Early Pharmacy Practice Experience 2 Workbook

Fall 2017/Spring 2018
Educational Philosophy

Vision and Mission Statements

Vision Statement

The Appalachian College of Pharmacy, through quality and innovative education, service and scholarship, will improve the general health and well-being of the residents of rural or underserved populations, particularly vulnerable populations within Central Appalachia. The College will educate pharmacists to embrace knowledge and technology to optimize pharmacist-delivered patient care and health outcomes in an interdisciplinary health care environment. The College will collaborate with stakeholders to develop centers of excellence to address identified needs in rural health.

Mission Statement

The Appalachian College of Pharmacy, a college of higher education conferring the Doctor of Pharmacy degree, provides academic, scientific, and professional pharmacy education to address the health-related needs of rural and underserved communities, particularly those in Appalachia, through education, service, and scholarship. The philosophy of the College is to cultivate a learning community committed to education, community outreach, and the professional development of pharmacists.
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Introduction to EPPE 2

EPPE 2 occurs during the fall and spring terms of the P2 year. The goal of EPPE 2 is to continue the development of professionalism begun in EPPE 1 while attaining ACPE competencies in a long-term care setting. Students will participate in a required IPE activity in October. Attendance is mandatory. Students will be exposed to other health care professionals working on an intradisciplinary approach to case studies.

EPPE 2 is structured with outcome expectations designed to reflect the didactic portion of the curriculum as well as to prepare students for the realities of pharmacy practice. Students will apply knowledge gained during the didactic portion of the curriculum to real word problems in the care of nursing home residents.

During EPPE 2, the class is divided into four (4) groups: A, B, C, and D. Each team is subdivided into Pharmaceutical Care Teams assigned to faculty mentors who will facilitate learning by guiding students through specific assignments. Each student will be assigned to a resident of Heritage Hall Grundy or Heritage Hall Tazewell and will be expected to visit the resident a minimum of one (1) hour each week.

Students participate in EPPE 2 forum. This forum occurs in small group, team meetings one (1) day every other week. During this time, students will meet to discuss their EPPE assignments and share practice experiences from the previous weeks. Faculty may assign group activities or other active learning exercises to reinforce learning outcomes and on-site experiences.

Overall goals of the EPPE sequence are as follows:

1. To develop a long-term relationship with an individual patient in the long-term care setting.
2. To develop an understanding of clinical and regulatory issues in long-term care.
3. To develop confidence in communicating with patients and health care providers.
4. To develop personal judgment.
5. To develop concern for the patient’s health and welfare and an appreciation for the importance of the pharmacist’s role in the long term care setting.
6. To apply knowledge gained in the didactic education component of the curriculum into clinical practice,
7. To provide an opportunity for improving both oral and written communication skills.
General Policies for EPPE Students

Students are expected to comply with all policies and procedures of the Appalachian College of Pharmacy (ACP) and the practice site. The information contained in this workbook is complementary to that in the Student Handbook and EPPE Manual. Questions or concerns pertaining to policies and procedures should be directed to the Office of Experiential Education (OEE).

ASSIGNMENT
The students are assigned one (1) patient during the fall and spring terms of the P2 year. In the event a patient can no longer participate in the EPPE 2 patient visits (e.g., death of the patient, patient request, request of responsible party, discharge from the facility, etc.), the student will be assigned another patient. The student may at the discretion of the faculty mentors be asked to complete additional assignments with the newly assigned patient.

PATIENT ASSIGNMENT RESTRICTIONS
A student may NOT be assigned to a patient if they are related in any way. It is the student’s responsibility to notify the course coordinator immediately if the student is assigned a patient to whom they are related. It is the student’s professional obligation to inform the OEE of any conflicts associated with these restrictions. Any violation of this policy will result in no credit (failure) for the rotation and referral to CARe and Honors, Ethics, and Professionalism Committee (HEP).

COMPENSATION and GRATUITIES
The student may NOT receive or request compensation or gratuities of significant monetary value from the patient, patient’s family or the facility staff for assignments and activities related to EPPE.

ATTENDANCE
Patient Visits
The first patient visit is scheduled with a clinical instructor. It is unacceptable to miss a visit due to busy week or heavy course load. You will not be allowed to start your weekly visits until the visit with a clinical instructor has been made.

It is the student’s professional responsibility to make a weekly visit and it is unacceptable to miss a visit due to a busy week or heavy course load. Unless a student is sick or a patient is unavailable (see below) there should be no other reason why a student cannot make a weekly patient care visit.

- **Student Illness**
  - If a visit cannot be made due to student illness, the course coordinator must be notified. The student will be required to make-up the visit. When and how that visit is made-up is at the discretion of the OEE and the course coordinator. Make up visits can occur during weekends, breaks, or other times deemed appropriate by the OEE and the course coordinator.
  - If a student has a personal emergency or is ill for a sufficient duration of time as to preclude completing a weekly visit, the course coordinator and the faculty mentors must be notified. These situations will be dealt with on an individual basis by the OEE and the course coordinator.

- **Known Patient Unavailability**
  - If a patient is known to be unavailable (e.g. hospitalized, on leave of absence, etc.), the student should determine an alternative manner of completing for his/her weekly visit (e.g. see if the patient can be visited in the hospital or scheduling a visit when the patient is not on leave of absence).

- **Hospital Visits**
  - If a patient is admitted to Buchanan General Hospital or Tazewell Community Hospital for a brief stay (less than 3 days) the student may make his/her weekly visit at the hospital if the patient’s clinical condition permits visitation; or, the student may choose to postpone the visit until later in the week after the patient returns to the nursing home. If postponed visit must occur during the defined week.
  - If the patient is admitted to Buchanan General Hospital or Tazewell Community Hospital for an extended stay (longer than three days), the student will make his/her weekly visit at the hospital as long as the patient’s clinical condition permits visitation. If the student is unable to visit the patient due to the patient’s clinical condition a new patient will be assigned to the student.
If the patient is admitted to a facility other than Buchanan General Hospital or Tazewell Community Hospital for a stay of greater than three days’ duration, the student will be assigned a new patient.

