Module Report

Simulation: HealthAssess 3.0

Module: Health history

Individual Name: **Tyranny Davis**

Institution: **Lakeview CON**

Program Type: **BSN**

Overview Of Most Recent Use

	Date	Time Use	Score
Lesson	10/17/2024	13 min 26 sec	N/A
Virtual Application: Amira Hill	10/17/2024	13 min	57.0%
EHR Chart	N/A	N/A	N/A
Test	10/17/2024	7 min	100.0%

Lesson Information:

Lesson - History:

Total Time Use: 48 min

	Date/Time (ET)	Time Use
Lesson	10/17/2024 7:33:16 PM	13 min 26 sec
Lesson	8/24/2023 7:23:42 PM	34 min 37 sec

Health history Information:

Virtual Application: Amira Hill - Score Details of Most Recent Use

	Individual Score	Individual Score (1 10 20 30 40 50 60 70 80 90 99)
COMPOSITE SCORES	57.0%	▲
Virtual Application: Amira Hill	57.0%	▲

Virtual Application: Amira Hill - History

Total Time Use: 13 min

	Date/Time (ET)	Score	Time Use	EHR Status
Virtual Application: Amira Hill	10/17/2024 7:33:03 PM	57.0%	13 min	Not Reviewed

Time Use And Score

	Date	Time
Virtual Application: Amira Hill	10/17/2024	13 min

Simulation		
Scenario	In this virtual simulation, you cared for Amira Hill. The goal was to complete a health history. Review your results below to determine how your performance aligned with the goals of this simulation.	
Overall Performance	You did not meet the requirements to complete this virtual scenario of a health history. Remediation is recommended before attempting this scenario again.	**Score:** 57%
Essential Actions	**Required actions - 19 of 29 correctly selected** You did not demonstrate a basic understanding of the required actions tocomplete a health history.You demonstrated an understanding of the following required actions: health history, providing infection control and safety, review of systems. Spend time reviewing: • Gender identity • Occupation • Primary language • Race and ethnicity • Relationship status • Reviewing components of social determinants of health (SDOH)	

Essential Actions	**Interactive actions - 8 of 27 performed correctly** You did not demonstrate a basic understanding of determining when additional information needs to be collected during a health history. Spend time reviewing the following assessment techniques: • Asking about accidents or injuries • Asking about past and chronic illnesses • Asking about the reason for seeking care • Determining gynecological history • Determining history of present illness • Gender identity • Occupation • Primary language • Race and ethnicity • Relationship status • Reviewing components of social determinants of health (SDOH) • Reviewing the client's concerns about abdominal status • Reviewing the client's concerns about neurologic status • Reviewing the client's concerns about respiratory status • Reviewing the client's concerns about skin
Neutral Actions	**Neutral actions - 0 selected** Neutral actions do not help or harm the client. Standard precautions of putting on gloves or sanitizing hands at the end of the scenario are not required.

EHR Chart	
Instructor Review Status	Not Reviewed
Instructor Review	This chart has not been reviewed by the instructor. This report will populate with additional information when the status has changed.
Instructor Feedback	Instructor feedback can be viewed by accessing the link on the on-line version of this report. If your instructor has enabled the Expert EHR Chart, you may view the example in the attached page.

Health History 3.0 Test Information:

Health History 3.0 Test - Score Details of Most Recent Use

	Individual Score	Individual Score 1 10 20 30 40 50 60 70 80 90 99
COMPOSITE SCORES	100.0%	▲
Health History 3.0 Test	100.0%	▲

Health History 3.0 Test - History

Total Time Use: 14 min

	Date/Time (ET)	Score	Time Use
Health History 3.0 Test	10/17/2024 7:41:00 PM	100.0%	7 min
Health History 3.0 Test	8/24/2023 7:31:00 PM	96.2%	7 min

Expert Chart
Amira Hill

This expert chart is intended to assist in evaluating student performance in documentation for this activity. Only the tabs and tables of the chart that warrant entries are included, and the expert responses for comparing against student responses are indicated with bold text.

Amira Hill	**DOB**: 03/19/XXXX	**Attending**: Rani Patel, MD
MRN: 3453895	**Height**: 61 in	**Code Status**: Full code
Allergies: none	**Weight:** 122 lb	**Comments**: none

Notes

10.0 Minutes after start	Nursing/Clinician Note	Nurse

Reports volunteering at the library, engaging in a lot of activity with assisted living community. No concerns about food security or financial difficulties. Reports falling "a little less than a year ago"; tripped over a rug in her living room. Fell on hip and braced with right arm; had hip bruising and sore arm for about a week. Has given the rug away. Mother passed away when client was 14 from motor vehicle crash. Has a kitchen, but eats most meals in dining room of assisted living "that way I don't need to keep track of my nutrition, they make sure all the meals are balanced."

Immunization Record

HH 10.0 Minutes after start

Vaccine Administration Information

Tetanus, diptheria, pertussis (Tdap) (7yr and older) 5 years before start	Facility/Location where immunization was given: Comments:
Influenza	Facility/Location where immunization was given: Comments: **Receives every year in October**
Pneumonia vaccine	Facility/Location where immunization was given: Comments:
Varicella	Facility/Location where immunization was given: Comments: **Reports having 2 doses**

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Flowsheet

Admission

HH 10.0 Minutes after start

Informant(s)

Informant - If not patient (name and relationship)	

Admission Problems

Chief Complaint	Recently moved to the area. States "This is my first time at this office I have osteoporosis and need to get my shot."
Principal Problem - Admission Diagnosis	

Additional Demographic Info

Marital Status	Widow
Is English Primary Language?	Yes
Preferred Language if Not English	
Educational Level	Masters Degree
Religion/Spirituality	"I'm a practicing Muslim." Request a female provider. States "I really like the community at the mosque I go to."
Occupation	Retired librarian (20 years ago). Began doctorate work but didn't complete dissertation
Race/Ethnicity	Black or African American
Comments	Client identifies as female gender and prefers the pronouns she/her/hers. Female sex assigned at birth

Home Medication List

Denosumab Every 6 months, Subcutaneous Ordered by: Reason: Osteoporosis Start Date: End Date:	Is patient taking medication? Taking Last taken: Last does 6 moths ago; has taken for 9 years

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Past Medical History

Pertussis (Whooping cough)

Date of diagnosis: **During grade school**
Details and treatments: **"I got really sick"**

Varicella (chickenpox)

Date of diagnosis: **During grade school**
Details and treatments:

"Occasional cold"

Date of diagnosis: About once a year; last 6 months ago
Details and treatments:

Menopause

Date of diagnosis: **During her 50s; denies bleeding or spotting post-menopause**
Details and treatments:

Measles

Date of diagnosis: **During grade school**
Details and treatments:

Osteoporosis

Date of diagnosis: **Age 75**
Details and treatments: **Bone density test at diagnosis. Began denosumab injection at that time.**

Past Surgical History

Cesarean Section

Date of procedure:

Has had 2 pregnancies, 2 Cesarean births at term; one 7 pounds, the other 7 pounds 3 ounces

Family History

Myocardial Infarction

Family members affect: **Pt's Father**
Cause of death at age 86

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Social/Environmental Safety Screening

Patient lives	Alone
Comments	Living in own apartment at an assisted living facility. No concerns about housing situation.
Support Systems	Reports help with errands and appointments from daughter and son-in-law. Sees family once a week, has "lots of friend," joined a sewing club. Apartment complex has a van for transportation, client used for appointment today. Denies transportation issues.
Abuse/Neglect/Exploitation screen	
Observations - Neglect/Abuse	
Abuse/Neglect Comments	Reports feeling safe in current situation

What impairments does the patient have that affects life at home and safety?

Vision impairment: Wears glasses for reading only

Hearing impairment: Wears a hearing aid

Flowsheet

Assessment

HH 20.0 Minutes after start

Eyes, Ears, Nose, Throat

Eyes	Glasses
Eyes Comments	
Ears	Hearing Aid
Ears Comments	Glasses for reading only.
Nose, Throat	
Nose, Throat Comments	

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Integumentary	
Skin Color	
Skin Temperature/Condition	
Skin Turgor	
Skin Comments	Reports "skin can be very dry and itchy." Relieved by fragrance-free lotion daily, year round. Worse during winter.

Musculoskeletal	
RUE	
LUE	
RLE	
LLE	
Musculoskeletal Comments	Reports feeling "a little stiff in the morning." Relieved by stretching during water aerobics. Attends women's water aerobics at the senior center "a few days a week." Reports muscle and joint pain; states "my hips give me trouble sometimes." Relieved by sitting and water aerobics. Reports that when she does have paint, it is a 1 to 2 on 0 to 10 scale.

Gastrointestinal	
Abdomen	
Bowel Sounds	
Passing Flatus	
Last Bowel Movement	
GI Comment	Reports constipation at times; attributes to Halal cheese. Tries to avoid eating it.

Pain Assessment	
Pain Location	
Numeric Pain Rating	0
Pain Rating – Faces	
Pain Relieved By	
Pain Comments	

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