OSCE Pneumonia Patient Instructions

Ohio State University College of Nursing

Patient Instructions for the COUGH Case

CONFIDENTIAL

For this case, the student will know that you are a 51-year-old patient who is being seen for fatigue and cough. Vital signs today are 101.2 – 90 – 22 BP 148/90

History of this Illness

- You own a landscaping business and work outside – you love your job, but at this time of year things have been really busy. You are currently enrolled full-time in counseling coursework at the community college, are a single mom of three "boys" (ages 17, 18, and 21), and you run your own business. Your stress level is very high, and you don't have time to be sick!

Today is Wednesday - This illness started Monday morning. You have fever and chills, and spent yesterday (Tuesday) in bed shivering; you have body aches and fatigue. You are having a significant cough. Of all the symptoms that you are having, the cough is the worst.

If asked to describe your cough, you can explain that this is a deep, harsh cough. You are bringing up discolored mucous in small amounts when you cough. You have spasms of coughing where you just cannot stop; morning is worse. Trying to work outside in the cold rain also makes this worse. You feel like you cannot get a deep breath. You woke up through the night last night with the cough.

You knew that you were getting sick two days ago (Monday) when you tried to run across campus to a class, and you had a bad coughing episode – you felt short of breath, had chest pain in the center of your chest, and thought that maybe you need an inhaler. (One of your teens has asthma and uses an albuterol inhaler.) Once you finally got into the classroom, you did feel better – but you were still coughing during class and you felt like you were disrupting class every time you coughed. You were exhausted trying to pay attention in class.

The fever started yesterday, and you stayed home from work and school. You don't know what your actual temperature was, but you were definitely feverish. You took two extra strength Tylenol every three times yesterday (about every 6 hours), and that helped a little. You had chicken soup, used Vicks on your chest, and stayed in bed.

If asked what makes it better, you can share that nothing has – and that your symptoms are getting worse. You don't believe that you have asthma, but you have never been tested. You do get bronchitis about this time every year. You usually need an inhaler and an antibiotic. You have not been on an antibiotic since last year at this time.

If asked, you don't think that you have allergies. You don't have a runny nose, itchy eyes, or sneezing. You don't have nausea, vomiting, abdominal pain or diarrhea. You DO have some nasal congestion, a bit of a dry, scratchy throat, and maybe a dull headache. You wonder if you have a sinus infection, and you have had those before – but believe most likely that this is bronchitis. Your sinus symptoms started three days ago (at the same time of the bad cough).

You haven't traveled outside of the country (although a trip to a tropical beach sounds nice!) Previous to this illness, you would say that you do cough in the mornings (you attribute this to smoking).

You smoke about ½ ppd, and have been a smoker since about age 17. You recently tried to quit by using e-cigarettes, and that worked for a while. Smoking is your stress relief, and right now you don't see yourself quitting. You would like to quit eventually. (You can share that at least you are not smoking anything else!) Please share that you are an alcoholic and an addict who has been sober for almost 7 years. When asked, share that you are active in recovery and that you have a sponsor. You are willing to take anything to quit coughing, and have a plan if prescribed codeine.

Additional Health History, Family and Social History
You have never been diagnosed with a chronic illness, although you have had sinus infections and bronchitis before. You don't know if your immunizations are up to date. You have not received a flu shot - - you just don't know if those work.

You don't really see yourself as physically healthy - mostly because you would like to lose weight and because you smoke. You do get a lot of exercise in because your job demands it – and at your last physical exam, your blood pressure, cholesterol levels, and blood sugar were all normal. You are glad about that.

You are not taking any medications routinely, and are not allergic to any medicines.
You are not currently in a relationship, and are not currently sexually active.
You are trying to be a responsible parent for three young adult boys who are giving you all kinds of stress…

When asked about your family's health, please share that your dad is healthy; you mom has early dementia or some "brain issues" that is related to a brain trauma from a car accident about a decade ago. Your mom also has high blood pressure. Your grandparents are all deceased, and you are not sure but were always told that they died from "old age."

You currently live in a safe neighborhood, you do not have guns or drugs in your home.
You are hoping to get something for this cough so that you can return to school and work as soon as possible!

