Cerro Coso College

Course Outline of Record Report

10/11/2021

HCRSC137 : Clinical Medical Assisting II

General Information

Author:	-
Course Code (CB01) :	HCRSC137
Course Title (CB02) :	Clinical Medical Assisting II
Department:	Allied Health
Proposal Start:	Fall 2013
TOP Code (CB03) :	(1208.10) Clinical Medical Assisting
SAM Code (CB09) :	Clearly Occupational
Distance Education Approved:	Yes
Course Control Number (CB00) :	CCC000532219
Curriculum Committee Approval Date:	10/04/2013
Board of Trustees Approval Date:	11/14/2013
External Review Approval Date:	06/21/2012
Course Description:	This course is designed to provide advanced education and training for the individual who is interested in working as a Clinical Medical Assistant in a medical or clinical back office. Topics include patient history and interviewing; techniques of assisting the physician with patients; minor surgeries and sterile dressing changes; staple and suture removal; theory of x-ray examination and treatment; patient education; electrocardiographic methods; and first aid. Common office procedures are discussed and practiced in the Skills Lab. Emphasis is placed on the role of the medical assistant.
Submission Type:	New Course
Author:	No value

Faculty Minimum Qualifications

Master Discipline Preferred:	No value
Alternate Master Discipline Preferred:	No value
Bachelors or Associates Discipline Preferred:	• Health Care Ancillaries (Medical assisting, hospice worker, home care aide, certified nurse aide, health aide, ward clerk, central service technology, childbirth educator, primary care associate, massage therapy)
Additional Bachelors or Associates Discipline Preferred:	No value

Course Development Options

Basic Skills Status (CB08)

Course is not a basic skills course.

Course Special Class Status (CB13)

Course is not a special class.

Grade Options

- Letter Grade Methods

☐ Allow Students to Gain Credit by Exam/Challenge

Allowed Number of Retakes

0

Course Prior To College Level (CB21)

Not applicable.

Rationale For Credit By Exam/Challenge

No value

Retake Policy Description

Type:|Non-Repeatable Credit

☐ Allow Students To Audit Course

Course Support Course Status (CB26)

No value

Associated Programs

☑ Course is part of a program (CB24)

Associated Program	Award Type	Active
CC HCRS Clinical Medical Assisting-	Certificate of Achievement	Spring 2018
CC HCRS Medical Assisting	A.S. Degree Major	Spring 2018

Transferability & Gen. Ed. Options

Course General Education Status (CB25)

No value

Transferability

Transferable to CSU only

Transferability Status

Approved

Units and Hours:

Summary

Minimum Credit Units (CB07)	3
Maximum Credit Units (CB06)	3
Total Course In-Class (Contact) Hours	72
Total Course Out-of-Class Hours	90
Total Student Learning Hours	162
Faculty Load	0

Credit / Non-Credit Options

Course Credit Status (CB04)

Credit - Degree Applicable

Course Non Credit Category (CB22)

Credit Course.

Non-Credit Characteristic

No Value

Course Classification Status (CB11)

Credit Course.

Funding Agency Category (CB23)

Not Applicable.

☐ Cooperative Work Experience Education Status (CB10)

☐ Variable Credit Course

Weekly Student Hours

	In Class	Out of Classs
Lecture Hours	2.5	5
Laboratory Hours	1.5	0
Activity Hours	0	0

Course Student Hours

Course Duration (Weeks)	18
Hours per unit divisor	0
Course In-Class (Contact) Hours	
Lecture	0
Laboratory	0
Activity	0
Total	72
Course Out-of-Class Hours	
Lecture	0
Laboratory	0
Activity	0
Total	90

Time Commitment Notes for Students

No value

Faculty Load

Extra Duties: 0

Faculty Load: 0

Units and Hours: - Weekly Specialty Hours

Activity Name	Type	In Class	Out of Class
No Value	No Value	No Value	No Value

Pre-requisites, Co-requisites, Anti-requisites and Advisories

Prerequisite

HCRSC136 - Clinical Medical Assisting I

HCRS C136: Clinical Medical Assisting I is a part of the core courses required in the new Administrative Medical Assisting Certificate. Students will need the basic medical procedures, standard precautions, and aseptic techniques learned in HCRS C137.

Entrance Skills

Entrance Skills	Description
No value	No value

Limitations on Enrollment

Limitations on Enrollment	Description
No value	No value

Specifications

Methods of Instruction

Methods of Instruction	Skills Development and Performance
Rationale	No value
Methods of Instruction	Written work
Rationale	No value
Methods of Instruction	Problem Solving
Rationale	No value
Methods of Instruction	Performance
Rationale	No value
Methods of Instruction	Presentations (by students)
Rationale	No value

Methods of Instruction	Laboratory
Rationale	No value
Methods of Instruction	Lecture
Rationale	No value
Methods of Instruction	Outside reading
Rationale	No value
Methods of Instruction	Discussion
Rationale	No value
Methods of Instruction	In-class writing
Rationale	No value
Methods of Instruction	Audiovisual
Rationale	No value
Methods of Instruction	Case Study
Rationale	No value
Methods of Instruction	Demonstration
Rationale	No value

Assignments

1. Write a 5 page research paper on a assigned topic such as the importance of HIPAA in the medical office or the role of the CMA in the healthcare field.
2. Read and outline the assigned textbook chapters prior to lecture.
3. Incorporating lecture notes with chapter outlines.
4. Answer assigned questions from the textbook study guide.
5. Practice scenario-based back office procedures: Case Scenario Example: Jimmy Stewart, a 19 year-old male patient, came to the physician's office after getting a cast in the emergency room for a broken right wrist. Jimmy is complaining of pain to his right arm. Jimmy's right hand is swollen and slightly bluish in color. His capillary refill is greater than 4seconds. What can you conclude about Jimmy's cast and right arm? What would you document?