- Other
  - ALL absences will be determined as excused or unexcused by the OEE and documentation for such absences may be requested. Unexcused absences from weekly patient visits may NOT be made-up and will result in a grade of “Failure” (F) for the course. Excused absences from weekly patient visits must be made up as determined by the OEE. Excused absences NOT made up within the time frame set by the OEE and absences determined to be unexcused will result in a grade of “Failure” (F) for the course, referral to the CARE Committee, and possible referral to HEP.

Team Meetings
Students are given a schedule of team meetings (See page 11) and the weeks in which patient visits are expected. Students are expected to attend every team meeting.

Students who miss a team meeting with an excused absence may be asked to complete an additional patient visit with accompanying paperwork or other additional assignments as determined by the OEE and the course coordinator. If the student does NOT complete the assignment(s) within the timeframe set by the OEE, the student will receive a grade of “Incomplete” (I) for the course until all additional requirements have been completed. An incomplete will become a failure within the time frame defined in the student handbook.

One (1) unexcused absence from a team meeting will result in a grade of “Failure” (F) for the course.

- ALL absences will be determined as excused or unexcused by the OEE and documentation for such absences may be requested. Unexcused absences from weekly patient visits may NOT be made-up and will result in a grade of “Failure” (F) for the course. Excused absences from weekly patient visits must be made up as determined by the OEE. Excused absences NOT made up within the time frame set by the OEE and absences determined to be unexcused will result in a grade of “Failure” (F) for the course, referral to the CARE Committee, and possible referral to HEP.

Absences
Personal illness, death in the immediate family, approved attendance at professional meetings, and bona fide emergencies will usually be considered as “excused absences” by OEE and the course coordinator. The student may be required to provide supporting documentation.

ACADEMIC PROBATION AND REMEDIATION
If a student fails to pass an experiential course, the student’s performance will be evaluated as outlined below. Note that the OEE will attempt to reschedule the student in the originally assigned region. However, it is possible that the student may have to relocate to another region (depending of faculty and site availability). The CARE Committee will recommend the appropriate remediation plan to the Dean to satisfy the pharmacy practice experience requirements.

The student will be assigned an “Incomplete” (I) for the course until all EPPE requirements have been completed. Completion of all EPPE assignments and evaluations is required for students to be promoted to the next professional year.

PROFESSIONAL STANDARDS
Professionals are expected to be honest, reliable, dependable, punctual, conscientious, and tactful, demonstrate commitment to excellence, be accountable to patients and colleagues, follow through on all responsibilities, and go above and beyond the call of duty.

Ethical and Legal Decision-Making
The student is expected to maintain professional ethics and adhere to practice laws when caring for patients. Students are also expected to behave ethically and professionally.

Priority for Patient Care
Students are responsible for following through with patient care assignments and reporting results back to the team within the time period established by the team.
Follow Through on Patient Care
Students are expected to address all medication-related patient care needs when they arise. The student is expected to do this in the best interest of the patient’s care regardless of the amount of time required.

Patient Care Recommendations
By law, students CANNOT practice as independent practitioners and must gain approval from their faculty mentor before making any recommendations directly to the patient, caregiver, patient's physician or other individual. ANY recommendations deemed necessary by the student and the student’s faculty mentor should be forwarded to the course coordinator for conveyance to the proper individuals.

Provision of Patient Education Materials
If the student identifies the need to provide a patient and/or caretaker with patient education materials, these materials must first be reviewed with the faculty mentor and the course coordinator.

Patient Emergencies
If a student encounters a patient who is exhibiting signs/symptoms of a medical problem or identifies a medication-related problem which may threaten the patient’s life, the student should contact the supervising nurse and the course coordinator immediately. If the course coordinator is unavailable for guidance, the faculty mentor should be contacted.

Diversity
Students are expected to be respectful of the culture, social status, and the lifestyle of all individuals they come into contact with during EPPE activities.

Respect for Patients and Colleagues
The student must exhibit respect for patients, peers and other professional colleagues.

Competency
The student is expected to demonstrate excellence in all aspects of patient care and team responsibilities consistent with his/her level of training.

Self-directed Learning
The student is expected to assume responsibility for one’s own learning and complete all EPPE activities and assignments.
EPPE 2 Forum

DESCRIPTION:
EPPE 2 forum is a 1-hour faculty/student team meeting held every other week in the fall and spring terms of the P2 year. During this time, students meet with their assigned faculty mentors to discuss the written assignments and share experiences from the previous 2 weeks. This time is used to introduce students to basic concepts of pharmacy practice in the long-term care setting. During the EPPE 2 forum, faculty may assign group activities or other active learning exercises to reinforce learning outcomes and enhance experiences.

During the EPPE 2 forum, time is spent sharing practice experiences and exploring the practice of pharmacy in the long-term care setting. Written assignments and activities will be structured to guide the student.

The major goal of EPPE 2 forum is the provision of an environment in which students are able to comfortably share and compare practice experiences with classmates. Each student will have unique experiences with other students.

FACULTY:
Course Coordinators:
Richard Nicholas, PharmD, ND, CDE, BCPS, BCACP  rnicholas@acp.edu
Sharon Deel, MSN, RN, FNP-C  sdeel@acp.edu

Course Faculty:
Samir Abdelfattah, PharmD  ssabdelfattah@acp.edu
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Todd Carter, PharmD  tcarter@acp.edu
Christopher Clark, PharmD  cclark@acp.edu
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Ingo Engels, Ph.D.  iengles@acp.edu
Brent Gravelle, MD, Ph.D.  bgravelle@acp.edu
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Caterina Hernandez, Ph.D.  chernandez@acp.edu
Marcy Hernick, Ph.D.  mhernick@acp.edu
Michael Justice, PharmD  mjustice@acp.edu
Ghous Khan, Ph.D.  gkhan@acp.edu
Afsana Momen, MBBS  amomen@acp.edu
Richard Nicholas, PharmD, ND  rnicholas@acp.edu
Brittany Palmer, PharmD  bpalmer@acp.edu
Crystal Phillips, PharmD  cphillips@acp.edu
Kristen Preston, PharmD  kpreston@acp.edu
US Rao, Ph.D.  USRao@acp.edu
Mamoon Rashid, Ph.D.  mrashid@acp.edu
Melissa Speed, MSIS, AHIP  mspeed@acp.edu
Ed Talbott, PharmD  etalbott@acp.edu
Charla Thompson, PharmD  cthompson@acp.edu
Kristen Wood, PharmD  kwood@acp.edu
TEAM STRUCTURE:
All members of the P2 class are divided into Pharmaceutical Care Teams. Each team of students has faculty mentors who serve as facilitators to the team and lead the EPPE forum sessions. Each student is assigned one (1) patient. Faculty and students will collaborate to learn more about the various disease states and medication related problems represented in the team’s case mix.

