**Diagnostic and Clinical Reasoning Paper Assignment**

The purpose of this assignment is to provide you the opportunity to expand the scope of your clinical documentation and your thought processes relative to complex patient care cases.

1. Select a patient encounter from dysmenorrhea,PCOS,OVarian Cysts,abnormal Pap,infertility,amenorrhea)
2. The patient encounter you select should be one of the more complex patient cases that you have experienced with your current clinical patient population. Given that you are to select complex cases, this assignment may not be completed for a ‘general health, well child, well woman, routine OB, routine physical exam (etc.)’ type of encounter.

You will need to identify which patient encounter you are expanding your documentation for by including the Typhon Case ID # under your name on the title page of your paper.

1. For this assignment you will utilize the same SOAP format that you do for your ‘expanded’ Typhon encounters. Construct this assignment ensuring that you adhere to the writing guidelines provided in the 6th edition APA manual.

Below is the overview of the required elements for this assignment:

**\*Title Page** (Page 1)**:** Follow APA guidelines for running head on page 1, and include Medical Diagnosis, Student Name, Typhon Case ID #, and Date.

**\*Subjective** (Start of Page 2)**:** Follow APA guidelines for running head on page 2 and subsequent pages.

**CC:** chief complaint - What are they being seen for? This is the reason that the patient sought care, stated in their own words, or paraphrased.

**HPI:** history of present illness - use the “OLDCART” approach for collecting data and documenting findings. [O=onset, L=location, D=duration, C=characteristics, A=associated/aggravating factors, R=relieving Factors, T=treatment, S=summary]

**PMH:** past medical history - This should include past illness/diagnosis, conditions, traumas, hospitalizations, and surgical history. Include dates if possible.

**Allergies:** State the offending medication/food and the reactions.

**Medications:** Names, dosages, and routes of administration.

**Social history:** Related to the problem, educational level/literacy, smoking, alcohol, drugs, HIV risk, sexually active, caffeine, work and other stressors. Cultural and spiritual beliefs that impact health and illness. Financial resources.

Click on the link below to explore the CDC’s information on the ‘social determinants of health’.

<https://www.cdc.gov/socialdeterminants/>

**Family history:** Use terms like maternal, paternal and the diseases and the ages they were deceased or diagnosed if known.

**Health Maintenance/Promotion:** Immunizations, exercise, diet, etc. Remember to use the United States Clinical Preventative Services Task Force (USPSTF) guidelines for age appropriate indicators. This should reflect what the patient is presently doing regarding the guidelines.

Click on the link below to access information about current guidelines.

<https://www.uspreventiveservicestaskforce.org/>

**Review of Systems (ROS):** this is to make sure you have not missed any important symptoms, particularly in areas that you have not already thoroughly explored while discussing the history of present illness. You would also want to include any pertinent negatives or positives that would help with your differential diagnosis. For acute episodic (focused) visits (i.e. sprained ankle, sore throat, etc.) you may be omitting certain areas such as GYN, Rectal, GI/Abd, etc. While the list below is provided for your convenience it is not to be considered all-encompassing and you are expected to include other systems/categories applicable to your patient’s chief complaint.

General: May include if patient has had a fever, chills, fatigue, malaise, etc.

Skin:

HEENT: head, eyes, ears, nose and throat

Neck:

CV: cardiovascular

Lungs:

GI: gastrointestinal

GU: genito-urinary

PV: peripheral vascular

MSK: musculoskeletal

Neuro: neurological

Endo: endocrine

Psych:

**\*Objective:**

**Physical Examination (PE):** either limited for a focused exam or more extensive for a complete history and physical assessment. This area should confirm your findings related to the diagnosis. For acute episodic (focused) visits (i.e.GYN, Rectal, Abd, etc.) you may omit other assessments. All SOAP notes however should have physical examination of CV and lungs. While the list below is provided for your convenience it is not to be considered all-encompassing and you are expected to include other systems/assessments applicable to your patient’s chief complaint. Ensure that you include appropriate female specific physical assessments when applicable to the encounter. Your physical exam information should be organized using the same body system format as the ROS section. Appropriate medical terminology describing the objective examination is mandatory.

VS: vital signs, height and weight, BMI

Gen: general statement of appearance, if there is any acute distress.

Skin:

HEENT: head, eyes, ears, nose and throat

Neck:

CV: cardiovascular

Lungs:

Abd: abdomen

GU: genito-urinary

PV: peripheral vascular

MSK: musculoskeletal

Neuro: neurological exam

Psych:

**Diagnostic Tests:** This area is for tests that were completed during the patient’s appointment that ruled the differential diagnosis in or out (e.g. – Rapid Strep Test, CXR, etc.).