Methods of Evaluation	Rationale
Tests	Theory applications will be evaluated by Chapter Quizzes, Mid-term and Final, e.g., questions include multiple choice, true-false, and short answer:\
Other	The student will demonstrate clinical patient care in the skills lab.
Other	The student will demonstrate medical back office procedures in the skills lab.
Other	Skills lab participation will be monitored with a Completion Check-off List.

Equipment

No Value

Textbooks

Author	Title	Publisher	Date	ISBN
	Bonewit-West, K.. (2012) Clinical Procedures for Medical Assistants, 8th, Saunders/Elsevier			
	Bonewit-West, K.. (2012) Clinical Procedures for Medical Assistants, Study Guide, 8th, Saunders/Elsevier			

Other Instructional Materials

No Value

Materials Fee

No

Learning Outcomes and Objectives

Course Objectives

No value

CSLOs

Compare and contrast the infection cycle and infection control in an outpatient facility. Expected SLO Performance: 70.0

Demonstrate the ability to assist with routine physical and specialty examinations. Expected SLO Performance: 70.0

Perform medical assisting procedures which include patient interviews; documentation on medical history forms; patient emergency procedures; minor surgery; and wound care. Expected SLO Performance: 70.0

ISLOs Core ISLOs	Students who are completing a program will be able to access, evaluate, and effectively use information.

Evaluate the patient interview process and documentation on the medical history form. Expected SLO Performance: 70.0

ISLOs Core ISLOs	Students who are completing a program will be able to communicate ideas, perspectives, and values clearly and persuasively while listening to others openly

Explain the role of the medical assistant in the care of patients with minor wounds as well as the application of wound dressings. Expected SLO Performance: 70.0

Evaluate cardiac arrest and abstracted airway procedures in an outpatient facility. Expected SLO Performance: 70.0

Analyze the role the medical assistant plays in patient satisfaction and performance improvement. Expected SLO Performance: 70.0

ISLOs Core ISLOs	Students who are completing a program will be prepared to engage in responsible citizenship at various levels.

Compare the theoretical and procedural requirements for assisting with patient screening and intake. Expected SLO Performance: 70.0

ISLOs Core ISLOs	Students who are completing a program will be able to think critically and creatively and apply reasoning.

Distinguish between the theoretical and procedural requirements for positioning and draping patients. Expected SLO Performance: 70.0

Consider strategies to obtain and maintain employment as a medical assistant. Expected SLO Performance: 70.0

Outline

Course Outline

I. **Spell and define key terms**
   A. Review the terms listed in the terminology section.
   B. Spell the listed terms accurately.
   C. Pronounce the terms correctly.
   D. Use the terms in their proper context

   I. **Medical history**
      A. Preprinted forms
         1. Section 1 - data or data base
            a. Patient's name
            b. Date of birth
            c. Address
            d. Home and work phone numbers
            e. Insurance carrier, policy number
            f. Social security number
            g. Gender and race
         2. Section 2 - past history
            a. Allergies
            b. Immunizations
            c. Childhood diseases
            d. Current and past medication
            e. Previous illness
            f. Traumatic illnesses

g. Surgeries
h. Hospitalizations

3. Section 3 - review of systems
    a. Respiratory
    b. Digestive
    c. Reproductive
    d. Immune
    e. Integumentary
    f. Sensory
    g. Musculoskeletal
    h. Nervous
    i. Cardiovascular
    j. Urinary
4. Section 4 – family history, health status of:
    a. Parents
    b. Siblings
    c. Grandparents
    d. Include specific diseases and disorders
5. Section 5 - social history
    a. Life style
    b. Marital status
    c. Occupation
    d. Education
    e. Hobbies
    f. Use of alcohol and tobacco
    g. Sexual history

I. **Six C's of charting**
    A. Client's words recorded exactly
    B. Clarity – use medical terminology and precise descriptions.
    C. Completeness
    D. Conciseness – save time and space.
    E. Chronological order – dates on all entries
    F. Confidentiality – cannot discuss patient's record, forward to another office, fax or show to anyone except physician without patient's written permission to do so.

II. **Guidelines for conducting a successful patient interview**
    A. Effective learning
        1. Think and respond to what patient has said.
        2. Provide feedback.
    B. Be aware of nonverbal clues and body language.
        1. Tone of voice
        2. Facial expression
    C. Use broad knowledge base.
        1. Medical terminology
        2. Symptoms
        3. Diseases
    D. Plan and research before interview.
        1. Review patient history.
        2. Have general questions ready.
        3. Ask patient's permission to ask questions.
    E. Make the patient fill at ease.
        1. Icebreakers
        2. Sit with patient
        3. Be relaxed
    F. Conduct interview in private without interruption.
        1. Private room
        2. Door closed
        3. Do not rush
        4. Maintain eye contact
        5. Use patient's name
    G. Deal with sensitive topics with respect.
        1. Non-threatening
        2. Know when to stop
    H. Avoid making diagnosis or giving diagnostic opinion.
    I. Summarize key points.
        1. Ask patient if they have questions.
        2. Ask patient if they have additional information that should be added.