FACULTY TEAMS:

<table>
<thead>
<tr>
<th>Team #1</th>
<th>Melissa Speed</th>
<th>Todd Carter</th>
<th>Brittany Palmer</th>
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<tbody>
<tr>
<td>Team #2</td>
<td>Mamoon Rashid</td>
<td>Michael Justice</td>
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<tr>
<td>Team #3</td>
<td>US Rao</td>
<td>Kristen Preston</td>
<td>Christopher Clark</td>
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<td>Team #4</td>
<td>Ingo Engels</td>
<td>Ed Talbott</td>
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<td>Team #5</td>
<td>Richard Nicholas</td>
<td>Afsana Momen</td>
<td>Caterina Hernandez</td>
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<td>Team #6</td>
<td>Ted Hagen</td>
<td>Brent Gravelle</td>
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<td>Team #7</td>
<td>Randall Cole</td>
<td>Shamly Abdelfattah</td>
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<td>Team #8</td>
<td>Ghouse Khan</td>
<td>Crystal Phillips</td>
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<tr>
<td>Team #9</td>
<td>Marcy Hernick</td>
<td>Kristen Wood</td>
<td>Charla Thompson</td>
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<tr>
<td>Team #10</td>
<td>Samir Abdelfattah</td>
<td>Sharon Deel</td>
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INSTRUCTION TIME:
Each team meets every other week, at a time designated by faculty team mentors, during the fall term and spring term. In preparation for the team meetings, all students are expected to meet with their assigned patient for one (1) hour each calendar week.

ABILITY OUTCOMES:
Upon successfully completing EPPE 2, the student shall be able to:
1. Demonstrate commitment to self-improvement of skills and knowledge through completion of weekly written assignments and participation in class discussion.
2. Prepare and present a case in an acceptable format.
3. Demonstrate leadership qualities during team meetings.
4. Keep and maintain a personal reflective journal of experiential activities, pertinent observations, and questions that may have arisen from their experience.
5. Prepare a written document that reflects personal thought and analysis.

METHODS OF LEARNING:
1. Participation in patient encounters with assigned resident during EPPE 2 and interaction with other health care providers
2. Self-directed learning through completion of written assignments
3. Participation in Pharmaceutical Care Team meetings
4. Participation in patient care
5. Independent and directed readings

DOCUMENTATION of PATIENT ENCOUNTER:
- Weekly documentation shall include a progress note for each weekly visit.
- Lab values shall include a reference range in SOAP notes, weekly progress notes, cases, etc.

DOCUMENTATION and ASSIGNMENT SUBMISSION:
- All students MUST submit documentation and assignments to the faculty mentors no later than 9:00AM on the Monday before that team’s scheduled forum.
- Failure to submit documentation and/or assignments on time will result in a grade of “0”. In addition to the grade of “0”, the student will receive a grade of “incomplete” (I) for the course until all documentation and assignments are completed and submitted.
- Students are responsible for maintaining copies of all materials submitted in both EPPE 2 electronic and hardcopy formats.
GRADING and ASSESSMENT:
Students are responsible for the completion and submission of all assessment forms. EPPE 2 forum is a component of the EPPE 2 course. The student will be assigned an incomplete (I) for the course until all EPPE requirements have been completed. Completion of all EPPE assignments and evaluations is required for students to be promoted to the next professional year.

The grade for the course will be determined as follows:

Assignments (Fall Term):
- SOAP note (1) : 10 points
- Weekly assignments (6) : 9 points
- Weekly progress notes (12) : 36 points
- Writing Assignment (1) : 15 points
- Professional portfolio (1) : 10 points
- Long Term Care Exercise : 10 points
- IPE Exercise : 10 points
**Total 100 points**

Assignments (Spring Term):
- SOAP note (1) : 15 points
- Weekly assignments (6) : 9 points
- Weekly progress notes (12) : 36 points
- Writing Assignment (1) : 15 points
- Professional portfolio (1) : 10 points
- IPE Reflective Paper (1) : 15 points
**Total 100 points**

Attendance (# each term):
- Patient visits (12)
- Team meetings per semester (6)
- Forum

GRADE:
- A (90-100 points)
- B (80-89.99 points)
- C (70-79.99 points)
- F (0-69.99 points and/or any unexcused absences)
- I (Failure to complete all required components of the course)

Suggested Reading
(Accessed 7/15/2014)
- F329 – Unnecessary Medications
- F332 – Drug Errors
- F333 – Drug Errors
- F425 – Pharmacy Service
- F428 – Drug Regimen Review
- F431 – Labeling of Drugs and Biologicals
- Medication Issues of Particular Relevance List
- Symptoms, Signs and Conditions That May Be Associated with Medications (Change in Condition)
- Tapering of a Medication Dose/Gradual Dose Reduction (GDR)
# EPPE Forum Content and Schedule

(Subject to change with advance notice)