**\*Assessment:** (number each diagnosis)

**Diagnosis/Diagnoses:** Start with the presenting chief complaint diagnosis first. Number each diagnosis. A statement of current condition of all other chronic illnesses that were addressed during the visit must be included (i.e. HTN-well managed on medication). Remember the S and O must support this diagnosis. Pertinent positives and negatives must be found in the write-up.

**\*Plan:** (number each plan specific to each diagnosis)

These are the interventions that relate to the above diagnosis and address the following aspects (they should be separated out as listed below):

**Diagnostics:** labs, diagnostics testing - tests that you planned for/ordered during the encounter that you plan to review/evaluate relative to your work up for the patient’s chief complaint.

**Therapeutic:** changes in meds, skin care, counseling

**Educational:** information clients need in order to address their health problems. Include follow-up care. Anticipatory guidance and counseling.

**Consultation/Collaboration:** referrals, or consult while in clinic with another provider. If no referral made was there a possible referral you could make and why? Advance care planning.

**\*Clinical Decision Making**

The next section summarizes your critical thinking, decision-making and diagnostic reasoning skills that provides you the platform to expand on your identified Typhon patient encounter. It is a reflection of the thought process you used in caring for the patient. Follow the directions under each section and label each area as appropriate. All information should be in your own words.

**Pathophysiology**:

Include information in regard to the pathophysiology related to the main diagnosis or illness process. This will help to understand how the S and O supported the diagnosis you assigned.

Do not copy and paste from credible sources. Paraphrase source information as you construct your discussion of the pathophysiology and ensure that you provide in-text and reference citations for the source.

**Pharmacology:** OR (\*\*\*Alternate - Therapy information):

Choose one drug that was prescribed at this visit or that is taken chronically by the patient to review. Please include the name of the drug (generic and brand), class, action, excretion, side effects and interactions, why this particular drug is being prescribed for this particular patient, what is this drug intended to treat, (specifically antibiotics, what organisms are we treating?). What other drug could be chosen instead that would work, if any? Keep in mind the cost and convenience for the patient.

\*\*\*NOTE: Since the patient encounter you select for this assignment is supposed to be one of the most complex encounters you have with this course population, the likelihood exists that you will have a pharmacologic agent to discuss for this assignment requirement. However, if there are no pharmacologic agents to utilize then choose a non-pharmacologic element of the therapeutic plan (e.g. this could be hyperbaric therapy, water therapy, relaxation training, biofeedback, PT, OT, Counseling [e. g. nutritional, emotional, behavior modification, etc.]or a Complementary Alternative Medical regimen [e.g. nutritional therapy, a spiritual intervention, Emotional Freedom Therapy (EFT), journaling, visual imagery, progressive relaxation, Cranial Electrical Stimulation (CES), etc.]

Do not copy and paste from credible sources. Paraphrase source information as you construct your discussion and ensure that you provide in-text and reference citations for the source.

**Clinical Diagnostic Reasoning**:

Include in this section:

1. **Differential diagnoses**

Include a list of all of the diagnoses you considered for your list of ‘differential diagnoses. This list may extend beyond the diagnoses identified in the ‘A’ section of the paper.

1. **Priority diagnosis discussion**

Discuss the key assessment [history and physical exam] findings that resulted in the identification of the priority diagnosis/diagnoses indicated in the ‘A’ section of the paper

1. **Rationale for key elements of the plan of care**

As an advanced practice student you need to explore the evidence relative to the patient’s care needs and be able to document the rationale for the elements of the plan.

Briefly provide rationales for the key elements of the plan of care [e.g. if a particular HTN medication is prescribed then reference the current JNC guidelines, if a particular antimicrobial is prescribed provide the source referenced for the decision, etc.]

Provide a rationale for any care aspect included in the plan that is not consistent with the care approaches found in your course materials, EBP, CPGs or encompassed in the ‘community standard of care’.

When using credible sources to support your discussion do not copy and paste from the sources. Paraphrase source information as you construct your discussion and ensure that you provide in-text and reference citations for the source.

**Ethical and or Cultural Concerns:**

Identify any ethical or cultural issues related to this patient’s care. Include how these concerns were addressed.

Discuss the following:

1. **Review the provisions of the ANA Code of Ethics**

Choose at least one of the provisions of the Code and discuss how your experience with the patient encounter aligns with the tenants of the provision OR how you advocated for the patient during the encounter to ensure your actions aligned with the tenants of the provision.