DEPRESSION SCREENING
- No sadness
- No insomnia
+ guilt
+ energy loss
+ some change in appetite
+ some trouble concentrating
Is able to experience enjoyment when healthy
+ fatigue
- No suicidal thoughts now or ever

OSCE Pneumonia Patient Chart

Student Clinic
The Ohio State University
1-614-000-0000

Date *November 5, 2014*

Patient Name *Maury Miller*

Birth date *October 2, 1963 (51 years old)*

Reason for visit: *Pt is here today to be seen for her cough and fatigue.*

Vital Signs *Temp 101.2, Pulse 90min., Respirations 22min BP 148/90*
Height 5'5" Weight 225#

Medications:
Ibuprofen and acetaminophen prn
Albuterol inhaler prn
No routine medications

Vaccine history:
Patient states that she has not had vaccines for the last 20 years - has never had a flu shot

Health history
Maury is a current patient of our primary care practice.
Smoker
Menopause at age 50, not currently sexually active
History of addiction, alcoholism prior to 2007

LINK TO Recording of Patient History:
http://panopto.con.ohio-state.edu/Panopto/Pages/Viewer/Default.aspx?id=d89a1b0a-8fe8-4048-b050-a7dfdbcc2935

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LABS, DIAGNOSTIC TESTS, IMAGING STUDEIS
Listed below are all of the tests available today in office
Not all of the tests listed below are required for this patient

O2 Sat	*90%*
CXR	*See the next page of this document*
Blood Glucose (non-fasting)	*120*
Hemoglobin	*12.2*
Urine pregnancy test	*Negative*
Pulmonary Function Tests	*FEV1/FVC >90%*
Peak Flow	*80% of expected*

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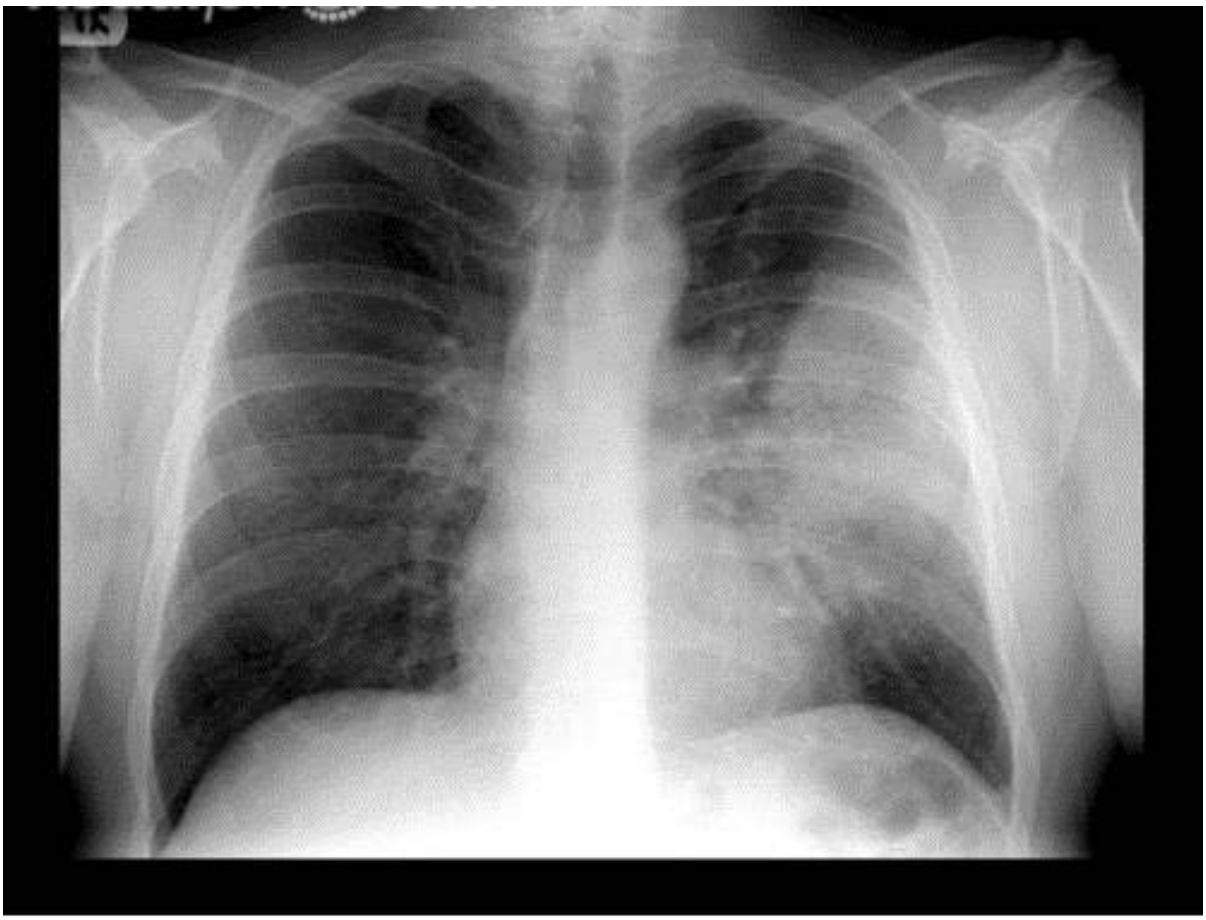
Chest X-ray



