

## Case Study: Preschool-Age Child with Cerebral Palsy / Diplegia / Constipation

**1. CASE AUTHORS**

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**2. TOPIC OF THE CASE:**

Preschool-Age Child with Cerebral Palsy / Diplegia / Constipation

**3. LEVEL OF EXAMINEE THIS CASE IS BEING WRITTEN FOR:**

Nurse Practitioner

**4. CATEGORY OF CLINICAL PROBLEM THIS CASE ADDRESSES:**

<input type="checkbox"/> Acute Serious	<input type="checkbox"/> Psychiatric/Behavioral
<input checked="" type="checkbox"/> Acute Limited	<input type="checkbox"/> Well-Care/Prevention
<input checked="" type="checkbox"/> Chronic Subacute	<input type="checkbox"/> Other:

**5. PURPOSE OF THIS CASE:**

Teaching  Assessment  With Feedback

**6. TIME ALLOTTED FOR ENTIRE TASK (includes SP/examinee encounter + interstation activity):  
FIFTEEN MINUTE STATION W/SP + 5 MIN INTERSTATION**

**7. DISTRIBUTION OF TIME AND TASKS**

Divide time allotted into tasks required of the examinee:

Check off skills this case is intended to evaluate or teach:	Estimate # min you believe examinee needs to perform each task:
<input checked="" type="checkbox"/> Data Gathering (History-Taking)	5 min.
<input checked="" type="checkbox"/> Education	2 min.
<input checked="" type="checkbox"/> Physical Examination	5 min.
<input checked="" type="checkbox"/> Advise Patient of Diagnosis	2 min.
<input checked="" type="checkbox"/> List of Different Diagnoses	1 min.
<input checked="" type="checkbox"/> Feedback from SP	5 min.

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**8. FACILITY/ROOMS RESERVED FOR THIS ACTIVITY:**

- Clinical Learning Lab/ SP Rooms                       Seminar Rooms  
 Auditorium     Campus  
 Other:

**9. INTERACTION FORMAT:**

Participants

- 1 Trainee, 2 SP     With SP Feedback     With Videotape

**10. SETTING OF THE INTERACTION:**

- Family practice office     Nurse practitioner care

**11. FURNISHINGS IN THE EXAM ROOM:**

Desk, Chairs, and Exam Table

**EQUIPMENT/PROPS IN THE EXAM ROOM:**

- X-Ray View Box     X-Ray Calipers     Reflex Hammer  
 Stethoscope     Tuning Fork     Neuro Exam Kit  
 Cardiac Monitor     Roll Board     Crutches  
 I.V. Pole + Solution     Collar - Type:  
 Other:

**EQUIPMENT/PROPS AT THE STUDENT CARRELS:**

- X-Ray View Box     X-Ray Calipers  
 Other:

**12. LIST POSSIBLE DIFFERENTIAL DIAGNOSES (asterisk actual diagnosis):**

- \*Constipation  
Obstruction  
Motility Disorder  
\*Diplegia

**13. PHYSICAL CHARACTERISTICS THE ACTUAL SP SHOULD HAVE:**

- Gender:                       Male                       Female     Immaterial  
Age:                                      Range 4 years     Immaterial  
Race/Ethnicity:     Immaterial  
Body Type:                       Slender                       Average                       Overweight     Immaterial  
Ideal Height/Weight:     Immaterial

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14. **ESSENTIAL "REAL" PHYSICAL FINDING(s) OR ATTRIBUTES THE SP SHOULD HAVE:**  
None.
15. **PHYSICAL FINDINGS THE SP SHOULD NOT HAVE:**  
Cardiac or Respiratory Abnormalities.
16. **PHYSICAL EXAM REQUIRED:**  
 Abdominal  Respiratory  
 Cardiac
17. **CASE REQUIRES THE SP TO SIMULATE THE FOLLOWING PHYSICAL FINDINGS:**  
 Abdominal distention  Lower limb mild spasticity

### INSTRUCTIONS FOR THE EXAMINER

**CASE INFORMATION:** This 4 year old has been followed in the practice for 2 years. This is your first encounter. He is accompanied by his mother. The patient was born 3 weeks premature, and diagnosed with diplegia/cerebral palsy. No history of seizures. No siblings, lives with mother and father. Immunizations UTD. Medications: Ht: 35 inches; Wt: 30 lbs; Temp: 99; HR: 90; RR: 20; BP: 100/65

**DURING THE ENCOUNTER:**

- Obtain a focused and relevant history
- Perform a focused and relevant physical exam
- Offer some initial recommendations to the patient and parent (see NOTE immediately below)

*The task in this case is to assess the GI status of a 4 year old boy, using history-taking with child and parent and physical examination.*

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### STANDARDIZED LIFE SKETCH

18. **Setting of Encounter:** Family Practice Office  
**Child SP:** Seated on the exam room fully clothed.  
**Mother of SP:** Sitting in chair next to the exam table.

#### EXAMINER WASHES HANDS ON ENTERING EXAMINING ROOM

19. **What do you want the SP to say to the examinee's first query:**  
*Parent SP: "I hope you can help. I know we were just here a couple of months ago for his checkup, but now he seems to be constipated. He hasn't had any problems since we were here until now."*
20. **IF THE EXAMINER REMAINS SILENT**, or acts as if waiting for more information, or asks an open-ended question:  
*Parent SP: "I'm really nervous. I don't know what to do for him."*
- IF THE EXAMINER ASKS THE CHILD SP: "How are you feeling today?"**  
*Child SP: "Ok."*

#### A. HISTORY OF PRESENT ILLNESS/DIMENSIONS OF SYMPTOMS:

21. Expand on your history and characteristics of major symptoms from onset to present in the form of a time line; *if pain, please include:* onset, duration, location, quality, radiation, intensity, exacerbating, alleviating, past experience w/symptom(s).

#### HISTORY GIVEN BY PARENT SP AND CHILD SP:

*Parent SP: "He hasn't had a bowel movement for at least a week!"*

**IF THE EXAMINER ASKS: "What time does he go to bed and wake up?"**

*Parent SP: "At 7:30 every night and wakes up at 7 every morning."*

**IF EXAMINER ASKS: "How is his mood?"**

*Parent SP: "Fine. He doesn't seem to be bothered."*

**IF THE EXAMINER ASKS: "What have you tried so far to help him?"**

*Parent SP: "I've been giving him more water and I've tried applesauce too. He likes applesauce and bananas best."*

**IF THE EXAMINER ASKS: "Has anything else changed?"**

*Parent SP: "He isn't eating as much as usual. He was grunting the last time he went to the BR."*

**IF THE EXAMINER ASKS: "Has anything changed at home? Or has anything upset him that you know of?"**

*Parent SP: "Not that I know of."*

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**IF THE EXAMINER ASKS:** *"What therapies is he receiving?"*

Parent SP: *"Physical therapy, occupational therapy and speech therapy 5 times a week! It wears both of us out."*

**IF THE EXAMINER ASKS, PARENT SP RESPONDS TO THE FOLLOWING QUESTIONS:**

Belly pain:

Child SP: *"No, but it hurts when I go to the bathroom."*

Pain anywhere else:

Child SP: *"No."*

Fever:

Parent SP: *"No."*

Any diarrhea before being constipated:

Parent SP: *"No."*

Has he passed any blood or mucus within the last few weeks:

Parent SP: *"No."*

Has he passed gas:

Parent SP: *"No."*

How many times a day do you eat:

Parent SP: *"He usually snacks all day but I think he is eating less."*

22. **IF THE EXAMINER ASKS** about exercise:

Parent SP: *"He is still playing like he usually does."*

**IF THE EXAMINER ASKS** if he uses an assistive device to walk:

Parent SP: *"No but he walks funny and I am afraid he is going to fall. They said he doesn't need braces or anything like that."*

23. **Psychosocial consequences: How does the problem influence or affect the pt?**

**IF THE EXAMINER ASKS:**

Parent SP: *"I don't think he notices!?! But I am really concerned that I am not doing something right."*

24. **Response to symptoms: What has the patient done about the symptoms (other than seeking health care)?**

**IF THE EXAMINER ASKS:**

Parent SP: *"I've been giving him more water and applesauce. My mother recommended that."*

25. **Meaning of the illness: patient's ideas/feelings about causes, implications, fears about problem/illness?**

Parent SP is upset but the child SP has no reaction.

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### B. PAST MEDICAL HISTORY: HISTORIAN: PARENT SP AND CHILD SP

#### 26. Medical:

Parent SP: *"No problems until now."*

Birth: *"I had him when I was 18. My pregnancy was normal but he was premature and I don't know why. He is my only child. You know he has all of his shots. I just don't know what I am doing wrong. I noticed that he didn't move around the same as other babies when he was about 1 and by 2 I knew something was not right because he wasn't walking yet. He started pulling himself up and walking around 3 to 3 1/2."*

#### 27. Surgical:

Parent SP: *"No."*

#### 28. Chief Complaint: He has not pooped for a week.

#### 29. Allergies:

Parent SP: *"None that I know of."*

#### 30. Medications:

Parent SP: *"A multivitamin. The doctor is considering a muscle relaxer but hasn't decided yet."*

### D. FAMILY HISTORY:

#### 31. Current and past health of parents, sibs, adolescent:

Parent SP: *"There is no history of anything like that that I know of. His grandparents are very healthy."*

#### 32. Deaths: dates and age at death of family members:

Parent SP: *"Why are you asking me these silly questions? Everything is in his chart. We have been coming here for two years! Just tell me what is wrong!"*

### E. PSYCHOSOCIAL HISTORY

Present/Past:

#### 33. Marital status:

Parent SP: *"His father thinks I am being silly about this and we've had a couple of arguments."*

#### 34. Home Environment:

Parent SP: *"We live in a single family home with a big yard for my son to play in. He has his own bedroom next to our bedroom."*

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37. Tobacco/alcohol/illicit drug use?:

N/A

38. Significant events in pt's life: stresses, pleasures, death, divorce, financial hardships?:

Parent SP: *"My husband did lose his job a couple of months ago but he found another one two weeks ago. All of this running back and forth to the therapists is tiring and costing money that we don't really have."*

39: Employment:

Parent SP: *"I don't work anymore so I can be home with my son."*

### F. MENTAL STATUS EVALUATION

42. Past psychiatric history?

No.

43. Anxiety?

No.

44. Mood changes?

No.

45. Memory or cognitive changes?

No.

46. Disturbing thoughts or ideas?

No.

47. Other?

No.

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### G. FUNCTIONAL STATUS:

49. Pt able to take care of daily activities? (school, dressing, washing self?)

SP: *"He needs a lot of help walking and dressing himself."*

### H. OTHER:

50. Other than HPI, any other medical/psychosocial problems the pt is currently facing?

SP: *"No. He gets along well with other children."*

51. What is your biggest worries/main concerns?

Parent SP: *"Find out why he hasn't had a bowel movement. Tell me what I am doing wrong."*

52. Patient expectations: what does the patient expect/want from health care provider?

Child SP is unaware of problem

53. Child SP Appearance: clothing, grooming, etc. (ex: neat, disheveled, in hosp. gown, etc., or: clothing and/or appearance unimportant to the case)?

Sitting on exam table in undershirt, pants, socks and shoes with legs splayed.

54. Affect/Behavior: body language, mannerisms, eye contact, angry, sad, talkative, nervous, happy to see NP today?

Child SP is pleasant, while Parent SP is anxious.

55. Do any questions posed by the examinee change the SP's appearance or affect (disturb either of the SPs or make either sad, fearful, reassured)?

No.

56. Creating empathic opportunities: what do you want the SP to say, or what kind of behavior would create an opportunity in this case, for the examinee to express empathy?

Parent SP: *"Yes, my whole life is just taking care of my son to get him to all of his appointments."*



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### SKILLS PERFORMED

- 1) Addresses parent and child
- 2) Takes adequate health history
- 3) Inspects pt head to toe
- 4) Inspects and auscultates anterior, posterior and lateral lung fields
- 5) Auscultates heart sounds
- 6) Performs complete abdominal assessment: inspect, auscultate, palpate and percuss
- 7) Assess musculoskeletal system

### CONTENT CHECKLIST

#### Category 1. Data gathering. I TOLD THE EXAMINER or /THE EXAMINEE ASKED ABOUT:

- 1) Past medical and psycho-social history from parent and child
- 2) History of present chief complaint including onset and duration
- 3) Management of problem
- 4) Immunizations
- 5) Diet and activity
- 6) Allergies
- 7) Medications
- 8) Behaviors
- 9) Living environment
- 10) Management of CP – (therapies, home management)

#### PHYSICAL EXAM EVALUATION: did the examinee perform:

- |   |   |
|---|---|
| <input type="checkbox"/> Head to toe inspection     | <input type="checkbox"/> Anterior, posterior and lateral respiratory assessment |
| <input type="checkbox"/> Cardiac assessment         | <input type="checkbox"/> Abdominal assessment                                   |
| <input type="checkbox"/> Musculoskeletal assessment |   |

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### **SKILLS CHECKLIST**

#### **I. DATA GATHERING SKILLS**

Did the examinee ...

- 1) Provide a safe environment for the child?
- 2) Allow the Parent and Child SP to finish opening statement without interruption?
- 3) Ask the chronology of the present concern from the beginning until now?
- 4) Use "open-to-close cone" question style?
- 5) Repeat or summarize information I've given at least once?

#### **II. INTERPERSONAL SKILLS**

Did the examinee...

- 6) Offer encouraging, supportive or empathic comments?
- 7) Demonstrate attentive listening?

#### **III. INFORMATION GIVING SKILLS**

Regarding the parent SP: Did the examinee...

- 8) Explain reasons for recommendations?
- 9) Ask about barriers to adherence?
- 10) Check my understanding at least once and/or solicit the parent's questions?
- 11) Use language I can understand?

#### **IV. ORGANIZATIONAL SKILLS**

Did the examinee...

- 12) Demonstrate organizational skills during the entire encounter?

#### **V. PATIENT SATISFACTION**

- 13) Overall, I was satisfied with this NP/patient interaction