Link to gain access to the ANA Code of Ethics – you will need to scroll down to ‘Select One’ [option] to progress to the page where you will have full access to the Code:

<https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses/>

1. **Discuss actual or potential cultural implications for this encounter – from the patient’s cultural perspective or your cultural perspective**

Links to articles that explore the issue of cultural concerns in health care:

<https://www.redorbit.com/news/health/1372127/transcultural_nursing_its_importance_in_nursing_practice/>

<https://journals.lww.com/academicmedicine/Fulltext/2003/06000/A_Strategy_to_Reduce_Cross_cultural.6.aspx>

<https://pdfs.semanticscholar.org/3e50/d2758210e1bd345ccf16fcf8dfcd2b1b5ec9.pdf>

**Barriers to Care:**

Construct a discussion that summarizes the barriers/potential barriers your patient faces relative to their ability to seek or receive healthcare services and exploration of at least 3 of the applicable ‘social determinants of health’ for your patient.

Discuss the Following:

1. **The actual and potential barriers you identified for your patient**

Your discussion needs to include observations about access to care, financial barriers, and non-financial barriers beyond access. Be sure to provide in-text citations as appropriate for APA style guidelines in your discussion to support the literature that you reviewed in identifying the actual/potential barriers.

Links to article exploring barriers

<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3393009/>

<https://academic.oup.com/fampra/article/23/3/325/475515>

<https://www.careatc.com/ehs/3-common-barriers-to-quality-medical-care>

1. **Three priority social determinants of health for your patient**

Your discussion needs to include exploration of the three social determinants of health that you identified as having the most significant impact on your patient’s health care and health status. Be sure to provide in-text citations as appropriate for APA style guidelines in your discussion to support the literature that you reviewed in identifying the social determinants of health.

Link to CDC’s information on Social Determinants of Health

<https://www.cdc.gov/socialdeterminants/>

1. **Health care policy or advocacy initiatives relevant to your patient’s care**

Include in your discussion at least one health care policy or initiative that you identified in the literature as having the potential to positively impact the identified actual/potential barriers or priority social determinants of health for your patient.

Resources for your ‘search’ include the Herzing Library, Google Scholar, PubMed, and/or the Virginia Henderson Repository <https://www.nursingrepository.org/>

**\*Evidence based practice:**

Evidence-Based Practice (EBP) is a thoughtful integration of the best available evidence, coupled with clinical expertise. As such it enables health practitioners to address healthcare questions with an evaluative and qualitative approach. EBP allows the practitioner to assess current and past research, clinical guidelines, and other information resources in order to identify relevant literature while differentiating between high-quality and low-quality findings. Evidence-Based Practice includes the application of evidence and the evaluation of the outcomes to guide future practice.

This section is a 1-2 paragraph summary of **all** the scholarly evidence utilized to complete this assignment. New resources, topics or ideas should not be introduced.

Discuss the following:

1. **Formulate a well-built question.**

What clinical questions and terms did you use to direct your search in the library database?

1. **Identify articles and other evidence-based resources that answer the question**. Identify all sources (APA citations) used that informed your decision making in this particular case.
2. **Critically appraise the evidence [research study, evidence based or clinical practice guidelines, published care standards, etc.] to assess its validity**. Comment on the quality of the research or evidence based practice guidelines used. What is the level of evidence? How credible is it? Is it a just a recommendation or an expected standard of care?
3. **Apply the evidence and evaluate for areas of improvement.**  How valuable was the evidence in understanding and directing the care in this case? How did it influence your decision making? Were you able to assess the outcome? If so, are changes needed?

\***Self-Reflection:**

**Reflection on decision making:** This is an area where you look over the data gathered and after a careful review of the available resources (i.e. text books, reference readings) will provide a reflection of what might have been added or deleted that would have made this note more conclusive or complete. This is not an area to critique the preceptor. Discuss areas could you have changed? What areas might you have added, perhaps additional questions you should have asked in the ROS, or additional areas you may have assessed for in the PE?

**Advanced Practice Practitioner Role Analysis:** Identify the specific person that drove this plan of care and developed the management, while including detail in how you advocated for the patient. It is entirely possible, and desirable, that you drove the development of the plan of care. Include how an individualized approach was applied to this patient’s care. Also include how you identified your advocacy for the role of the Nurse Practitioner.

**\*Reference Page:** Follow APA guidelines for constructing all reference page citations and ensure you used APA style for all in-text citations.