I. **Signs and symptoms**
   A. Signs are objective indications of disease or bodily dysfunction that can be perceived by others.
      1. Rash
      2. Bleeding
      3. Cough
      4. Discharge
      5. Vital signs
   B. Symptoms are subjective indications of disease and changes in body as sensed by patient and not recognized by anyone else.
      1. Leg pain
      2. Nausea
      3. Headache

1. **Explain chief complaint and present illness**
   A. Chief complaint – description of symptoms that led patient to seek physician care such as:
      1. Headache for two days
      2. Lifted and strained back
      3. Document in patient's chart, patient's own words
2. Resent illness – more specific account of chronic complaint, chronological order of events including:
   1. Onset
   2. Home remedies
   3. Over the counter medications
3. **Contents of a patient's chart**
   A. Patient registration form
   B. Patient medical history form
   C. Test results
      1. Laboratory
      2. Radiological
      3. Other
4. Records from other physicians or hospital
5. Physician diagnosis and treatment plan
6. Operative reports
7. Informed consent forms, signed by patient
8. Discharge summary forms from hospitalizations
9. Correspondence with or about the patient
10. **Formats used for documenting information**
    A. Source – oriented medical records/all similar categories or sources of information are grouped together in reverse chronological order.
       1. Billing/Insurance
       2. Physician's orders
       3. Progress notes
       4. Laboratory results
       5. Radiographic results
       6. Patient education
    B. Problem - oriented medical records lists each patient problem at the beginning of the folder and references each problem with a number throughout the folder.
       1. Data base
          a. Chief complaint
          b. Present illness
          c. Patient profile
          d. Review of systems
          e. Physical examination
          f. Laboratory reports
       2. Problem list
          a. Social
          b. Demographic
          c. Medical
          d. Surgical
       3. Treatment plan
          a. Management
          b. Additional work-ups
          c. Therapist
       4. Progress notes
          a. Structured
          b. According to SOAP
    C. Documentation forms

1. Progress notes are written statements about various aspects of patient care, recorded on lined paper with two columns, left column date and time; right column to write note.
2. Formats
    a. Narrative – paragraph
        i. What is wrong with patient?
        ii. What was done to help the patient?
        iii. Did treatment work?
    b. SOAP
        i. Subjective component – what patient says, accurate quotes
        ii. Objective component – what is observed about patient during assessment
        iii. Assessment – phrase stating your impression of what is wrong with the patient
        iv. Plan – list of interventions that have been done
    c. PIE
        i. Problem – statement of patient's problem
        ii. Implementation – interventions provided
        iii. Evaluation – how implementation helped the patient
    d. Focus
        i. Focus
        ii. Data
        iii. Action
        iv. Result
    e. Flow sheets – preprinted check list of most commonly asked questions
    f. Charting by exception (CBE)
        i. Only abnormal events are charted in narrative form
        ii. Normal or expected findings are checked off in flow sheets
    g. Computerized charting

11. **Rules for medical record entry**
    A. All entries are to be accurate, timely and legible.
    B. Golden Rule of documentation is "if it isn't documented, it wasn't done."
    C. Correct patient chart; use birth date, or SS# for double check.
    D. Document in ink (black or dark blue only).
    E. Always sign your name and title.
    F. Date and time all entries (military time).
    G. Write legibly.
    H. Check spelling, medical terminology, and abbreviations.
    I. Use quotation marks for direct patient statements.
    J. Document as soon as possible after completing a task.
    K. Document missed appointments and your attempts to contact the patient by phone.
    L. Document any telephone conversations with the patient in the chart.
    M. If you have made an error, given the wrong medication, performed an incorrect procedure, notify the MD immediately, document it, then complete an incident report.
    N. Never document for someone else, and don't allow anyone else to document for you.
    O. Never document false information.
    P. Never delete, erase, scribble over, or white-out in a medical record. This will be construed as tampering with a legal document.
        1. To correct a written error, draw a single line through the entry, initial it, and write error.
        2. Document the correct information immediately adjacent to the lined-through information.

12. **The origin and purpose of screening patients**
    A. Origin
        1. Screening is one of the most critical and significant of all the responsibilities.
            a. The term triage originated during war time.
            b. Referred to the sorting and assessment of soldiers' injuries.
            c. After the medic made a decision about care, the soldier was dispatched for treatment.
        2. The term triage also used in prioritizing the conditions of injured persons following a disaster.
            a. Injured separated into groups according to the seriousness of their needs.
            b. Injured tagged with a particular color-coded tape or cloth.
    B. Purpose in medical facility
        1. Term common in medical facilities across the country.
            a. Emergency room
            b. Office
            c. Clinics
        2. Private area established for the interview process.
        3. Patient's symptoms are appraised and a judgment is made regarding the nature of the patient's complaints.
            a. It is vital that the patient's immediate needs are met. The nature of their managed care should be a secondary concern.
            b. Reason for the patient's visit may be determined by the medical assistant who performs the screening interview along with input as necessary from other members of the health care team.
            c. Process occurs both via the telephone and with the patient present in the office.

C. Job responsibility under much debate
    1. The terms triage, screening, and assessment are often interchanged.
    2. The medical assistant's role is to interview the patient for the necessary information.
        a. It is essential that accurate and thorough information be obtained and documented.
        b. The medical assistant is not to make any medical judgments.
        c. The information obtained is passed on to the physician.
    3. The physician's role is to make medical judgments regarding the patient's care relying in part or information obtained by the medical assistant during the screening interview.

13. **Forms used to document patient information**
    A. Progress note sheet
    B. Flow sheets
    C. Problem lists
    D. Telephone message forms
    E. Medical history form