<table>
<thead>
<tr>
<th>EPPE Forum</th>
<th>Date</th>
<th>Team</th>
<th>Location*</th>
<th>Person Presenting/Date** (Spring)</th>
<th>Topics Covered</th>
<th>Faculty</th>
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<tbody>
<tr>
<td></td>
<td>Aug 7, 2017</td>
<td>All</td>
<td>P2 Classroom</td>
<td>EPPE II Orientation; Introduction to Geriatrics and Long Term Care</td>
<td>Deel Nicholas</td>
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<td>Aug 8, 2017</td>
<td>All</td>
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<td>Aug 30, 2017</td>
<td>A&amp;B</td>
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<td>C&amp;D</td>
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<td>- Patient Progress Update</td>
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<td>Classroom</td>
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<td>Oct 4, 2017</td>
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<td>Oct 23rd &amp; 25th</td>
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<td>C&amp;D</td>
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<td>C&amp;D</td>
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<td>Nov 8, 2017</td>
<td>A&amp;B</td>
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<td>10</td>
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<td>12</td>
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<td></td>
<td>Spring Break</td>
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<td>13</td>
<td>Apr 11, 2018</td>
<td>C&amp;D</td>
<td>Classroom</td>
<td></td>
<td>- Review and Discuss EPPE Assignment</td>
<td>All</td>
</tr>
<tr>
<td></td>
<td>Apr 18, 2018</td>
<td>A&amp;B</td>
<td></td>
<td></td>
<td>- Patient Progress Update</td>
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<tr>
<td></td>
<td><em><strong>Portfolios Due April 16th</strong></em></td>
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</table>
EPPE 2 Assignments

General Student Instructions

During each weekly visit:

- Arrive professionally dressed with your white coat and name badge. If the student is not professionally dressed according to policy, the student will be asked to leave the facility.
- **Sign-in** on the ACP Student Visitation Log (Appendix A) located at the nursing home.
- Verify the location of your patient at Heritage Hall Grundy or Heritage Hall Tazewell.
- Upon arrival at the nursing home, introduce yourself to the nurse caring for your resident and ask if you may review the patient’s chart and visit with the resident at this time. You should familiarize yourself with the layout of the nursing home and any pertinent rules or company policy to which you must adhere while on site.
- Next, familiarize yourself with the layout and contents of the patient’s chart. At a minimum, you should review the current medication recertification sheet, latest physician’s progress note, current lab values, H&P, monthly vitals, nurse’s notes, MDS sheet and the consultant pharmacist’s monthly note. Please note that the Medication Administration Record (MAR) will be located separately from the chart and is generally located in the Medication Room on the Medication Cart. **Students should NOT access the MAR alone or in any way attempt to access the medication cart. If you need information located on the MAR, please ask the medication nurse to assist you in accessing this information.**
- Then, introduce yourself to the resident and ask if you may visit with them. Although many residents may not be able to fully comprehend your role, you should preserve the dignity of each resident by obtaining their permission to visit with them.
- After each visit, promptly document your visit in a brief progress note.
- **Sign-out** on the ACP Student Visitation Log after the visit.

***Late submission of any assignment will result in a grade of “0” for that assignment. If the student fails to complete any assignment, the student will receive a grade of “I” for the course until the assignment is completed. The grade of “I” for the course will be in addition to the grade of “0” for the late submission of the assignment.***

Procedure for hospital visits:

- Arrive professionally dressed with your white coat and name badge.
- **Check-in** with the Nursing Supervisor for that shift.
- Verify the location of your patient at Buchanan General Hospital or Tazewell Community Hospital.
- Introduce yourself to the nurse caring for your patient and ask if you may review the patient’s chart and visit with the patient at this time. You should familiarize yourself with the layout of the hospital and any pertinent policies or rules to which you must adhere while on site.
- Next, familiarize yourself with the layout and contents of the patient’s chart.
- Complete the Inpatient EPPE2 Visitation Verification Form (Appendix B) **PRIOR** to leaving the hospital. A copy of this completed form will be given to the course coordinator and the team’s faculty mentors to document the visit.
- Promptly document your visit in a brief progress note.
Learning Outcomes:

The student must be able to:

1. Collect pertinent patient medical data utilizing effective communication skills.
2. Collect pertinent patient medical data utilizing the patient’s medical record.
4. Evaluate health and medication related events and document in a SOAP note.

Assignment:

1. **Week 1**: Obtain and document a medical history on your assigned patient utilizing the medical history form (Appendix C).
2. **Week 2**: Write an initial SOAP note on your assigned patient.
Learning Outcomes:

The student must be able to:

1. Document the patient visit in SOAP format.
2. Evaluate a patient’s medications for drug-drug, drug-disease, and drug-food interactions.
3. Evaluate health and medication related events and document in a progress note.
4. Reflect on experiences at the long-term care facility.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Evaluate the patient's medications for drug-drug, drug-disease, and drug-food interactions and document in your weekly progress note.
3. Write Writing Assignment #1.
Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Discuss the meaning of the term “unnecessary medication” in the CMS guidelines.
3. Explain when a medication is considered an unnecessary medication in the long-term care setting.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. List each current medication and the indication for which the patient is receiving the medication. Is the indication documented in the patient’s medical record?
Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Explain the significance of the Beer’s List.
3. Identify medications listed in the Beer’s List.
4. Explain the significance of the Medication Issues of Particular Relevance List.
5. Identify medications listed in the Medication Issues of Particular Relevance List.
6. Identify appropriate monitoring of medications listed in the Medication Issues of Particular Relevance List.
7. Evaluate appropriateness of risk versus benefit documentation.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. List any medication the patient currently receives which is listed on the Beer’s List or the Medication Issues of Particular Relevance List.
   a. Is there documentation in the medical record assessing risk verses benefit for this medication?
   b. Is the medication being monitored appropriately?

CMS Manual- page 372
(Accessed 7/31/17)

Suggested Reading:
EPPE 2 Assignment 5:  
Weeks 9 & 10

**Learning Outcomes:**

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Identify immunizations currently recommended for adults.
3. Identify specific situations where individual patients should not receive immunizations.
4. Identify the appropriate yearly time frame to administer the influenza vaccine.
5. Reflect on experiences at the long-term care facility.

**Assignment:**

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Assess the patient’s current immunization status. What immunizations should the patient receive?
3. **Bring your portfolio to the team meeting** for preview prior to submission.

