tests performed with the intention of identifying causes of health problems and to evaluate treatments. Surgical procedures are preformed to identify and/or repair health problems with some form of incision. My sole purpose of my ER rotation is to increase my skill level in performing medical and surgical procedures.
2. I have sutured approximately 11 individuals, performed one I&D, two pelvic exams, insertion of two rhino blasters, removing one rhino blaster, assisted with the reduction of a subluxed patella, shoulder and great toe; removal of a Lego from an ear, 7-8 inch steel hook from a foot, and assisted in multiple immobilizations of joints and fractures. The knowledge and experience I have gained through this rotation in the ER is priceless.
3. Master of this competency includes:
* Continued experience in performing these procedures.
* Expanding knowledge base of techniques and procedures.
1. Textbooks: Essential Procedures for Practitioners in the Emergency Department

Mentors

12. Interpret patient responses to treatment and recommend □ □ □ □ ... □ □

 changes to the treatment plan as indicated

1. The action of explaining and understanding how a patient has responded to any interventions and/or treatments. Based on this understanding recommend options to improve patient’s response and outcomes as needed. Communication is key when interpreting and evaluating the patient’s responses to treatment. Though there is some objective information to obtain such as decreased redness and swelling to the site of cellulitis, subjective information is extremely enlightening in recognizing possible treatment failure. Challenges to this competency include every individual is unique and experiences things differently, for example pain tolerance, medication tolerance, health literacy, or assertiveness. Recommended changes should be done in collaboration with the patient based on the needs and wants of the individual.
2. Example:

\*50-year-old female presents to the ER for dizziness. Patient is concerned there is something wrong with her brain; she would like a CT or MRI. Symptoms have persisted for months but recently increased today. Associated symptoms include nausea, vomiting, and increased dizziness with movement. Patient upon exam patient did not have any acute neurological findings requiring an emergent CT or MRI. Exam showed positive findings for vertigo. Symptoms resolved with Valium, meclizine and Zofran. However patient began having an additional symptom of a headache. At this point, a CT of the brain was performed to rule out any acute disease findings (i.e. CVA, tumor.) Patient declined lumbar puncture to rule out a subarachnoid hemorrhage. The patient was subsequently admitted for observation and consult with neurology. Patient was diagnosed with vertigo and discharge from the hospital 24 hours later after all following tests were negative. In this instance, the plan of care was changed due to progression of symptoms to rule out life threatening acute disease and peace of mind for the patient that her current symptoms were not life threatening.

\*The patient from competency #3 is another example of interpreting patient response to treatment and making appropriate changes. Based on treatment failure of the amoxicillin and physical findings, symptom management was encouraged that included: Lortab, viscous lidocaine mouth wash, steroid injection to help with inflammation and swelling. No further antibiotics were ordered pending results of the throat culture (which was negative for bacterial agents). Before discharge from ER symptoms had improved significantly.

\*A 16-year-old male presents to the ER with a 7-8 inch steel metal rod in the sole of his foot. Initially he was in pain, then I caused more pain by numbing the area to remove the steel rod however upon numbing medication kicking in, pain was significantly relieved allowing for easy removal of the rod and exploration of the wound and surround tissue.

\*A 90-year-old male presents to the ER with complaints “I just don’t feel right”, weakness and feeling dizzy. History of CVA and recent TIA. From Chicago area, just had full neurological work-up within a week for similar symptoms that came back negative for another CVA. A head CT, EKG and lab were ordered to cover any acute changes which were negative. Patient was treated with Zofran, valium, and meclizine which resolved his symptoms. After resolution of symptoms, discussion with patient, family and his health care providers in Chicago patient was discharged home with a diagnosis of Vertigo and instructed to follow up for any neurological changes versus having another full neurological work up including an MRI.

C) To gain additional skills in mastering this competency include:

* Continue to improve communication and assessment skills.
* Utilizing critical thinking skills with diagnostic reasoning.
* Staying up to date and studying current guidelines.
* Ask questions during clinical and work if I do not understand the reasoning/process behind a decision-making.
* Utilize mentorship

D) Epocrates

Sanford Antimicrobial Guide

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13. Document using professional terminology, □ □ □ □ □ . . □

 format and technology (ie: ICD9, E/M coding, CPT)

A) Professional terminology is the language that is spoken within one’s profession. It is essential that you are able to communicate with fellow health care providers, this is done through using professional terminology, format and technology. In todays health care environment, a health care provider must be proficient in the current medical technology and use of computer software.