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ABNORMALITIES NOTED WITH PHYSICAL EXAM
Only those assessments that were abnormal are listed

HEENT
Left TM is retracted
Pharynx with mild erythema, no exudate; tonsils absent
Nasal turbinates swollen, erythematous

Anterior cervical lymph nodes palpable, mobile, tender

RESPIRATORY
Breath sounds abnormal at bases
(Audio at the end of the recording)

Breath sounds abnormal over left upper lobe
(Audio at end of the recording)

In the area of the left upper lobe:
Dullness to percussion
Increased tactile fremitus
+egophony, + bronchophony, + pectoriloquy

OSCE Pneumonia Checklists across Curriculum

Ohio State University College of Nursing

Objective Structured Clinical Exam (OSCE) Checklists

Case Title _____Example: COUGH/PNEUMONIA _____
Student Name _____
SP Name & Bio data: *Ms. Miller, 51-year-old smoker with cough; Vital signs are 101.2 – 90 – 22 BP 148/90*

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
INTRODUCTION				
	Worth 3%	Worth 2%	Prior to PE	Worth 10%
Knock, introduce self, explain role, wash hands	1.5 points	1 point		Professional introduction
Confirm reason for seeking care *"Very bad" cough and fatigue*	1.5 points	1 point		
HISTORY OF PRESENT ILLNESS or REASON FOR SEEKING CARE				
	Worth 15%	Worth 10%		
Onset *Three days ago illness started with cough and fatigue; fever started yesterday*	1.5 points	1 point		
Location; region and radiation *Chest pain occurs with coughing spasms, located in the center of chest*	1.5 points	1 point		
Duration *Cough is persistent throughout the day, & wakes the patient at night*	1.5 points	1 point		
Characteristics *Cough is deep, harsh, and productive of discolored mucous in small amounts*	1.5 points	1 point		
Aggravating factors *Trying to work outside doing landscaping, running across campus to class*	1.5 points	1 point		
Relieving factors *Tried using Vicks VapoRub; chicken soup, and resting, which only helped a little*	1.5 points	1 point		
Treatment tried *Tried 2 Extra Strength Tylenol every 6 hours yesterday for fever*	1.5 points	1 point		
Timing *Cough, fatigue continues to get worse, does get bronchitis every spring*	1.5 points	1 point		

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
Severity and scale; impact of illness *Stayed home from work and school yesterday to rest; rates cough "8" on 1-10 scale*	1.5 points	1 point		
Precipitating factors; exposures *No known exposures; is a smoker and typically has a morning cough*	1.5 points	1 point		
REVIEW OF SYSTEMS				
	Worth 8%	Worth 5%		
Associated systems clarified *Primary symptoms cough, fatigue, fever; also has tender lymph nodes, congestion,& is feeling stressed about missing school, work*	3 points	1.5 points		
Pertinent negatives noted *Denies body aches, N/V, allergy symptoms, audible wheezing, abdominal pain*	2 points	2 points		
Pertinent systems reviewed *Tried 2 Extra Strength Tylenol every 6 hours yesterday for fever*	3 points	1.5 points		
HEALTH HISTORY				
	Worth 10%	Worth 9%		
Medications: Prescribed, OTC, Herbs *Tried 2 Extra Strength Tylenol every 6 hours yesterday for fever; no Rx medications*	2 points	2 points		
Allergies (and reaction if allergic) *PCN allergy; causes rash*	2 points	2 points		
Hospitalizations/ Surgeries / ER visits *Cholecystectomy 5 years ago; G3P3 – three sons age 21, 18, and 17-years old*	2 points	1 points		
Chronic illnesses, co-morbidities *Never diagnosed with chronic illness, although told at last visit that BP was a "little high" also very aware "that I weigh too much"*	2 points	2 points		
Health maintenance *Stays active doing landscaping; needs annual women's health exam and follow up for BP*	2 points	2 points		
FAMILY, SOCIAL and CULTURAL ASSESSMENT				
	Worth 9%	Worth 12%		
Family history of disease or illness *Dad healthy; mom has brain issues related to MVA & has HTN; youngest son has asthma*	1.5 points	2 points		

