

Module Report

Simulation: HealthAssess 3.0

Module: Health history



Individual Name: **Laura Duncan**

Institution: **Lakeview CON**

Program Type: **BSN**

Overview Of Most Recent Use

	Date	Time Use	Score
Lesson	1/28/2025	55 min 51 sec	N/A
Virtual Application: Amira Hill	1/28/2025	36 min	90.4%
EHR Chart	N/A	N/A	N/A
Test	1/28/2025	8 min	100.0%

Lesson Information:

Lesson - History:

	Date/Time (ET)	Time Use	Total Time Use: 56 min
Lesson	1/28/2025 3:48:07 PM	55 min 51 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	90.4%												▲
Virtual Application: Amira Hill	90.4%												▲

Virtual Application: Amira Hill - History

	Date/Time (ET)	Score	Time Use	EHR Status	Total Time Use: 36 min
Virtual Application: Amira Hill	1/28/2025 3:46:11 PM	90.4%	36 min	Not Reviewed	

Time Use And Score

	Date	Time
Virtual Application: Amira Hill	01/28/2025	36 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 met the requirements to complete this virtual scenario of a health history. Score: 90.4%
Essential Actions	<p>Required actions - 29 of 29 correctly selected</p> <p>Congratulations! You have demonstrated a thorough understanding of the required actions to complete a health history. You demonstrated an understanding of the following required actions: biographic data, current health status, health history, providing infection control and safety, review of systems.</p> <p>Required actions - 29 of 29 correctly selected</p> <p>Congratulations! You have demonstrated a thorough understanding of the required actions to complete a health history. You demonstrated an understanding of the following required actions: biographic data, current health status, health history, providing infection control and safety, review of systems.</p> <p>Interactive actions - 16 of 27 performed correctly</p> <p>You did not demonstrate a basic understanding of determining when additional information needs to be collected during a health history.</p> <p>Spend time reviewing the following assessment techniques:</p> <ul style="list-style-type: none"> • Asking about past and chronic illnesses • Asking about past surgeries • Asking about the reason for seeking care • Determining gynecological history • Determining history of present illness • Faith and spirituality • Primary language • Reviewing components of social determinants of health (SDOH) • Reviewing the client's concerns about abdominal status • Reviewing the client's concerns about respiratory status

Essential Actions	<p>Interactive actions - 16 of 27 performed correctly</p> <p>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:</p> <ul style="list-style-type: none"> • Asking about past and chronic illnesses • Asking about past surgeries • Asking about the reason for seeking care • Determining gynecological history • Determining history of present illness • Faith and spirituality • Primary language • Reviewing components of social determinants of health (SDOH) • Reviewing the client's concerns about abdominal status • Reviewing the client's concerns about respiratory status
Neutral Actions	<p>Neutral actions - 2 selected</p> <p>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.</p>
	<p>Neutral actions - 2 selected</p> <p>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.</p>

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	<p>Instructor feedback can be viewed by accessing the link on the on-line version of this report.</p> <p>If your instructor has enabled the Expert EHR Chart, you may view the example in the attached page.</p>

Health History 3.0 Test Information:

Health History 3.0 Test - Score Details of Most Recent Use		
	Individual Score	<u>Individual Score</u> 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: 8 min	
	Date/Time (ET)	Score	Time Use
Health History 3.0 Test	1/28/2025 4:05:00 PM	100.0%	8 min

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

10.0 Minutes after start	Nursing/Clinician Note	Nurse
<p>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."</p>		

Immunization Record

HH 10.0 Minutes after start

Vaccine Administration Information

Tetanus, diphtheria, 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

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

Is patient taking medication? Taking

Last taken: Last does 6 moths ago; has taken for 9 years

Ordered by:
Reason: Osteoporosis
Start Date:
End Date:

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

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

Date of procedure:

Family History

Myocardial Infarction

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

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	

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