B) Both clinical sites use electronic medical records and charting. I continue to strive to improve

my charting skills. I ask for regular evaluation on my charting techniques and study my mentors charting techniques. Dr. Evers specifically challenged me to be as concise in my charting as I could be, to decrease redundancy. When charting the HPI, not to repeat information within the review of systems section. At Sprint, we code each chart so I feel very comfortable using ICD9 and CPT coding. The computer automatically E/M codes, however on the super bill you are able to review and edit if needed.

1. Mastery will come from continued use and experience. Increasing my vocabulary to correctly communicate with my peers both written and orally.

Upon completion of this semester my charting has become much more concise. Through continued and experience I will continue to move toward mastering this competency. I am always increasing my vocabulary whether through reading at leisure or researching specific disease processes. I work on my annunciation of difficult words by slowing my self down when talking.

D) <http://icd9cm.chrisendres.com/>

 Mosby’s Medical Dictionary

 Textbooks: Ferris’s Clinical Advisor, Primary Care, Mosby’s Guide to Physical Examination.

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14. Initiate referrals by collaborating and consulting with □ □ □ □ □ □

 members of the health care team

A) As health care providers, it is our duty to provide optimum management of an individual’s wellness and disease state. As the primary health care provider it is essential to acknowledge when another opinion, specialized knowledge and/or services are necessary. Utilizing other members of the health care team can and will only add to the overall care and health of the individual. In mastering this competency challenges include knowing and making use of all available resources. Recognizing in the primary care setting what is appropriate to treat in the office and what needs to be referred can be a challenge. Strengths include having the humility to communicate when one needs help, assistance, advice, another brain to process the situation.

B) For example: \*At Sprint, from 8:00 am to 5:00 pm there are at least three advanced practice nurses present and at all times the collaborating physician, Dr. Henley, is available by telephone, this allows for constant communication and support for difficult cases. Plain film x-rays are available on site, referring to Johnson County Imagining for any other needed radiography studies. A radiologist reviews each image done at Sprint. Referrals to other specialties include cardiology, orthopedics, ob-gyns, and GI specialists to name a few. Use of other disciplines such as on-site physical therapy, wellness coaches and pharmacists.

\*During clinical at Sprint I have referred a 15 year old male to a surgeon after diagnosing a hernia, 30 year old male to cardiology with palpitations, a female with a full thickness burn with cellulitis to foot and ankle to wound care specialist, numerous back and joint pains to physical therapy, multiple patients to Sprint Alive for wellness coaching regarding healthy lifestyle choices, weight loss, stress, smoking cessation, sleep habits…etc.

\*During clinical in the ER, every disposition includes a referral or follow-up physician. The difference in the ER is not everyone has insurance, so making sure that an individual has a health care provider to follow up with and the means to follow up with that provider and be extremely challenging. Through my multiple job sites I have found a resource guide for safety net clinics in the Kansas City Metropolitan area that is produced by Blue Cross Blue Shield. It provides all the area safety-net clinics including the care each can provide: primary care, ob-gyn, STD checks…etc. It is written in both English and Spanish. Provides information on resources for medications and affordable insurance. Olathe now carries these booklets to provide as resources to patients.

C) To master competency:

* Communicate with all members of the health care team.
* Learn area providers and companies policies on referrals.
* Become knowledgeable about companies insurance policies to know whom individuals can be referred to. (Sprint is United Healthcare, Sprint employees have two-three options.)
1. Area providers and companies policies on referrals

Companies insurance policies

Hospitals provider referrals

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15. Incorporate access, cost, efficacy and quality when □ □ □ □ □ □

 making care decisions

A) To provide the best care to an individual is to understand that every person is unique and their individual situations are as unique as they are physiological. When providing care to diverse population across the age span you must have an understanding of access to health care and specific health care costs while providing efficacious and quality care. The quality of care is exhibited every day by the personalization, respect, and effective communication between the health care team and patients, their families and caregivers. Personalization is the ability to make it about the person, making the care unique to the individual.

B) \*Within both clinical sites, we discuss all four of these subjects on a daily bases. We discuss possible coming changes to health care such as the medical home, expectations of the provider, accessibility, cost, efficacy, and quality. When prescribing medications we discuss the efficacy, for example whether or not to prescribe Cipro or Bactrim for three days versus seven to ten days for a UTI based on severity of UTI and the areas susceptibility.

 \*The ER often sees individuals for conditions that were preventable or could be treated and managed by a primary care physician, however these individuals do not have the financial means nor health insurance to get the health care they need. I found a resource guide that shows area safety net clinics, with a graph that shows the type of care provided: dental, OB, GYN, pediatric, etc… I use this resource when having patients that do not have a PCP nor financial/health insurance to gain access to managed primary care.