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
Family relationships, including marital status, sexual history, living arrangements *Divorced; not currently sexually active; lives with 3 sons who "are giving me problems"*	1.5 points	2 points		
Social relationships with friends; involvement with work, school, or other activities *Attends community college, major- counseling; owns a landscaping business*	1.5 points	2 points		
Use or abuse of alcohol, tobacco, other drugs *Smokes ½ ppd, since age 17; tried to quit by using e-cigarettes Not interested in quitting now; No alcohol use for more than 7 years* *Shares that she is an alcoholic and addict who is active in recovery and has a sponsor*	1.5 points	2 points		
Cultural perception of health and illness (patient's perception) *Believes that she might have a really bad bronchitis, and 'doesn't have time to be sick like this" Is hoping for an antibiotic at today's visit*	1.5 points	2 points		
Safety and violence screening *Lives in a safe neighborhood; does have a history of being a victim of domestic violence (ex-husband) – does worry that her sons are becoming verbally abusive towards her*	1.5 points	2 points		
PHYSICAL EXAM				
	Worth 40%	Worth 15%	Worth 25%	

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
PHYSICAL EXAM Washed hands (0.5 points – see above) General survey of skin and nails (1 point) <u>ENT:</u> Speculum exam of ear (2 points) Speculum inspection of nares (1 point) Percussion of sinuses (1.5 points) Inspection of oral mucosa, posterior pharynx (1 point) *Left TM is retracted* *Pharynx is erythematous with exudate* <u>Neck:</u> Palpate lymph nodes, cervical, submandibular, submental (2 points) *Anterior cervical lymph nodes palpable, mobile, tender* *CONTINUED ONTO NEXT PAGE*	*The points noted can be used for the assessment course, & add:* Exam done in an organized manner (5 points) Exam done in a timely manner (5 points) No extraneous or inappropriate PE elements included (5 points)		*The points and abnormalities noted are for the advanced clinical course*	

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
PHYSICAL EXAM (continued) <u>Chest/Heart/Lungs:</u> Inspection of bare chest, anterior (1.0 point) Inspection of bare chest, posterior (1.0 point) Inspection of bare chest, AP:lateral (0.5 point) Heart auscultation: 5 areas (2 points) Lung auscultation anterior fields (2 points) posterior lung fields (2 points) *Breath sounds abnormal at bases AND over left upper lobe (Audio at end of the recording)* Symmetric expansion (1.0 point) Tactile fremitus (1.0 point) Percussion of lung fields (1.0 point) Egophony or pectoriloquy (1.0 point) Diaphragmatic excursion (0.5 point) *In area of the left upper lobe: Dullness to percussion, Increased tactile fremitus +egophony, + bronchophony, +pectoriloquy* Assessment for chest tenderness with palpation and/or with deep inspiration (1 point) <u>Abdomen:</u> Inspection of bare abdomen (1 point) Palpation for tenderness (1point)			*The points and abnormalities noted are for the advanced clinical course*	
DIAGNOSIS				
	Worth 3%	Worth 5%	Worth 10%	Assigned
Diagnosis List Pertinent to the case Minimum of three Community Acquired Pneumonia Cough, Chest pain, Fatigue, Fever Tobacco Use Disorder History of Bronchitis Stress Obesity History of Substance dependence or disorder	Should give one diagnosis to the patient		3 points loss if did not diagnose with pneumonia 3 points loss if the only diagnosis is pneumonia	PNEUMONIA COPD Tobacco Use Disorder Student defines the diagnoses and associated symptoms (See below)