 Centers for Disease Control and Prevention. Recommended Adult Immunization Schedule---United States, MMWR 2011. MMWR 2011 ; 60(4).  
[http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6004a10.htm](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6004a10.htm)  
(Accessed 7/28/2017)
EPPE 2 Assignment 6:  
Weeks 11 & 12

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Identify medications used for behavioral disorders.
3. Does the facility have a Behavior Management Program?
4. Describe the guidelines for gradual dose reductions for each class of medication listed in the “Guidance to Surveyors”.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. List any current medications the patient is receiving for behavioral disorders. Has gradual dose reductions (GDR) been attempted in a timely manner? If not is there documentation as to why a GDR is clinically contraindicated?
3. Is the patient on a Behavioral Management Program and what approaches are used to modify behavior before giving medication to this patient?
4. **Submit your portfolio to the Office of Experiential Education by November 17th.**

CMS Manual- page 367
(Accessed 7/28/2017)

A behavioral management program consists of five (5) components:

1. Identification of problem behavior
2. Patient assessment
3. Specific systemic behavioral interventions
4. Documentation of behavioral interventions
5. Necessary adjustments of program based on observed results.

This program helps the facility to identify certain behaviors in patients, assess what the need may perform certain interventions.
EPPE 2 Assignment 7:  
Weeks 13 & 14

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Evaluate the results of a Mini-Mental State Exam.
3. Identify medications that may increase a patient’s risk of falling.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Perform a Mini Mental Status Exam and MOCA on your patient.
   a. What are the scores?
   b. How do the scores compare to each other and do they compare to previous scores if any?
3. Perform a fall risk assessment on your patient.
4. Does the patient use any assistive devices?
5. List five (5) fall precautions.

Sample Falls Risk Assessment Forms

Morse Fall Risk Assessment Tool  
http://www.networkofcare.org/library/Morse%20Fall%20Scale.pdf

Missouri Alliance for Home Care Fall Risk Assessment Tool  

Suggested Reading:


http://journals.sagepub.com/doi/pdf/10.1177/070674370705200508

To download the Montreal Cognitive Assessment Tool and instructions sign up at the following link.  
www.mocatest.org
EPPE 2 Assignment 8:  
Weeks 15 & 16

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. List monitoring parameters for medications that the patient is currently taking.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. List monitoring parameters for 5 drugs that the patient is on and how do you monitor them?
3. For each medication ordered, are appropriate monitoring measures ordered and performed? For example, is there an HgA1c ordered at least q6 mo. for patients with diabetes and are the results in the medical record in a timely manner?
EPPE 2 Assignment 9:
Weeks 17 & 18

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Define 10-year Cardiovascular Heart Disease (CHD) Risk.
3. Given individual patient information, calculate that patient’s 10-year CHD Risk.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Perform a 10-year Cardiovascular Heart Disease Risk on your patient using a 10-year risk calculator. If current labs are not available, use the latest available values. If no lab values are available, perform the calculation with assumed normal lab values. State the date of the lab values used or that assumed values were used.

ASCVD Risk Estimator
http://tools.acc.org/ASCVD-Risk-Estimator/
(Accessed 7/31/2017)
EPPE 2 Assignment 10: 
Weeks 19 & 20

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Given individual patient data assess the patient’s nutritional status.
3. Calculate BEE for an individual patient.
4. Calculate total daily calories, protein, and fluid requirements for an individual patient.
5. Reflect on experiences at the long-term care facility.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Perform a nutritional assessment (Appendix D) on your patient.
3. Compare your nutritional assessment with the last nutritional assessment made by the dietician located in the patient’s chart.
4. Write Writing Assignment #2
EPPE 2 Assignment 11:  
Weeks 21 & 22

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Describe the stages of pressure sores.
3. Use the Braden Risk Assessment Scale to determine if a patient is at risk for a pressure sore.
4. Review the chart to see what interventions are in place if patient is at risk for pressure sore. If patient is immobile check to see if a turning schedule is ordered, diet, assistive devices such as a Wedge for turning and air mattress on bed.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Assess the patient’s risk for pressure sores using the Braden Risk Assessment Scale. If the patient currently has a pressure sore, stage the sore.
3. Bring portfolio to team meeting for preview prior to submission.
4. Review the chart to see what interventions are in place if patient is at risk for pressure sore. If patient is immobile check to see if a turning schedule is ordered, diet, assistive devices such as a Wedge for turning and air mattress on bed.

Braden Scale:  
(Accessed 7/31/2017)
EPPE 2 Assignment 12:
Weeks 23 & 24

Learning Outcomes:

The student must be able to:

1. Evaluate health and medication related events and document in a progress note.
2. Summarize a patient’s clinical course in SOAP format.

Assignment:

1. After each visit, write a weekly progress note. If your patient has been sent to the hospital or has fallen since your last visit, write a full SOAP note.
2. Write a final SOAP note to sign-off the patient.
3. Submit your portfolio to the OEE by April 16th.
Guidelines for Weekly Documentation

You must document each patient visit by writing a brief progress note in SOAP format. The progress note should be \( \frac{1}{2} \text{-} 1 \) typed page and should describe what has occurred since the last visit.

The progress note should contain at a minimum:
- Week #
- Date, Time, Location, Length of Visit
- Activities During the Visit
- New subjective and objective information
- Complete problem list with an assessment of any new information
- Plan to correct each problem identified
- Lab reference ranges for all laboratory value

Guidelines for SOAP Notes

You must write an initial note and a sign off note in SOAP format.

This shall be a formal all-inclusive SOAP note. After the SOAP note has been graded, you may choose to accept this first attempt grade or you may resubmit the SOAP note a second time to attempt to achieve a higher grade. If you do not resubmit, the initial assessment will serve as your grade for the SOAP note assignment. \textbf{If you choose to resubmit the SOAP note, only the second assessment will serve as your grade for the SOAP note assignment.}

The final grade SOAP note grade may increase or decrease depending on the quality of your work and how well you have taken into account suggestions for improvement. Faculty may require the student to rewrite the SOAP note multiple times in attempt to help the student improve SOAP note writing skills, however \textbf{NO} further attempts to rewrite the SOAP note will be allowed to count toward the SOAP note assignment grade. Faculty may require the student to rewrite the SOAP multiple times in attempt to help the student improve SOAP note writing skills.