 \*18-year old Caucasian female presents to the ER with axillary abscess, same young lady that I had treated for folliculitis of the mons pubis within the last 7-10 days. Reports folliculitis on the mons pubis has resolved however she did not ever fill the prescription because she did not have the money to purchase, prescription was too expensive and her Medicaid is not valid at this time. I researched the cost of Bactrim, which in the generic form is $4.00 at Walmart. I discussed this with the patient, and supplied her with a prescription discount card.

C) To master this competency:

* Strive to discuss access, cost, efficacy, and quality of care in the decision making process.
* Being involved in current events
* Continuing education: health care finance, understanding insurances and the constant changes involved, policy and research.

D) Health Resource Guide

 Textbooks: Ferris’s Clinical Advisor, Primary Care

 Epocrates

 Sanford Antimicrobial Guide

 NCBI

 UpToDate

 PubMed

 National Clearing House Guidelines

 CDC

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16. Perform care in a timely manner □ □ □ □ .. □ □

1. As a health care provider, you must be able to deliver care in a timely manner. Challenges to providing care in a timely manner include balancing patient’s need for your attention versus the clinic flow, patient load, and schedule. Some patients take more of your time than others, finding this unique balance of giving the patient your attention, allowing them to feel that you are actively listening yet containing time. I personally struggle at this. I continue to aim at decreasing the time I spend in the room and spent developing a care plan.
2. For example when counseling patients I spend more time than needed talking with patients, losing track of time or what else maybe going on in the clinic at that time.

\*29 year-old male Caucasian presented to the clinic for follow up for initiation of Wellbutrin SR. I spent 45 minutes discussing how he was responding to the medication, encouraging patient to attend counseling, and healthy lifestyle changes that he could help him feel better and have more energy such as exercising and eating a well balanced diet. I do not feel that this time was not used wisely I do realize that I must acknowledge that this is too long for a follow up visit, I must recognize that what is going on within the clinic that day, schedule and patient flow. One change I have made is performing the physical exam while discussing relevant information related to the visit.

\*14-year old Caucasian female presented to the clinic for a rash. Diagnosed with folliculitis with abscesses on leg, history of MRSA. When talking with patient and her father, I did not use bullet points when discussing treatment plan prevention of folliculitis and spreading MRSA. When taking care of an 18 year female with folliculitis to the mons pubis with a history of MRSA, I did a much better job of bullet pointing prevention of folliculitis and spreading MRSA to others.

1. Ways to master this competency:
* Acknowledge my chatty personality and work on bullet pointing my discussions.
* Paying attention to time
* Continue to increase my knowledge base and staying up to date of treatment guidelines to increase efficiency.
1. Watch/clock

Epocrates

Sanford Antimicrobial Guide

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17. Maintain confidentiality and privacy □ □ □ □ □ □...

1. Health care is a delicate matter for many individuals. Many discuss topics with their health care providers that they would not discuss with anyone including loved ones. Patients must know that what is discussed is within the confidence between the provider and the individual so that a trusting and open relationship can be obtained and maintained.
2. I continue to maintain confidentiality and privacy of patients during clinical. I focus on staying compliant with HIPPA regulations to guide my actions. Examples include \*privately discussing cases/clients that we are treating with my preceptor so as to prevent others from overhearing the conversation. I also protect the \*security of electronic information by logging out of electronic devices when not in use and \*only accessing the information of the patient being seen at that time while with patients.
3. To master this competency is to respect every individual patients privacy and to continue to maintain confidentiality in every way possible.
4. HIPPA guidelines

State and federal regulations and legislation regarding mandated reporting.

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18. Demonstrate professional behavior □ □ □ □ □… □

1. Professional behavior consists of behaviors that are deemed acceptable by a particular profession. This is hard to quantify or measure since it is primarily determined by perception. Within the medical community professional behavior is related to responsibility, relationships with patients, peers, and co-workers, honesty, and being aware on ones behaviors and ability to reflect on these.
2. I consistently arrive to \*clinical on time, \*dress in professional and \*appropriate attire, I am \*respectful of clinical staff, \*conscientious of patient confidentiality and needs, and \*address patients respectfully. I feel these behaviors are indicators of my professionalism based upon etiquette I have learned during undergraduate and graduate training as well as observing my role models such as preceptors and instructors. I know this is perceived as professional behavior by the positive way other professionals and patients receive me. Two issues I am constantly working on is talking too loud and procrastinating. I regularly attempt to acknowledge the volume of my voice and work on keeping it to an acceptable range. I am a procrastinator and continue working on ways to prevent myself from procrastinating, especially in regard to others.
3. In mastering this competency, I will continue to exhibit professional behaviors and persist in working on the volume of my voice and procrastination by adopting ways to acknowledge and decrease my loudness and behaviors to decrease my procrastination.
4. Behavior modification online seminars

Organizational online seminars

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 adaptability, flexibility and tolerance of ambiguity

 A) Part of being a health care provider is being objective. As health care providers we deal with complex issues and people. Health care providers must show stability, adapt to changes, be flexible and accept others for as they are. Personally I have a hard time with ambiguity, I do not like uncertainty. I get frustrated with not knowing everything; however you cannot know everything, but you can continue to expand your knowledge daily. Then as a health care provider you use that knowledge to provide the best possible care. My favorite prayer is the Serenity Prayer: God, grant me the serenity to accept the things I cannot change, the courage to change the things I can and the wisdom to know the difference.