14. **Obtaining pertinent information regarding a patient's condition**
    A. Effective listening
        1. Listening attentively (active listening) is one of the most important skills you will need for a successful interview.
        2. Active listening
            a. Hear what's said.
            b. Think about what is said.
            c. Respond to what the patient has said.
    B. Be aware of nonverbal clues and body language.
        1. Nonverbal communication
            a. Tone of voice
            b. Facial expression
            c. Body language
        2. The medical assistant may need to have extra patience and offer encouragement.
    C. Use a broad knowledge base.
    D. Summarize to form a general picture.
    E. Steps to help you conduct a successful interview:
        1. Do your research before the patient's interview**:**
            a. Patient's history
            b. Medications
            c. Chronic problems
            d. Family issues
        2. Plan the interview.
            a. Have a general idea of questions to ask.
            b. Stay focused.
            c. Obtain all the necessary information.
        3. Approach the patient and request the interview.
            a. It is courteous to seek permission to ask questions than to say you need to take a history.
            b. Helps patient feel more comfortable and emphasize**s** importance of the interview process.
        4. Making the patient feel at ease**:**
            a. Use icebreakers to put patient at ease and create a relaxed atmosphere.
                i. Acknowledge patient's reason for the visit.
                ii. Comment on weather.
                iii. Ask how patient prefers to be addressed.
                iv. Clarify pronunciation of a difficult name.
            b. Sit with the patient.
            c. Appear relaxed.
            d. Recognize if patient is anxious or depressed.
        5. Conduct the interview in private without interruptions.
            a. Escort patient to private room or area.
            b. Close the door.
            c. Develop a rapport.
            d. Do not rush.
            e. Maintain eye contact.
            f. Effective methods of collecting patient data:
                i. Ask open-ended questions.
                ii. Ask hypothetical questions.
                iii. Mirror patient's responses and verbalize the implied.
                iv. Focus on the patient.
                v. Encourage patient to take the lead.
                vi. Encourage patient to provide additional information.
                vii. Encourage patient to evaluate his situation.

I. **Patient education**

A. Talking to the patient is a prime time to give patient education appropriate to their needs.
    1. Give appropriate printed material.
    2. Discuss how to stay healthy.
B. Ask if there are further questions.
C. Instruct patients to write down questions and subjects they wish to discuss.
D. Include companion / caregiver in discussions when appropriate.
E. Supply phone number where the physician can be reached day or night.
F. Hand out appropriate printed material.
G. Clarification of medical terminology, tests and procedures decrease patient confusion.
H. If patient is sedated, only give one instruction at a time.
I. If you perceive embarrassment, explain the need for the position, and help the patient assume the position when necessary.
J. Always tell the patient what movement to expect.
K. Give specific instructions to the patient on whether the gown should be open in the back or the front.
L. Patient needs to know why the physical exam must be performed accurately.
M. Explain the data collected forms a database against which all future exams and observations will be compared.
N. Patient needs to understand what is taking place and why.
O. Important that patient be relaxed while being examined.
    1. Some exams can be embarrassing.
    2. Clearly explain to relieve anxiety.
P. Never assume patient knows what clothing to remove or what position to assume simply because it is not the first visit to the office.
Q. Answer all questions the patient has regarding the procedure to be performed.

II. **Legal and ethical implications of screening patients**
A. Remember all data you obtain are subject to legal and ethical considerations.
    1. Privacy
    2. Confidentially
B. Discuss the components of the patient's bill of rights.
C. Review the physician's and medical assistant's role in screening patients.
    1. Only physician can give diagnosis.
    2. Medical assistant can only obtain information and is NOT to offer any medical advice.

III. **Purpose of each of the patient examination positions**
1. Anatomic (erect or standing) position
    1. Examine musculoskeletal development
    2. Examine skin color
    3. Assess posture
2. Sitting position
    1. Examine anterior / posterior aspect of head
    2. Examine anterior / posterior aspect of chest
3. Supine (recumbent, horizontal recumbent) position
    1. Examine abdomen, chest, leg
    2. Anterior aspects of body available for examination
4. Dorsal recumbent position
    1. Vaginal exam when lithotomy position is not advisable
    2. Rectal examination
    3. Examination of abdomen
    4. Resting
5. Lithotomy position
    1. Pelvic examination
    2. Examination of the female genitalia
6. Trendelenberg position
    1. Treat shock
    2. Abdominal surgery
    3. Treat hypotension
    4. Postural drainage
7. Semi-Fowler's (45º angle) position
    1. Patients with difficult breathing
    2. Examination of the head, neck and chest
8. Fowler's (90º angle) position
    1. Patients with difficult breathing
    2. Examination of the head, neck and chest
    3. Good for lower back injury patients
9. Prone position
    1. Examination of the back, spine or legs
    2. Posterior (ventral) aspects of body available for examination
10. Sim's (lateral Sim's) position
    1. Anal and rectal examination
    2. Perineal and certain pelvic examination
    3. Flexible sigmoidoscopy on elderly patients

11. Knee – chest position
    1. Exam of anal and perineal areas
    2. For certain proctologic procedures
12. Proctologic position
    1. Proctologic examination with sigmoidoscopy
    2. Exam of perineal area, anus, and hemorrhoids
13. Jackknife position
    1. Examination and instrumentation of the male urethra
    2. Often referred to as proctologic position (controversial issue)

IV. **Safety precautions regarding patient positioning**

A. If a power table is used, the medical assistant must know how to operate it.
B. A female medical assistant should remain in the room when a female patient is being examined by a male physician.
C. Instruct the patient on the use of the gown to avoid unnecessary exposure.
D. Never leave a very ill patient or small child alone on a table.
E. Utilize effective body mechanics.
F. Explain the need for the position and help the patient assume the position when necessary.
G. Changes in position should be done gradually.
H. Always tell the patient what movement to expect.
I. Cover the patient with an appropriate drape.
    1. Warmth
    2. Privacy
J. Assist the patient onto and off of the exam table to decrease the chance of an accidental fall.

V. **Basic principles of properly draping a patient for examination**

1. Anatomic
    1. Patient with hospital gown on, open either in front or back
    2. Can hold drape around waist.
2. Sitting position
    1. Drape placed across the patient's lap for men
    2. Drape placed across the patient's chest and lap for a woman
3. Supine position
    1. Normally draped from the neck down to the feet
    2. Draped from the underarms down to the feet
4. Dorsal recumbent position
    1. Drape from the neck or underarms down to the feet
    2. Diamond drape
5. Lithotomy position
    1. Large drape that covers the patient from the breast to the ankles
    2. Drape wide enough to prevent the sides of the thighs from being exposed
6. Trendelenberg
    1. Drape from the neck down to the knees
    2. Drape from the underarms down to the knees
7. Semi-Fowler's and Fowler's position
    1. Drape from the neck or underarms down to the feet.
    2. The drape will vary according to the exposure of the patient.
    3. Female patients should have their breasts covered.
8. Prone
    1. Drape from the upper back to the feet
    2. Female patients should be draped high enough to cover the breasts if she is to be turned over to the dorsal recumbent position.
9. Sim's
    1. Drape from the upper back to the feet
    2. Drape from under the arms to below the knees
10. Knee-chest and proctologic positions
    1. Commonly covered with a fenestrated drape
    2. Opening provides access to the area being examined.

VI. **Legal and ethical implications in positioning and draping patients.**

A. Utilize a variety of safety measures to protect you, the physician and the patient from disease transmission.
B. Never leave an acutely ill or medicated patient or an infant/child unattended on the exam table.
C. If the patient is unclothed, a second person should be present during the physical exam.

VII. **Preparing for the complete physical examination (CPE) of a patient**

A. Prepare the room for the physician and patient.
    1. Clean
    2. Well lighted
    3. Well ventilated
    4. Comfortable temperature for the patient.
    5. Ensure all instruments and supplies are readily available for the physician.
    6. Restock as necessary.

B. Prepare the patient.
    1. Develop a positive rapport with the patient.
    2. Create a positive, supportive, caring and friendly atmosphere.
    3. Assess patient's facial expression and level of anxiety.
    4. Treat the patient as an individual and speak clearly and with a confident tone of voice.
    5. Use simple, direct language the patient can understand.
    6. Describe what the patient can expect to feel and how their cooperation can contribute to the success of their procedure.
    7. Emotional preparedness is especially important when dealing with children.
    8. Prepare patient physically by allowing an opportunity to empty bladder/bowels and disrobe/gown as necessary.
C. Assisting the physician
    1. May need to remain in room for legal reasons.
    2. Hand the instruments and supplies as needed.
    3. Direct the light appropriately.
    4. Adjust patient's position/drape as necessary.
    5. Document findings as provider dictates

VIII. **Instruments, equipment, and supplies used on the complete physical examination (CPE)**
A. Patient's chart, black pens, forms needing completion
B. Stethoscope, sphygmomanometer
C. Tonometer
D. Otoscope
E. Nasal speculum, penlight
F. Tongue depressor, sterile gauze square, laryngeal mirror
G. Latex gloves, water-soluble lubricant
H. Vaginal speculum, gooseneck lamp, tissues
I. Test of occult blood
J. Tape measure, percussion hammer
K. Vision chart
L. Alcohol, alcohol wipes, betadine, hydrogen peroxide
M. Chlorhexidine Gluconate- in swab form also known as Choraprep
N. Bandages, gauze dressings (4x4, 3x4, 2x2)
O. Cotton balls, cotton-tipped applicator, drapes, emesis basin
P. Biohazardous waste containers
Q. Gloves – latex, non-sterile disposable, sterile disposable
R. Soap dispenser
S. Tape, tape measure
T. Tissues, personal wipes
U. Thermometers

IX. **Basic sequence of the physical examination**
A. General appearance
B. Head
C. Neck
D. Eyes
E. Ears
F. Nose and sinuses
G. Mouth and throat
H. Chest and lungs
I. Heart
J. Breasts
K. Abdomen
L. Genitalia
M. Rectum
N. Musculoskeletal system
O. Neurological system

X. **Examination methods used by physicians**
A. Inspection (visual examination)
    1. Posture/Gait
    2. Mannerisms
    3. Affect
    4. Hygiene
B. Auscultation
    1. Lungs
    2. Heart
    3. Carotid arteries
    4. Bowel Sounds
C. Palpation
    1. Chest
    2. Abdomen

D. Percussion
    1. Chest
    2. Abdomen
    3. Extremities

XI. **Recommended physical examination schedules for adults and children**

A. Adults
    1. EKG –PRN with baseline at 40 if not before
    2. Eye exam – tonometry and fundoscopy at 40, then every 4 years
    3. H&P – every 3 years between ages 20-30, annually after 40
    4. Mammogram – baseline at 35, then annually
    5. Pap test, pelvic – begin at 20 or when female becomes sexually active, annually thereafter
    6. Pulmonary function tests – PRN for high risk patients, COPD, and smokers
    7. Sigmoidoscopy – 2 consecutive at 50, every 3-5 years thereafter
    8. Rectal exam – begin at 40, then annually
    9. Stool for guaiac – begin at 40, then annually
    10. Thyroid screening – PRN, baseline at menopause females every 2 years

B. Children
    1. 3 days –diet and nutrition assessed, exam
    2. 3-4 weeks – diet and nutrition assessed, lab tests and procedures, exam
    3. 2 months – check up, immunizations begin
    4. 4-6 – check up, immunizations continues
    5. 9 mo., 12 mo., 15 mo., - exam, immunizations
    6. 4 years – 6 years – annual exam

XII. **Legal and ethical implications of the physical examination**

A. The medical assistant may be required to act as a witness during some examinations.
B. The medical assistant must recognize that a legal and ethical contract exists between the patient and physician and therefore any information gained through the CPE is confidential and must remain that way.

XIII. **Three primary structures of the integumentary system**

A. Epidermis
    1. Top layer
    2. Composed of tightly packed epithelial cells
    3. Keratin

B. Dermis
    1. Second layer
    2. Composed mainly of connective tissue
    3. Contains several appendages
        a. Hair
        b. Receptors
        c. Nails
        d. Glands
            i. Sebaceous (oil)
            ii. Sudoriferous (sweat)

C. Subcutaneous
    1. Third layer
    2. Composed of adipose cells

XIV. **Factors that might affect wound healing**

A. Blood supply
    1. It is adequate for proper oxygenation and the need for an increased blood flow.

B. Presence of infection
    1. Most common complication in wound healing.
    2. Causes an increase in edema, erythema, temperature and pain.
    3. Adherence to standard precautions is necessary when handling an infected wound.

C. Nutrition - Must have adequate supply of the essential nutrients to encourage wound healing and prevent infection.
    1. Protein synthesis requires amino acids, vitamin B complex and magnesium.
    2. Collagen synthesis and maturation requires vitamin C and D and the minerals iron and copper.
    3. Immune reaction requires vitamin C. Inflammatory response and anti-inflammatory action requires vitamins A and E.
    4. Prothrombin synthesis requires vitamin K.

D. Size, shape and location of wound which can affect:
    1. Likelihood of bleeding – Head and neck wounds bleed more readily.
    2. Extent of swelling is more likely to cause difficulties in the distal extremities than in other areas.
    3. Need for compression and/or immobilization – bone for joint injuries
    4. Type and amount of drainage expected - Abdominal, thoracic and alimentary tract wounds tend to drain fluid in higher volume and of more varied character.

E. Extent and nature of injury/surgical procedure
    1. Degree to which tissue has been injured or surgical dissected
    2. Clean, approximated and uncomplicated wounds
    3. Contaminated, accidental wounds

F. Age and physical condition
    1. Wound healing is delayed due to the overall slowing down of body system.
    2. Conditions such as atherosclerosis, cardiopulmonary disease, renal pathology and immobility often associated with the aging process will delay wound healing.
G. Presence of drainage - possible complication
    1. Healthy skin surrounding the wound may become over-hydrated, macerated and susceptible to breakdown.
    2. May increase the need for additional dressings.
    3. Client may experience doubt and apprehension, with a possible impact on convalescence.
    4. Sudden profuse drainage of clear, pale pink fluid saturating the dressing on an abdominal wound may indicate wound dehiscence.
    5. Sudden bloody drainage is a sign of hemorrhage.
    6. Increase in viscosity, a strong and unpleasant odor and a color change may indicate infection

XV. **Various types of wound dressings**
A. Primary dressings
    1. Placed directly on the wound and the adjacent to the skin.
    2. Wick away drainage (exudate) from wound.
    3. Preserve a moist environment between the wound margins.
B. Secondary dressings:
    1. Placed over primary dressing
    2. Provide compression
    3. Provide protection

XVI. **Various wound dressings according to specific qualities**
A. Non-occlusive
    1. Absorbent, ventilated
    2. Woven or non-woven material
B. Occlusive
    1. Tightly woven gauze material heavily impregnated with a petrolatum emulsion
    2. Does not allow the passage of air or fluid to or from the wound.
C. Semi-permeable (semi-occlusive)
    1. Transparent, waterproof, plastic film
    2. Barrier to external fluids and bacteria
    3. Permeability allows skin to "breathe"
    4. Helps prevent wound dehydration
    5. Allows for inspection of the wound without removing dressing, which may decrease the number of dressing changes.
D. Non-adhering
    1. Designed not to stick to the wound site or skin
    2. Must be used in conjunction with a primary dressing in the presence of drainage.
E. Medicated
    1. Contains medication
    2. Can be applied by the manufacturer or the medical health care provider.
    3. Used primarily to treat skin ulceration, burns and some postoperative infections.
F. Conforming bandages
    1. Secondary bandages
    2. Provide compression
    3. Hold primary dressing in place
    4. Increase absorbency

XVII. **Dynamics of wound healing**
A. First 24-72 hours are marked by the inflammatory and repair processes.
    1. Wound begins to seal
    2. Critical phase
B. Sequence of events
    1. Blood vessels release blood which fills the wound area.
    2. Blood components, called platelets, form a clot which helps create stasis in surrounding small vessels, preventing hemorrhage at site.
    3. Scab begins to form on the surface of the wound.
        a. Usually begins to form within 2 hours
        b. Composed of dried blood proteins
        c. Provides a natural seal to prevent invasion of pathogens.
    4. Plasma and white blood cells escape through the walls of the nearby blood vessels and enter the wound site.
        a. Plasma contains proteins which are needed for the formation of new cells.
        b. White blood cells – phagocytosis
    5. Granulated forms to fill the gaps and allow epithelial cells to migrate.
    6. Proliferation of cells within the wound closes the surface of the wound under the scab.
    7. The scab sloughs off and newly formed skin tissue is exposed.

XVIII. **Postoperative wound complications**
A. Infection
    1. Contamination of a wound

2. Recall signs and symptoms of infection.
3. Prevention is aimed at:
    a. Utilizing medical asepsis
    b. Patient education

B. Dehiscence
1. Bursting open of the wound
2. Most frequently seen in surgical abdominal wounds.
3. Prevention is aimed at:
    a. Assessing nutritional status and risk factors such as obesity
    b. Support for the wound during coughing and movements that may strain the incision

XIX. **Types of wounds based on cause**

A. According to manner in which it is made
1. Incised
    a. Made by a clean cut with a sharp instrument.
    b. Example: surgeon's incision with a scalpel
2. Contused
    a. Made by blunt force
    b. Skin remains intact
    c. Causes soft tissue damage
    d. Example: bruises
3. Lacerated
    a. Made by an object that tears tissues
    b. Results in jagged irregular edges
    c. Example: blunt knife, glass
4. Puncture
    a. Made by a pointed device.
    b. Example: ice pick, bullet, knife stab, nail

B. Surgical classification
1. Clean
    a. Aseptically made wound
    b. Blood vessels have been ligated
2. Contaminated
    a. Exposed to excessive amounts of bacteria
    b. Not grossly infected and have a higher risk for infection than other wounds.
    c. Examples: unprepared colon surgery, dirty laceration
3. Infected
    a. Contains bacteria
    b. Cannot be closed as it may contain devitalized material

XX. **Closed wound and an open wound**

A. Closed wound
1. Integrity of skin remains intact.
2. Reduces risk of infection due to contamination.

B. Open wound
1. Integrity of skin has been interrupted.
2. Increase in risk of contamination

XXI. **Reasons a physician might choose to dress a wound**

A. To protect the wound from mechanical injury
B. To absorb drainage and fluid wastes
C. To promote homeostasis and minimize accumulation of fluid, as in a pressure dressing
D. To prevent contamination from bodily discharges
E. To inhibit or kill organisms by using dressings that contain antiseptic medications
F. To reduce the risk of contamination from the environment

XXII. **The advantages and disadvantages of dressing a wound**

A. Advantages
1. Reduces the risk of infection
2. Protects the wound from mechanical injury
3. Absorbs drainage and fluid wastes

B. Disadvantages
1. Provides bacteria with growth requirements
2. Expense of dressings

XXIII. **The functions of a bandage and guidelines when applying a bandage**

A. Functions
1. Apply pressure to control bleeding.
2. Holds a dressing in place
3. Protects dressings and wounds from contamination.
4. Immobilize an injured body part.

B. Application guidelines

1. Maintain medical asepsis – prevent the transfer of pathogens into the wound.
2. Keep area to be bandaged dry and clean
    a. Moisture encourages the growth of pathogens.
    b. Moist dressing will be uncomfortable to client.
3. Do not place bandage directly over a wound.
    a. Apply a sterile dressing first.
    b. Bandage should extend approximately 1-2 inches beyond the edge of the dressing.
4. Do not allow skin surfaces of two body parts to touch each other. During wound healing opposing surfaces may adhere and result in scar tissue.
5. Pad joints and any body prominence – reduces irritation caused by the bandage rubbing against the skin over a bony area.
6. Bandage the affected part in the normal position -joints should be slightly flexed to avoid muscle strain, discomfort and pain.
7. Apply bandages beginning at the distal part and extending to the proximal part of the body.
    a. Aid in the return of venous blood to the heart
    b. Blood flow and valves in the veins
    c. Help make the bandage more secure
8. When bandaging hands and feet, leave fingers and toes exposed if possible – check for circulatory impairment, such as:
    a. Coldness
    b. Pallor
    c. Cyanosis of nail beds
    d. Swelling

XXIV. **The role and responsibilities in minor office surgery**

A. Medical assistant administrative role in minor surgical procedures
B. Medical assistant clinical role in minor surgical procedures
C. Guidelines the medical assistant must follow during a sterile procedure

1. **Five main components of the circulatory system**
    A. Heart – acts as pump to circulate the blood
    B. Arteries - the vessels that carry blood away from the Heart
    C. Veins – the vessels that return blood to the heart
    D. Capillaries – the microscopic vessels where exchange between the blood and the body's tissue take place
    E. Blood – the fluids and cells that are circulated to carry oxygen and nutrients to tissues and wastes away from tissues
2. **The circulation of blood and the pulmonary system**
    A. Located in the center of the thoracic cavity
    B. Muscular organ, the size of your fist
    C. Four chambers
        1. Right atrium
        2. Left atrium
        3. Right ventricle
        4. Left ventricle
3. Heart mechanism
    1. Atria contract at the same time
    2. Blood forced into the heart's lower chambers
    3. Ventricles contract simultaneously to pump blood out of heart
4. Path of the blood flow
    1. Right atrium
    2. To right ventricle which pumps blood to lungs via pulmonary arteries
    3. Returned to the heart, via pulmonary veins
    4. Blood re-enters heart in the left atrium
    5. To left ventricle which pumps the blood to aorta, which carries oxygenated blood to the body tissue
5. Pulmonary circulation
    1. Blood enters lungs via the pulmonary arteries
6. Very low in oxygen
7. Carrying waste carbon dioxide
    1. Air enters body via the nose through the trachea
    2. Air passes into lungs via the bronchioles
    3. Wastes are exchanged from the blood with fresh oxygen at the alveoli
8. **Major causes of cardiac arrest**
    1. Heart disease
        1. Risk factors
    2. High blood pressure
    3. Elevated cholesterol and triglyceride
    4. Cigarette smoking
    5. Obesity
    6. Stress
        1. Disease process
    7. Atherosclerosis
    8. Coronary artery spasm

9. Myocardial infarction
9. Drowning
10. Electrocution
11. Suffocation
12. Drug intoxication
13. Trauma
14. **Management of a patient with chest pain**

A. Chest pain
   1. May have existed for several days before presenting to the doctor's office.
   2. Usually patient has one or more risk factors for cardiac disease.
   3. Risk factors
      a. Hypertension, previous MI, History of Coronary artery bypass graft (CABG), Coronary artery disease (CAD).
      b. Hypercholesterolemia, LDL and HDL abnormalities, and atherosclerosis.

B. Primary approach to patient with chest pain
   1. Notify MD and RN to assess patient.
   2. Ask patient if they have medication for chest pain (Nitroglycerine-NTG) and instruct them to take it as prescribed.
   3. If MD or RN not available, follow protocol for notifying Emergency Medical System (EMS). If in an outpatient setting, call 911 immediately.
   4. Get AED or send someone to get it.
   5. Place patient in low or high fowlers position if tolerated and or a position of comfort.
   6. Loosen clothing – or assist patient with a hospital gown (for EKG)
   7. Reassure patient in a calm manner.
   8. Take vital signs.

C. Gathering data about chest pain (if registered nurse or doctor not available, while waiting for EMS)
   1. Onset
   2. Activity at onset – what waste patient doing
   3. Location
   4. Severity/intensity (scale 1-10)
   5. Duration/Quality (length/time of pain, pressure, jabbing?)
   6. Radiation
   7. Associated symptoms
   8. Review any history of previous chest pain episodes and compare to current experience
   9. Assess for any mechanism of injury

D. Subjective signs and symptoms (what patient reports or demonstrates as discomfort),
   1. Central chest pain, substernal, or crushing pain
   2. Pressure, tightening, heaviness, cramping, burning, aching sensation
   3. Pain radiating to the neck , jaw, back and/or arms
   4. Shortness of breath (SOB)
   5. Nausea and/or vomiting
   6. Diaphoresis

E. Objective signs and symptoms: (what the patient physically manifests and you observe during data collection)
   1. Increased blood pressure.
   2. Diaphoresis
   3. Dilated pupils
   4. Restlessness
   5. Shortness of breath
   6. Anxiety
   7. Facial mask of pain, chest or throat guarding (patient defending airway).
   8. Crying or moaning.

XLI. Job Preparation and Success Skills

A. Obtain and maintain employment

1)Job market issues and prepare an organized plan of action for a job search.
2)Job descriptions or titles that match individual areas of experience and training.
3)Networking activities utilizing newspapers, internet, community agencies and personal contacts.
4)Advantages and perils of internet applications
5)"Dress for Success."
6)Employers in person, by telephone, fax or letter of interest to arrange interviews for employment.
7)Portfolio, professional resume, and cover letter.
8)In depth employment interview and questions.
9)Business thank you notes.
10) Application for employment utilizing a "master application".

Lab Outline

I. Examinations:
A. Routine physicals
B. Specialty examinations
II. Patient interviews
III. Medical history **forms and documentation**

A. Chief complaint (cc)
B. Present illness (P.I.)
C. Past medical history
    1. Childhood diseases
    2. Major illness
    3. Injuries
    4. Hospitalization
    5. Surgeries
    6. Allergies
    7. Immunizations
    8. Current medications
        a. Prescription
        b. O.T.C.
D. Family medical history (blood relative)
E. Personal history (lifestyle patterns)
F. Assessment of body systems (ROS)
G. Other areas your physician / institution has deemed your responsible

IV. Minor surgery
A. Prepare and maintain the surgical area

1. Instruments in performing minor surgeries
2. Setting up and maintaining a sterile field
3. Sterile pack

B. Surgical prep for post operative wounds

1. Techniques for preparing the patient's skin for minor surgery.
2. Types of anesthetics most frequently seen in minor procedures.
3. Methods of skin closure performed in the medical office.
4. Techniques used for removal of sutures and surgical staples.
5. Instruments used for minor surgery
6. Informed consent form.
7. Surgical asepsis
8. Set up a sterile field.

V. Wound care
A. Supplies needed to change a non-sterile and sterile dressing
1. Sterile gloves or sterile transfer forceps
2. Sterile dressings
3. Scissors
4. Appropriate bandages and tapes
5. Medication to be applied to the dressing as ordered

B. The removal and application of a non-sterile dressing
1. Don non-sterile exam gloves.
2. Have appropriate waste receptacle at hand.
3. Remove tape, pulling gently towards the center of the dressing.
4. If dressing adheres to wound, saturate with sterile normal saline to loosen dressing.

C. Wound culture
1. Written order
2. Assemble the equipment – culture kit with transport media
3. Do not clean the wound prior to culturing as this may remove contaminates

D. Documentation
1. Date and time of procedure
2. Wound and drainage observations
3. Approximate size of the wound
4. Description of the wound and surrounding tissue
5. Description of drainage if present
6. Client reactions

VI. Emergency Procedures
A. Chest pain
B. Airway obstruction
C. Stroke
D. Shock
E. Chest compressions
VII. Positioning and draping patients

A. Anatomic position
B. Sitting position
C. Supine (recumbent, horizontal recumbent)
D. Dorsal recumbent
E. Lithotomy
F. Trendelenberg
G. Semi-Fowler's
H. Fowler's
I. Prone
J. Sim's (lateral Sim's)
K. Knee-chest
L. Proctologic
M. Jackknife

Delivery Methods and Distance Education

Delivery Method: Please list all that apply -Face to face -Online (purely online no face-to-face contact) -Online with some required face-to-face meetings ("Hybrid") -Online course with on ground testing -iTV – Interactive video = Face to face course with significant required activities in a distance modality -Other

Face 2 Face
Hybrid
Interactive

Rigor Statement: Assignments and evaluations should be of the same rigor as those used in the on-ground course. If they are not the same as those noted in the COR on the Methods of Evaluation and out-of-class assignments pages, indicate what the differences are and why they are being used. For instance, if labs, field trips, or site visits are required in the face to face section of this course, how will these requirements be met with the same rigor in the Distance Education section?

No Value

Effective Student-Instructor Contact: Good practice requires both asynchronous and synchronous contact for effective contact. List the methods expected of all instructors teaching the course. -Learning Management System -Discussion Forums -Moodle Message -Other Contact -Chat/Instant Messaging -E-mail -Face-to-face meeting(s) -Newsgroup/Discussion Board -Proctored Exam -Telephone -iTV -Interactive Video -Other (specify)

contact_moodle_forums
contact_moodle_message
contact_chat
contact_email
contact_face2face
contact_proctored
contact_phone
contact_itv

Software and Equipment: What additional software or hardware, if any, is required for this course purely because of its delivery mode? How is technical support to be provided?

eBooks

Accessibility: Section 508 of the Rehabilitation Act requires access to the Federal government's electronic and information technology. The law covers all types of electronic and information technology in the Federal sector and is not limited to assistive technologies used by people with disabilities. It applies to all Federal agencies when they develop, procure, maintain, or use such technology. Federal agencies must ensure that this technology is accessible to employees and the public to the extent it does not pose an "undue burden". I am using -iTV—Interactive Video only -Learning management system -Publisher course with learning management system interface.

s508_itv
s508_moodle
s508_publisher

Class Size: Good practice is that section size should be no greater in distance ed modes than in regular face-to-face versions of the course. Will the recommended section size be lower than in on-ground sections? If so, explain why.

20