A full SOAP note must be written any time a patient has been admitted to the hospital or has fallen.

**SOAP Format**

\textbf{Subjective:} Information that is reported by the patient or his/her caregiver or agent.

- **Patient Demographics and Background**
  - Patient’s initials, age, gender
- **Chief Complaint (CC)/Current Symptoms**
  - A summary of the patient’s major problem or greatest health care concern at the moment
- **History of Present Illness (HPI)**
  - When did the problem/concern begin?
- **Past Medical History (PMH)**
  - Include current medical problems for which the patient is receiving drug therapy. Describe other important past medical events that may impact the patient’s care.
- **Medication History**
  - Identify all medications presently taken by patient with dosages, schedules, indication and start and stop dates if possible.
- **Allergies**
  - Identify allergies and adverse reactions. Distinguish between true drug allergies and other adverse effects if possible.
- **Immunization History/Social History**
  - Caffeine, tobacco, alcohol and illicit drug use
- **Family History**
**Objective:** Information that can be measured, directly observed, or obtained from an original source (e.g. a lab report).
  - Review of Symptoms and Physical Exam (ROS & PE)
    - Includes height, weight, vital signs and any other pertinent physical findings
  - Labs- Include reference ranges

**Assessment:** A numbered list of the patient’s health and medicine related problems. What are the problems based on the information you have obtained?

**Plan:** How do you plan to resolve each of the problems listed in your assessment? You should have a plan for each identified problem and a problem identified for each thing you plan to do.
# Writing Assignments

**Writing Assignments #1:** Write a 1 to 2-page paper (typed single-spaced) in which you describe an encounter with another member of the healthcare team in the long term care setting and how this encounter will influence your future interactions with members of the healthcare team.

**DUE DATE:** September 20, 2017  
**All Groups**

**Writing Assignments #2:** Write a 1 to 2-page paper (typed single-spaced) in which you reflect on how your relationship with your patient has evolved over the year and how this relationship has changed you and the patient.

**DUE DATE:** March 07, 2018  
**All Groups**

**Assessment Criteria:**

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Superior (15-20 points)</th>
<th>Sufficient (10-15 points)</th>
<th>Minimal (5-10 points)</th>
<th>Unacceptable (0 points)</th>
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<tbody>
<tr>
<td><strong>Depth of Reflection</strong></td>
<td>Statement directly addresses the issue and is reflective in nature.</td>
<td>Response demonstrates a general reflection on, and personalization of, the theories, concepts, and/or strategies presented in the course materials to date. Viewpoints and interpretations are supported.</td>
<td>Response demonstrates a minimal reflection on, and personalization of, the theories, concepts, and/or strategies presented in the course materials to date. Viewpoints and interpretations are unsupported or supported with flawed arguments.</td>
<td>Response demonstrates a lack of reflection on, or personalization of, the theories, concepts, and/or strategies presented in the course materials to date. Viewpoints and interpretations are missing, inappropriate, and/or unsupported.</td>
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<tr>
<td><strong>Required Components</strong></td>
<td>Response includes all components and meets or exceeds all requirements indicated in the instructions. Each question or part of the assignment is addressed thoroughly.</td>
<td>Response includes all components and meets all requirements indicated in the instructions. Each question or part of the assignment is addressed.</td>
<td>Response is missing some components and/or does not fully meet the requirements indicated in the instructions.</td>
<td>Response excludes essential components and/or does not address the requirements indicated in the instructions.</td>
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<tr>
<td><strong>Structure</strong></td>
<td>Writing is clear, concise, and well organized with excellent sentence/paragraph construction. Thoughts are expressed in a coherent and logical manner. There are no more than three spelling, grammar, or syntax errors per page of writing.</td>
<td>Writing is mostly clear, concise, and well organized with good sentence/paragraph construction. Thoughts are expressed in a coherent and logical manner. There are no more than five spelling, grammar, or syntax errors per page of writing.</td>
<td>Writing is unclear and/or disorganized. Thoughts are not expressed in a logical manner. There are more than five spelling, grammar, or syntax errors per page of writing.</td>
<td>Writing is unclear and disorganized. Thoughts ramble and make little sense. There are numerous spelling, grammar, or syntax errors throughout the response.</td>
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<tr>
<td>Evidence and Practice</td>
<td>Response is word-processed, handed in at beginning of class on due date, and contains all required elements (student name, date, EPPE1 Forum in bold on top of first page).</td>
<td>Response is word-processed, handed in at beginning of class on due date, and contains some required elements (student name, date, EPPE1 Forum in bold on top of first page).</td>
<td>Response is not word-processed, handed in at beginning of class on due date, and contains all required elements (student name, date, EPPE1 Forum in bold on top of first page).</td>
<td>Response is handed in AFTER the due date.</td>
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SOAP NOTE EVALUATION FORM

Student: _______________________ Evaluator: ________________________ Date: ___________