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
MANAGEMENT PLAN				
	Not required	Worth 18%	Worth 25%	Worth 40%
Treatment decisions accurate and thorough – including in-office management, lab tests or imaging, medications, and follow-up 1. REST and HYDRATION (3 points) 2. SMOKING CESSATION (5 points) 3. MEDICATIONS Azithromycin, Clarithromycin, Doxycycline OR levofloxacin (3 points) Cough Suppressant (2 points) Antipyretic use - fever management (1 point) Consider nebulizer for home, saline sinus rinse, or nasal spray (1 point) 4. IN OFFICE MANAGEMENT Nebulizer (1 points) Pulse oximeter (1 points) Chest X-ray (3 points) Pulmonary function tests (may be ordered with follow up) (1 point) Blood work (Optional): CBC, blood glucose Medications accurately prescribed (4 points for prescription writing accuracy)	Students can ask for lab tests if needed to clarify differential		*The points noted are for the advanced clinical course*	Explain rationale for treatment plan Outline plan for management, include typical schedule of visits Explain at least two medications that are used at the initiation of treatment Explain at least one medication that is often needed as a next step
PATIENT / FAMILY EDUCATION				
		Worth 18%	Worth 25%	Worth 20%
Explained findings		3 points	3 points	10 points
Explained diagnoses		3 points	3 points	10 points
Explained the treatment plan, including Rx Includes risks, SE, benefits, use of medications		3 points	9 points	*Included above*
Addressed health and wellness Stress management; Smoking cessation Other (may include rest, nutrition, flu shot) Can discuss as part of return visit		3 points	4 points	*Included above*

GUIDLINE	Advanced Assessment	Novice NP Clinical Course	Advanced NP Clinical Course	Patient-Focused Education
Explained follow up – what to expect, symptoms to report, when to return RTO in 48-72 hours to monitor response Cough, sputum production, dyspnea should improve over the next 48-72 hours, but take 7-14 days to resolve. Follow up CXR in 3 months (recommended for pts > 40 or smokers) Call or to ER for: worsening dyspnea or pain, new chest pain, high fever.		3 points	4 points	*Included below*
Verified understanding, addressed questions and/or concerns	*Included below*	3 points	2 points	*Included below*
THERAPEUTIC COMMUNICATION				
	Worth 12%	Worth 6%	Worth 15%	Worth 30%
Verbal communication was professional, without jargon; non-judgmental and culturally appropriate in approach Clear explanation of expectations for the visit; kept control of the interview and communicated competence	4 points	2 points	4 points	10 points Acknowledge the difficulties associated with diagnosis of chronic illness (through verbal and nonverbal communication)
Nonverbal communication was pleasant, professional; eye contact and gestures communicated active listening	3 points	2 points	4 points	
Patient-centered care included being responsive to patient, authentic expressions of empathy, and establishment of rapport (Advanced students are expected to develop a partnership with the patient for decision-making)	3 points	1 points	4 points	10 points Establish partnership, coaching, and patient-centered care
Clear closure to the visit	2 points	1 point	3 points	10 points Encourage questions and office follow up

OSCE Pneumonia Self-Reflection Survey

Ohio State University College of Nursing

Self-Reflection Survey
OSCE: Pneumonia

1. What parts of physical exam did you complete today? Choose what you did.
I washed my hands
Skin inspection
Nail inspection
Any assessment related to the headache
Speculum exam of ears
Speculum inspection of both nares
Percussion or palpation of sinuses
Inspection of oral mucosa
Inspection of posterior pharynx
Palpation of lymph nodes: cervical
Palpation of lymph nodes: submandibular
Palpation of lymph nodes: submental
Inspection of bare chest, anterior
Inspection of bare chest, posterior
Inspection of bare chest, compared AP vs Lateral
Auscultation of heart at all 5 spots
Auscultation of heart in less than the 5 correct spots
Assessed for symmetric expansion
Measured diaphragmatic excursion
Assessed for chest tenderness with palpation at the site of pain
Assessed for chest tenderness with deep inspiration
Palpated for tactile fremitus
Percussed anterior lung fields
Percussed posterior lung fields
Assessed for egophony or whispered pectoriloquy
Auscultation of lungs, anterior fields, 3-5 spots on left and right
Auscultation of lungs, anterior fields, less than 3-5 spots on left and right
Auscultation of lungs, posterior fields, 3-8 spots on left and right
Auscultation of lungs, posterior fields, less than 3-8 spots on left and right
Inspection of bare abdomen
Palpation of abdomen light
Palpation of abdomen deep

2. What was the primary diagnosis for the patient's chief complaint?
Anxiety
Asthma exacerbation
Bronchitis
Community acquired pneumonia
COPD
Depression
GERD
Headache

Obesity
Otitis
Pertussis
Pleural effusion
Pleurisy
Pulmonary embolism
Sinusitis
Tobacco use disorder
Viral illness
Other

3. The signs and symptoms that you considered IMPORTANT when forming the primary diagnosis included:
Abnormal breath sounds
Anxiety about school, sleep, finances, work
Audible rattling
Body aches
Chills
Cough- productive
Cough- spasms
Dullness to percussion
Dyspnea
Fatigue
Fever
Headache
History of addiction
History of asthma
History of smoking
Increased tactile fremitus
Left TM retracted
Malaise
O2 sat = 90%
Poor fluid intake
Sinus congestion
Sore throat
Subjective chest pain
Temperature = 101.2

4. List any other diagnoses you identified at this visit.
Anxiety
Asthma exacerbation
Bronchitis
Community acquired pneumonia
COPD
Depression
Diabetes
Environmental allergies
Fatigue
Febrile illness
GERD
Headache

Immunization needs
Obesity
Otitis
Pertussis
Pleural effusion
Pleurisy
Pre-diabetes
Pulmonary embolism
Sinusitis
Tobacco use disorder
Upper respiratory infection
Viral illness
Other

5. What did you include in the treatment plan for the patient during this visit?
Send to ER for immediate evaluation
Activity restriction
Addressed addiction issues
Advised hydration
Advised rest
Advised smoking cessation
Discussed antipyretic use
Discussed GAD-7 and PHQ-9 results
Flu vaccine
Pneumonia vaccine
Nebulizer treatment- at home
Nebulizer treatment- in office
Prescribed a cough suppressant
Prescribed a narcotic pain medicine
Prescribed a penicillin or a sulfa
Prescribed one of the following antibiotics: azithromycin, clarithromycin, doxycycline, levofloxacin
Prescribed one of the following inhalers: SABA, LABA, ICS
Prescribed or recommended nasal spray
Prescribed oral steroid
Provided psychosocial support
Referral to pulmonologist

6. What diagnostic tests did you order?
Accucheck
Blood gas
CBC
Chemistry
Chest CT
CXR
D-dimer
Hemoglobin A1C
Peak flow
Pulmonary function test
Pulse oximetry
Urine pregnancy test

Urine toxicology screen
VQ scan

7. What teaching did you discuss with the patient about the condition and treatment?
Explained physical exam findings
Explained rationale for imaging, tests or labs ordered
Explained findings of imaging, tests or labs ordered
Explained diagnosis- what it is
Explained diagnosis- disease course
Explained diagnosis- rationale for EVERY part of the management plan
Explained diagnosis- rationale for SOME parts of the management plan
Explained antibiotic- risk
Explained antibiotic- side effects
Explained antibiotic- benefits
Explained antibiotic- use
Explained cough suppressant- risk
Explained cough suppressant - side effects
Explained cough suppressant - benefits
Explained cough suppressant - use
Explained antipyretic- risk
Explained antipyretic - side effects
Explained antipyretic - benefits
Explained antipyretic - use
Explained nebulizer/inhalers- risk
Explained nebulizer/inhalers- side effects
Explained nebulizer/inhalers- benefits
Explained nebulizer/inhalers- use
Explained oral steroids- risk
Explained oral steroids- side effects
Explained oral steroids- benefits
Explained oral steroids- use
Other
None

8. List the health and wellness needs addressed with this patient (choose what you did).
Stress management
Smoking cessation options
Immunization
Hydration
Sobriety plan
Weight management
Other
Did not address wellness needs

9. How did you address follow up plan?
Return in 48 to 72 hours
Return in one week
Return in two weeks
Return in one month
Return after more than one month
Return as needed

Advised about symptom resolution (what to expect)
Advised about symptom exacerbation (treatment failure)
Advised when to go to ER
Did not address follow-up plan

10. How did you carry out therapeutic communication?
I established rapport and partnership for decision-making
I could do better in building rapport and partnership
I communicated professionally without jargon
I did use some jargons
I was pleasant in my demeanor and nonverbal communication
I could have used more smiles and been more friendly to the patient
I provided clear closure by saying goodbye, or I clearly ended the visit in a professional way
I did not provide clear closure to end the visit

11. List 3 omissions/errors from your OSCE today and how you would correct them.