B) \*Patients can be extremely demanding and just plain mean sometimes. At Sprint we had a 53-year old Caucasian male come in with complaints of a sinus infection x 2 weeks. At Sprint they are usually well aware of “problem” patients and usually do not have students work with them. This individual however was not flagged and I went into evaluate. Upon introduction, the man was agitated and confrontational, telling me what he needed and I just needed to look at his chart. I was able to with a little finesse get him to give me all constitutional symptoms. Upon exam pertinent findings were inflamed nasal mucosa and a cobblestone posterior oropharynx, a chronic cough, (smoker for 20+ years), negative findings included clear lungs sounds, no history of fever, vital signs all within normal limits. I began to discuss the treatment plan and he continued to cut me off repeatedly, even cussing at times. Upon presentation of this patient to my preceptor, his chart was reviewed more thoroughly and it was found that they have had multiple problems with this patient regarding his aggressive behavior. My preceptor went in with me to evaluate the patient and discuss treatment plan again, when the patient exhibited similar behavior as when I was by myself. The preceptor asked me to leave the room. After which she asked the patient what was wrong, why he was continuing to act in this manner, he stated nothing was wrong, I was doing a great job, and she now made me feel like I was doing something wrong by making me leave the room. She diagnosed him with acute sinusitis and an upper respiratory infection, prescribed doxy to cover both sinus and lungs and prescribed Qvar, since he was out of it. Being asked to leave the room did not bother me, after the patient left we discussed the situation. I was fine, my feelings were not hurt. She apologized for having to deal with that, I reminded her when I go out into practice I will have to. I am unsure why the patient acted the way he did to me, it was evident in the chart he had an explosive temper that he often exhibited in the clinic, however dealing with individuals like this is a part of life and our profession. You must not take it personal.

\*I walked into ER room one after being warned that this is one of out problem

patients, to be yelled at “I need PAIN medicine NOW!!”. She is a 40-year old female who was brought in for altered mental status by her family after what is described as seizure like activity. Patient has been seen frequently in our ER for abdominal pain, flank pain, and other pain related complaints. It was reported that she would not talk with staff, referring all questions to her teenage daughter in the room. After introducing myself, I asked what she needed pain medicine for, she stated that she was having flank pain and this is what started this whole thing. I explained that when dealing with anyone with altered mental status, possible head injury from seizure activity we could not give narcotic pain medicines due to altering the mental status more not allowing us to know if it is the medication or something else. After a full work up of her altered mental status, addressing her pain, she was discharged home. She thanked me for the great care I gave. Again you can not take things personal, you must not lose your temper when being yelled at, but also not get walked all over. By being firm but not dismissing the patients concern we were able to have a happy medium.

 \*I had the opportunity to assist in a code, a 53-year old Caucasian male in cardiac arrest. I went with the doctor to notify the family of his death. His fiancé was hysterical. We were able to get family to come be with her. She was there when he went down, attempted CPR and had EMS there within minutes. She was going through the stages of grief from denial to guilt and back and forth. The Chaplin was called to be with her and the family. In our profession we have to deal with death, and we have to deal with individuals at their worst, this can take an emotional toll. As a health care provider you have to show stability to help these individuals and their families make it through these tough times.

1. To master this competency:
* Take care of myself: you must be in good health, physically, mentally and spiritually to deal with the struggles involved in the health care profession.
* Do not judge the individual, understand that everyone is unique and the shoes that they have walked in is not my own. Help to assist them in any way I can.
1. Bible

Psychology textbooks

Kubler-Ross stages of grief

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20. Employ effective communication methods with patients, □ □ □ □ ..□ □

 families, preceptor, and staff

1. To effectively communicate one must have the ability to be complete, accurate, concise, considerate, clear, courteous, and articulate. I devote efforts in employing effective communication methods with my patients, families, preceptor and health care staff. I constantly strive to provide effective communications with patients and families by talking open and honestly with them, up dating them regularly on the plan of care, making myself available for further questions or follow up. I involve patients in their care by providing them information to make knowledgeable decisions in regard to their wellness and health care. With my preceptors I am frequently asking questions, requesting feedback on my practice and knowledge. I communicate with my preceptors in person, also through phone, text, and email, so that we are able to stay up to date on schedules and discussions. I am respectful of the medical staff that I have had the opportunity to work with. I address them, I say please and thank you, and invite them into discussions regarding care of specific patients they are involved with.
2. At Sprint multiple individuals were seen due to ear pain or decreased hearing that was found to be from cerumen impaction. Individuals would always ask, if I am not to use q-tips how do I keep my ears clean and prevent this from happening again. The appropriate use of debrox, that you should never put anything in your ears, that this actually perpetuates the impaction. It is amazing that so many individuals are unaware of OTC debrox and that putting foreign bodies in their ears is always a bad thing. Through effective communication I am able to educate these individual on how to properly care for their ears.

 When dealing with children, you must be able to effectively communicate not only with them but their parents as well. Families and caretakers must be well aware of the care that is needed in a treatment plan. We had a 1-year old Hispanic female brought in for a second visit for bleeding gums. The child was teething. Upon exam and discussing the treatment plan with the mother, multiple methods of communications were utilized to help increase mothers level of understanding of condition and how to take care of it. We used the language line phone so that she could use her native language, although she spoke some English, Spanish was primary. Discharge instructions were discussed using language line and were printed in both English and Spanish. Demonstration on how to rub ora-gel on gums. Education on treating fever and pain. It is okay if she doesn’t eat as long as she is drinking and wetting diapers. Discussed follow up care with a family health care provider as well.

 Dr. Evers reiterates constantly the need for good communication with patients and families, the patient should be involved in their health care and ultimately make the decisions regarding their care. For example: a 34-year old Caucasian female presented to the ER for evaluation of migraine. Not typical migraine, OTC migraine medications not working, worst pain of life. Results of head CT were negative, pain resolving with IV medications. Discussion of a whether or not to perform a lumbar puncture to rule out a subarachnoid hemorrhage. Dr. Evers explained the entire procedure, the purpose of the procedure, and possible adverse outcomes of the procedure. The decision to do the procedure was then left to the patient. The patient decided not to have the LP, but verbalized understanding of follow up and possible needs to have one done. With this style of communicating with the patient, the patient feels in control and knowledgeable regarding the care they have received and possible options and outcomes of the care done or not done.

1. Master of this competency includes:
* Continuing to communicate effectively
* Reflect on situations that effective communication seemed to have lacked and come up with ways to change this.
1. Reviewing information from previous college classes including: Interpersonal communication and Public speaking. Discussion and review of motivational interviewing on line and with individuals who use motivational interviewing as well such as other health care providers, parole/probation officers, and social workers.

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21. Assess the agency for cultural competence □ □ □ □ .. □ □

1. Cultural competence is the ability to interact effectively with individuals of another culture or ethnicity.
2. Sprint’s population diverse including multiple individuals from India, China, Korea, the Middle East and Japan. Though these individuals all speak English, upon my own assessment many of these individuals have difficulty understanding the treatment plan. There is no language line or interpreter at Sprint. When written instructions are given, they are in English, most often hand written. I do not feel that the cultural competence is up to par at Sprint, interventions could be implemented to increase competence by having some sort of language line or interpreter for individuals who’s primary language is not English. Written discharge instructions in primary language. Cultural competence training for the individuals that work within Sprint to better understands the various ethnicities and cultures in their diverse population of patients.

An Emergency Room must be ready for anything and anyone to present with a medical emergency. Olathe Emergency Room has a diverse population, including large community of Spanish speaking, hearing impaired, Sudanese, and rural individuals. Within the ER there are resources to assist with non-English speaking or hearing impaired patients such as language line, on-call Spanish and Sign Language interpreters 24 hours a day. The ER has two physicians that speak Spanish fluently. The Cerner software allows for discharge instructions to be printed off in Spanish. I feel that the ER makes an effort to be culturally competent and to have the resources for their patients and staff to assist in this.

1. To master this competency:

I am not this can be done. I feel that there is always something to learn when it comes to other cultures and ethnicities. By recognizing what you do and don’t know, recognize resources to use or resources that are needed to help increase cultural competence is vital. By being open minded, recognition of your own short comings in the knowledge of other cultures and ethnicities will allow opportunities for growth.

1. Google Translator

Google

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22. Communicate practice knowledge effectively both □ □ □ □.. □ □

 orally and in writing

1. I am able to communicate my practice knowledge effectively with the current documentation tools at both clinical sites. I discuss and ask for constructive criticism on all my documentation. I am currently working on being concise, decreasing repetition, and increasing the speed at which I document. I verbally discuss every patient and their evaluation with my preceptors. I provide the top three to five differential diagnosis, history of present illness, review of systems, physical exam, and the plan of care. I am working on making my presentation more concise and efficient. With my patients I have felt that my communication skills have regressed slightly, as a nurse I have no problem discussing plan of care, answering questions, talking in terms that they understand. As a student and increasing my knowledge base, I often find myself sounding very textbook, broken, having a hard time explaining in simple terms. I am working on this by slowing down, making eye contact with my patients, sitting down when I am able, watching for visible cues that they do not understand or what I have said has surpassed the threshold of information consumption. My preceptor at Sprint told me information is great, but bullet points, and watch when their eyes glaze over they are no longer there. With continued practice and experiences my communication with my patients will continue to grow and perfect.
2. At Sprint, the electronic software is Primesuite and at OMC, the electronic software is Cerner: FirstNet. Both software’s offer premade templates to highlight, I have found that I prefer to free text the majority of my charting at this time to increase my knowledge base, versus click and go. Every one of my charts are reviewed by the preceptors at both the ER and Sprint. In the beginning I often had difficulties with repeating things and not being concise enough. By the end of the clinical rotation I felt and was told by my preceptors that my charting had improved, I was charting more efficiently and concisely. I also developed a clearer concise presentation to my preceptors. Dr. Evers stated that by the end of my rotation with her she would like me to be able to present as the physician assistants present to her, patient presenting with, positive/negative findings indicating this. By the end of the clinical rotation I was able to present in less than five minutes with pertinent findings and treatment plan.
3. Mastering this competency includes:
* Continue to develop my communication skills
* Reflect on situations that effective communication seemed to have lacked and come up with ways to change this.
1. Reviewing previous college classes such as Interpersonal communication, Public Speaking, and composition I and II.

Reviewing medical charts

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23. Integrate best available evidence to continuously □ □ □ □.. □ □

 Improve quality clinical practice

1. Quality means high grade, superior standards, and excellence. One should strive to improve the quality of clinical practice at all times. By using current evidence based guidelines, a provider is continuously improving quality clinical practice. Challenges to this competency are being able to stay current with the ever-changing health care environment, technologies, research, and practices.
2. At Sprint one of the things they offer the employee population is to come in for a rapid strep test without seeing a provider. This guideline was reconsidered while I was in clinical based on the over use and not needed tests being done. Strep tests now are preformed based on Centor guidelines to yield better use of equipment/tests and decreased waste on individuals that can be ruled out based on symptoms alone.

9-year old Caucasian male presented to the ER with dyspnea and diagnosed with bilateral lower lobe pneumonia. Based on current treatment he was treated for the most common bacterial pathogens, Strep. Pnuemonae, with IM rocephin and Zithromax. Treatment plan included close follow up with primary care physician next day.

At Sprint we see complaints of sinusitis regularly, many patients come in requesting a Z-pack. I have become quite proficient in explaining how Z-pack was previously overused and does not effectively treat sinusitis. Treatment guidelines include amoxicillin, Bactrim, cephalosporin, and Augmentin as first line antibiotics. Primary treatment is symptom management.

1. Mastering this competency includes:
* Staying up to date on current guidelines
* Be active in the policy and procedures of my employer
* Promote evidence based practice
1. Textbooks: Ferri’s Clinical advisor

Phone applications: Epocrates, Medscape, Pubmed, Uptodate

Weblinks: CDC, US Department of Health and Human Resources, PubMed, Medline, Up-to-date, and the National Clearing House.

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24. Analyze agency educational tools □ □ □ □ □.. □

1. Each agency has their own set of educational tools to be utilized to expand knowledge and also to help support evidence based medicine. Both have access to the internet. Sprint has an employee portal that has access to multiple medical, nursing and health related journals and PubMed. Olathe Medical Center has Lexicomp and the hospital library that has access to just about any journal, or can get you a copy of any medical, nursing, or health related journal. Both organizations encourage continuing education through online and face-to-face workshops/seminars.
2. For example: At Sprint on my desktop I have the ATP III guidelines risk calculator. One of my preceptors, Heather Myers allowed me to go through her educational folders that she has kept through the years with journal articles, quick references, and even hand made notecards. She allowed me to copy the ones I knew I would need in daily practice. At the ER I was able to use lexicomp to verify medication interactions or to identify medications that I was not familiar with. I also used textbook resources while at the ER such as the Washington Manuel of Medical Therapeutics.
3. Mastering this competency includes:
* Knowing available educational tools
* Utilizing available educational tools
1. References: Lexicomp

Wash Manuel

ATP guidelines calculator

World Wide Web

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25. Evaluate the outcomes of coaching patients □ □ □ □.. □ □

1. Coaching patients is educating and supporting them while they achieve healthy goals. Evaluating these outcomes is done by the health care provider to decide what further teaching, tests, or procedures need to be done to improve the health outcomes.
2. At Sprint we had a 49 year-old Caucasian male present requesting assistance with alcohol withdraw. He refused to do inpatient detox due to employment concerns. He reported a history of alcohol abuse. A treatment plan and verbal agreement were made: he was to stop by the clinic twice a day to have vitals checked and discuss symptoms of withdraw. He was to attend alcoholics anonymous daily. He was given a small supply of Xanax to help with the symptoms of withdraw. The first three days went well, patient stated he was doing well, Xanax is helping with anxiety and urges, he was doing daily meetings with AA along with constant contact with AA sponsor. Unfortunately after the weekend he did not return for further care or a new prescription. Attempts to contact him were unsuccessful. Due to the sensitivity of alcohol and other substance abuse, only a small amount of Xanax was prescribe to not to enable another addiction. When evaluating the outcomes initially, the treatment plan was going well. Unfortunately the final outcome was not able to be evaluated due to the unsuccessful attempts to follow up.

As I stated in a previous competency, at Sprint we see multiple patients that have complaints of allergic rhinitis and sinusitis. Every patient that I saw that stated “well this happens once or twice every year especially when the weather changes” I coached the patient ways to prevent severe symptoms of allergic rhinitis and ways to prevent acute sinusitis. At this time I am unable to evaluate the effectiveness of this coaching, however upon follow up next Spring at the change of weather this will be able to be better evaluated by the symptoms the patients report.

17-year old Caucasian female presented to the ER with dyspnea. Patient was tearful, inconsolable. I coached to patient to focus on her breathing, slowing it down, breathing 1-2-3 out and 1-2-3 in. Upon slowing the patients breathing she began to calm down and breathe easier. Patient had a history of anxiety but had never had a true stress reaction until today. She was educated on was to calm her self down with breathing techniques and removing stimuli.

1. Mastering this competency includes:
* Coaching effectively
* Evaluation of patient outcomes
1. Online courses for motivational interviewing such as: [www.motivationalinterviewing.com](http://www.motivationalinterviewing.com)

http://www.nova.edu/gsc/forms/mi\_rationale\_techniques.pdf

http://www.ncbi.nlm.nih.gov/books/NBK64964/

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26. Integrate appropriate technology for knowledge □ □ □ □ .. □ □

 management to improve health care

1. To use an old saying that applies technology is the future. The government is stressing the need for all health care facilities to covert to electronic medical records, paperless systems, and electronic safety checks such electronic medical administration records. It is important that providers stay current with technologies and have to ability to use these advancements to provide safer, efficient, quality care. With information now at the fingertips of just about everyone it is important to know what information is accurate and evidence based. The need to have go to applications that help the provider to be efficient and knowledgeable.
2. For example: At the ER, multiple safety checks are in place to make sure that an individual does not get a medication that they are allergic to or may interact with other medications prescribed or ones they are currently taking. For example: when prescribing Keflex with for the patient in competency #3, her parents reported an allergy to penicillin. When the parents were asked what the reaction was, they stated well her mother and her brother are both allergic, so we don’t want her to have it. When asked what the reaction mother and brother had to penicillin it was GI upset. The decision to give Keflex was kept due to no documented or reported allergy to penicillin other than fear and misconception of what an allergy is. When the order was placed into the computer, it flagged the allergy to make sure that it was addressed before this medication was given. It flagged again for the nurse when she scanned the medication. These are all safeguards that technology is able to provide.

Utilizing specific technology can make you efficient or actually provide way to much information to sift through when trying to find information in a timely manner to support your clinical decision making. My go-to clinical application on my phone is Epocrates. It contains up-to-date drug reference, interaction checks, pill ID, disease references, lab tests and various tables and formulas that are easy to navigate through.

In the ER it was recommended that I obtain the EMRA Antibiotic guide that can be downloaded as a phone application that provides the top three antibiotic therapies by organ systems. We have newer young physicians, some just out of residency, that highly recommend this easy for quick references.

1. Mastering this competency including:
* Staying up-to-date on current health care technology
* Researching various technological tools for effectiveness
* Knowing information that you are using is evidence based and factual
1. Reference: Epocrates

World wide web

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27. Integrate ethical principles in decision-making □ □ □ □ □ □

1. As a health care provider we are responsible for diagnosing and treating a variety of illnesses and diseases across the age span. With theses responsibilities come additional ethical and legal liability. Ethical decision-making is an expected standard within today’s health care environment. Ethics are moral principles that are accepted by the masses. The key factors regarding ethics include: autonomy, beneficence, non-maleficence, veracity, and paternalism. Autonomy is allowing the individuals the ability to be in control and make their own, decision. Beneficence is the duty of a person to promote good through their actions. Non-maleficence is to do no harm. Veracity is being honest and transparent. Paternalism allows one to make a decision for another.
2. Example:

\*A 27-year-old Caucasian male presents to the ER with palpitations, he has a history of SVT, hypo-potassium, HTN, chronic back pain, anxiety, and PTSD. Reports 3-4 hours of feeling SOB, feeling anxious, and tachycardia. Exam and evaluation of patient was negative. In this instance, further testing needed to be done by cardiologists, patient was asymptomatic and did not have an arrhythmia while being in the ER. All diagnostic tests were reviewed with the patients and discussed further evaluation and testing that should be done. The decision was then left up to the patient whether he would like to be admitted for further evaluation or follow up out patient with cardiologists. This is autonomy, allowing the patient to make an informed decision.

\*A 61-year old, over weight Caucasian male presents to the ER with chest pain. History of HTN, smoker and high cholesterol. Reported 4 hours of sub-sternal chest pain. Labs were negative, along with the rest of the exam. Options were discussed in detail, what they mean and purpose of these tests. The patient was encouraged to stay in the hospital to have serial cardiac enzymes ran and other cardiac tests to rule out cardiac involvement due to his risk factors. This is an example of autonomy with a small amount of paternalism.

1. Mastering this competency includes:
* Making ethic decisions
* Reflecting on ethical decisions, especially those that are difficult that cause moral dilemma.
* RESPECT and treating others how I myself would want myself, or my family to be treated.
1. ANA- Determing Scope of Practice for APRNs

Nurses Service Organization: Risk Advisor for APN’s

Ethical and Legal Guidelines for Nursing Practice by Wacker Guido & Watson

Purpose of a Code of Ethics and Code of Conduct for Nursing Students by Stone for the National Student Nurses’ Association

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28. Demonstrate respect, compassion and integrity □ □ □ □ □..

1. I believe that as a health care professional it is my job to demonstrate respect and compassion to everyone I come into contact with at the very least. Merriam-Webster dictionary defines compassion as the consciousness of others sufferings and the desire to alleviate it. Compassion is inherent to the art of nursing. Respect is defined by Merriam-Webster as holding in high or special regard. Nurses are one of the most trusted professions in the United State’s, nurses are believed to be honest and ethical. By being a member of such a respected profession, it is my duty to uphold charge by being empathetic, kind, compassionate, respectful…human, and treat others the way I would or better yet the way I would want my loved ones to be treated. I realize that at times my patients may try my abilities to demonstrate these qualities, when this occurs I bring myself back to the present moment, take in what I may be feeling and then begin to figure out the best plan of care for the individual.
2. Example:

\*A 57-year old Caucasian female presented to the ER with EMS and in police custody. It was reported that she was intoxicated, in a car, and being aggressive to police. Upon assessment patient was agitated and crying. She was appeared disheveled. Upon exam patient reported that she did not want to be here, she discussed her problems with her family and her life. After talking with her PCP, and discussing treatment plan with patient she was discharged to police custody without any further testing. She was A&Ox4; we showed her respect and compassion by listening to her, not judging her. We let her make decisions about her health care even though she was in police custody.

\*53-year old Caucasian male came in cardiac arrest. We coded the patient for 45 minutes. Compassion and respect was shown to the patient and his family. The staff as well as the doctor and myself showed the upmost integrity, being completely transparent with the family about what occurred in the code.

1. Mastering this competency includes:
* Continue to show compassion, and respect, continue to practice with integrity.
* Be honest and have accountability for my actions.
* Reflect on situations where it may be hard to show respect or compassion and be myself, true to myself not let others perpetuate their negativity onto me.
1. Understanding stages of grief and counseling http://www.omh.ny.gov/omhweb/grief/

Reviewing previous course work in psychology and sociology

My mother and father

Bible

What Would Jesus Do?

Golden Rule

Mentors such as Dana Hanson, APRN, Julie Westphal, RN, Megan Suri, APRN…

**State Board of Nursing Requirement**

|  |  |  |  |
| --- | --- | --- | --- |
| **KSBN Requirements for Nurse Practitioners** | **Met** | **Not Met****or N/A** | **Comments** |
| Demonstrates advanced practice role |  |  |  |
| Displays ability to decide to order and/or perform diagnostic procedures |  |  |  |
| Able to interpret diagnostic and assessment findings |  |  |  |
| Selects and provides prescription of medications and other treatment modalities for clients |  |  |  |

**Submission #1 after 80 hours of practicum**

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

**Submission #2 after 160 hours of practicum**

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

**Final Submission after 225 hours of practicum**

Student Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Faculty Comments/Final Grade:**

November, 2011

Revised August 2012