<table>
<thead>
<tr>
<th>Category</th>
<th>Score</th>
<th>Comments</th>
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<tbody>
<tr>
<td><strong>Part I.</strong></td>
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<td></td>
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<tr>
<td><strong>SUBJECTIVE</strong></td>
<td>5</td>
<td>4</td>
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<tr>
<td>Chief complaint, demographics and history of present illness <em>(while protecting patient privacy)</em></td>
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<tr>
<td>Identified and collected all the necessary/pertinent information <em>(i.e. non-compliance, medication misuse, recent medication changes, social history, immunization’s, etc…)</em></td>
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<td>Categorized and organized data using appropriate format</td>
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<tr>
<td><strong>OBJECTIVE</strong></td>
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<td>Identified, filtered and collected all necessary data <em>(vital signs, diagnostics and labs)</em></td>
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<td>Incorporated all pertinent data and is complete <em>(includes, diagnostic imaging, dates, and reference ranges)</em></td>
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<td>Current list of medications with indications, dosage, and allergies</td>
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<tr>
<td>Categorized and organized data using appropriate format</td>
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<tr>
<td><strong>Part II.</strong></td>
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<td><strong>ASSESSMENT</strong></td>
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<td>Problems are clearly stated and individualized to patient specific therapeutic goals <em>(listed in appropriate order of priority)</em></td>
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<tr>
<td>Identifies and evaluates relevant medication problems to develop a rational assessment <em>(including missing date, gaps in therapy, drug-drug interactions, underuse/overuse of meds, suboptimal doses, nonpharmacological options, etc…)</em></td>
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<tr>
<td>Interpreted relationships/patterns/trends from S&amp;O to support each problem based on therapeutic goal(s)</td>
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<td>Developed reasonable therapeutic assessment(s) and provided logical and complete rationale behind each <em>(evaluated all drug therapy issues)</em></td>
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<td><strong>PLAN</strong></td>
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<td>Developed reasonable/appropriate therapeutic plan(s) for each problem identified in the assessment <em>(plan is organized with a logical rationale for each recommendation including any pertinent labs to justify plan)</em></td>
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<tr>
<td>Provides complete and logical rationale for therapeutic plan <em>(includes any pertinent labs to justify plan)</em></td>
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<td>Plan includes non-pharmacological options <em>(OTC, lifestyle modifications, etc…)</em></td>
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<td>Plan is appropriate includes desired therapeutic goals/endpoints, monitoring, and follow-up</td>
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<tr>
<td>Plan is complete including drug, dose, route, frequency, directions and monitoring <em>(includes enough info for PCP to write an order)</em></td>
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Mean Score: ______________ (grade is between 1 and 5 points)

Additional Comments:
Professional Portfolio

The establishment of the professional portfolio will enable the experiential preceptors to assess the outcomes of experiential activities over a longitudinal time period and compare outcomes with professional expectations. The goals for the development of a portfolio are to:

1. Establish a student-centered approach to learning where students actively participate in the learning process and take responsibility for their learning.
2. Track learning and achievement outcomes in experiential learning over the 3 years of the curriculum.
3. Develop the student’s communication and organizational skills.
4. Provide tangible evidence of the wide range of knowledge and skills that students possess as they grow professionally.
5. Enable the experiential preceptors to develop and refine learning goals and objectives for specific rotations based on past student experiences and competencies.

The student professional portfolio must include the following items and should be kept in both paper and electronic format:

1. Title page.
2. Table of contents.
4. Copy of current VA Board of Pharmacy Intern license (all states applicable).
5. Verification of background check.
6. Copy of up-to-date immunization records.
7. Copy of certification of HIPAA training.
8. Copy of certification of OSHA training.
9. Copy of current adult and pediatric CPR certification.
10. Liability insurance.
11. List of experiential sites the student rotates through as well as preceptor contact information. (For all rotations: EPPE 1, CPPE 1, CPPE 2, EPPE 2 and APPE I-VI)
12. EPPE 1
   a. Personal Reflective Essay (Essay 1)
   b. Personal professional SOAP note (Essay 2)
   c. Student’s Personal Reflective Journal, including assignments and projects
13. CPPE 1
14. CPPE 2
15. EPPE 2
   a. Initial SOAP note.
   b. Weekly progress notes/assignments
   c. Sign off SOAP note
   d. Case presentation with journal article(s)
   e. Reflective Essay #1
   f. Reflective Essay #2
16. Student Competency Checklist and Documentation

The portfolio will be evaluated at the end of the first professional year by faculty involved with experiential learning. During the P2 year, the portfolio will be evaluated at the beginning and conclusion of each year. Since the portfolio will continue to be used in subsequent experiential learning courses, completion of a satisfactory portfolio is a requirement to advance to the next professional year (e.g., P1 to P2 and P2 to P3).
The maintenance of a professional portfolio was initiated in EPPE 1, continued in CPPE, and will also be utilized in EPPE 2. The student’s portfolio will be checked at the completion of each term to ensure that it is up to date and contains all required information as stated in the EPPE Manual.

A black, 3-ring binder with tabs that divide the portfolio into the required sections is required. EPPE 2 materials should be placed in a separate section. Tabs should be typed, not hand-written for a professional appearance. (Partial points may be given if work is not neat.)

<table>
<thead>
<tr>
<th>CONTENT</th>
<th>POINTS (FALL)</th>
<th>POINTS (SPRING)</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title Page</td>
<td>0.5 point</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Table of contents</td>
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<tr>
<td>Curriculum Vitae</td>
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<tr>
<td>Copy of Intern license</td>
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<tr>
<td>Copy of Background Check</td>
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<tr>
<td>Immunization Record</td>
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<tr>
<td>Certification of HIPAA training</td>
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<td>Certification of OSHA training</td>
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<tr>
<td>CPR certification</td>
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(10 points per term)
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<td>Nurse signature: _____________________________</td>
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# PATIENT PROFILE/HISTORY FORM

Name: ___________________________  Gender: M/F  DOB: __________
Address: ___________________________  Home Phone: ______________
                     ___________________________  Work Phone: ______________
Primary Care Provider: ___________________________  Pharmacy(s): ______________
Specialist(s): ___________________________  Signed Consent Form: Y/N

## Prescription Medications

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<tr>
<th>Name/Strength/Route/Frequency</th>
<th>Indication</th>
<th>Prescriber</th>
<th>Start Date</th>
<th>Comments (Efficacy/Adherence)</th>
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## Over-the-Counter Medications (consider pain relief, cough/cold/allergy, stomach and vitamins)

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## Herbal Medications

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## Allergies

- ☐ No known (NKDA)
- ☐ Penicillin
- ☐ Aspirin
- ☐ Sulfa
- ☐ Codeine
- ☐ Other:
- ☐ Erythromycin
- ☐ Other:
PATIENT HISTORY FORM (cont’d)

Name: ___________________________ Gender: M F DOB: ____________

Medical Conditions

☐ Arthritis (OA or RA) ___________________________ ☐ Liver disease ___________________________
☐ Asthma ___________________________ ☐ Menopausal status (pre or post) ___________________________
☐ Cancer (type: __________) ___________________________ ☐ Migraines ___________________________
☐ COPD ___________________________ ☐ Osteoporosis ___________________________
☐ Diabetes (type 1 or type 2) ___________________________ ☐ Seizures ___________________________
☐ Emphysema ___________________________ ☐ Sexual dysfunction ___________________________
☐ Heart attack ___________________________ ☐ Stroke ___________________________
☐ Heart failure ___________________________ ☐ Thyroid disease (hypo/hyper) ___________________________
☐ High blood pressure ___________________________ ☐ Other: ___________________________
☐ High cholesterol ___________________________ ☐ Other: ___________________________
☐ Kidney disease ___________________________ ☐ Other: ___________________________

Surgical History: ________________________________________________

Family History

☐ Maternal: ______________________________________________________
☐ Paternal: ______________________________________________________

Social History

Height: ____________ Weight: ____________

Nicotine Use

☐ Never smoked ___________________________ ☐ Does not consume ___________________________
☐ _____ packs/day for _____ years ___________________________ ☐ _____ drinks/day ___________________________
☐ Stopped _____ ___________________________ ☐ _____ drinks/day ___________________________
☐ Stopped _____

Caffeine Intake

☐ None ___________________________

Alcohol Consumption

☐ Does not consume ___________________________

Diet

☐ Low saturated fat/low cholesterol ___________________________
☐ Low sodium ___________________________

Exercise

☐ None ___________________________

Information collected by: ___________________________ Date: ____________

Interventions

☐ Aspirin ___________________________
☐ Calcium ___________________________
☐ Flu shot ___________________________
☐ Pneumonia shot ___________________________

Signature of preceptor: ___________________________ Date: ____________
Appendix D

NUTRITIONAL ASSESSMENT

Patient (initials) _______   Student ______________  Date __________

SUBJECTIVE:
Appetite:  <25%  25-50%  50-75%  >75%
Food Allergies: ___________________________________________________
Food/Beverage Preferences: _________________________________________
Chews: with / without problem
Swallows: with / without problem

OBJECTIVE:
Diagnosis: _______________________________________________________
Age ___ Height  Current Wt. _____ BMI _____
IBW _____ Admission Wt.  Usual Wt._____
Weight loss: ____% lost in the last 30 days____% lost in the last 180 days
Diet Ordered ______________
Feeding Devices:  Weighted Forks/Spoons  Lipped Bowls  Divided Plates
Resident eats in:  Room  Dining Hall  Other
Feeding:  Independently  Eats with assistance
Spoon fed  Syringe (bolus)  Tube fed  IV
Dentition:  Own Teeth  Few Teeth  Poor Dentition  No Teeth
Upper/Lower Dentures  Ill-fitting Dentures
Status:  Alert  Withdrawn  Confused  Combative  Cooperative
Communication:  Hearing Impaired  Blind  Language Barrier  Aphasia  Non-
Responsive
Laboratory Data:  ALB  TP  NA  K  BUN  CR  GLU  CHOL  TG  HG  HCT
Date:  ____________
Medications: ____________________________________________________________
____________________________________________________________________
____________________________________________________________________
____________________________________________________________________

BEE  Total Caloric Needs __________

Protein requirements _______ Fluid Requirements _______--__________

Hydration Status:  Dehydrated  Adequately Hydrated  Over-Hydrated

Skin Condition:

**ASSESSMENT:**

Dietary Intake Is:  Poor  Fair  Good

Weight is:  Below  Within  Above the Normal Range

Recent Appetite has been:  Poor  Fair  Good

Bowel Function:  Regular  Constipated  Diarrhea

**PLAN:**
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<th>Student 2</th>
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Weekly Assignments (9) 0.00 0.00 0.00 0.00 0.00 0.00 0.00
SOAP Note (10)
IPE Exercise (10)
Writing Assignment (15)
Long Term Care Final (10)
Professional Portfolio (10)
Final Grade 0.00 0.00 0.00 0.00 0.00 0.00 0.00
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Appendix F

EPPE 2 ASSESSMENT FORM
COMPLETED BY STUDENT

A. Learning Outcomes
1. The learning outcomes were clear □ Yes □ No
   Comments:

2. The learning outcomes were reasonable in terms of the level of difficulty □ Yes □ No
   Comments:

3. The learning outcomes were relevant to the materials covered during team meetings □ Yes □ No
   Comments:

4. After completing this course I am able to:
   a. Demonstrate commitment to self-improvement of skills and knowledge through completion of weekly written assignments and participation in class discussion □ Yes □ No
   b. Prepare and present a case in acceptable format □ Yes □ No
   c. Exhibit leadership qualities during team meetings □ Yes □ No
   d. Keep and maintain a personal reflective journal of experiential activities, pertinent observations, and questions that may arise □ Yes □ No
   e. Prepare a written document that reflects personal thought and analysis □ Yes □ No

5. Participation in this course has enabled me to:
   a) Develop a long-term relationship with an individual patient in the long-term care setting □ Yes □ No
   b) Develop an understanding of clinical and regulatory issues in long-term care □ Yes □ No
   c) Develop confidence in communicating with patients and healthcare providers □ Yes □ No
   d) Develop personal judgment □ Yes □ No
   e) Develop concern for the patient’s health and welfare and an appreciation for the importance of the pharmacist’s role in the long term care setting □ Yes □ No
   f) Apply knowledge gained in the didactic education component of the curriculum into clinical practice □ Yes □ No
   g) Improve both oral and written communication skills □ Yes □ No

B. Assignments
1. Assignment content was relevant to the learning outcomes □ Yes □ No
   Comments:

2. I was able to complete the assignment in a reasonable amount of time □ Yes □ No
   Comments:
C. Miscellaneous

1. How beneficial did you find the following components of this course? Please rank these components in order from 1-5 with 1 being least beneficial and 5 being most beneficial.

   ___ Weekly patient visits
   ___ SOAP notes/Progress notes
   ___ Weekly activities
   ___ Case presentations
   ___ Team meetings

2. What were the best parts of this experience?

3. What were the worst parts of this experience?

4. What information from your didactic courses have you been able to incorporate into the care of your resident?

5. What are your strengths and weaknesses in terms of providing patient care?

Additional Comments: