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|  | CAP Competency Table |  |
| ***HISTORY*** | ***Preceptor e-verification*** |
|  | Complete History |  |
| ***EXAM*** |  |
|  | Annual Physical Exam |  |
|  | HEENT Exam |  |
|  | Neck Exam |  |
|  | Cardiovascular Exam |  |
|  | Pulmonary Exam |  |
|  | Abdominal Exam |  |
|  | Neurologic Exam |  |
|  | Extremity Exam |  |
| ***ADVANCED COMMUNICATION*** |  |
|  | Establish Rapport |  |
|  | Oral Case Presentation |  |
| ***OFFICE SKILLS*** |  |
|  | Intro/Room Patients (MA/RN) |  |
|  | Point of Care Information Mastery |  |
| ***DOCUMENTATION*** |  |
|  | SOAP Note |  |
|  | Medication Reconciliation |  |

# CAP Competency Checklists

**History**

**Complete History**

* History of present illness: open-ended questions plus pertinent (+) and (-)
* Elicits PMH (including PSH)
* Confirms medications and dosages
* Elicits allergies to medications
* Elicits social history
* Elicits family history
* Elicits cultural history

**Exam**

**Annual Physical Exam**

* General appearance and vitals
* HEENT
* Neck
* Cardiovascular
* Pulmonary
* Abdomen
* Extremities/musculoskeletal
* Neurological

**HEENT Exam**

* H: Inspects scalp
* E: Checks pupillary response, extra-ocular movements, fundi
* E: Inspects ears with otoscope
* N: Inspects nose/nasal mucosa, percusses sinuses
* N: Palpates lymph nodes
* T: Inspects mucous membranes, posterior pharynx, tonsils

**Neck Exam**

* Palpates for lymphadenopathy
* Palpates thyroid from behind (with swallow)
* Checks neck range of motion (supple, not rigid)
* Palpates and auscultates carotids

**Cardiovascular Exam**

* Determine height of jugular veins
* Auscultate and palpate carotid arteries
* Determine location of PMI
* Auscultate all four cardiac areas with bell and diaphragm
* Palpate the aorta’s outline/listen to renal arteries
* Check peripheral pulses (PT, DP, radial, femoral)
* Check for peripheral edema

**Pulmonary Exam**

* Observes respiration (accessory muscle use)
* Auscultates each lung lobe
* Percusses all lung lobes
* Checks for egophony

**Abdominal Exam**

* Positions patient supine with arms by side
* Inspects abdomen
* Auscultates for bowel sounds – until heard or two minutes
* Auscultates for renal and aortic bruits
* Palpates all four quadrants with superficial and deep palpation
* Percusses in all four quadrants
* Checks for organomegaly
* Check for peritoneal signs

**Neurologic Exam**

* Comments on alertness and orientation
* Examines CN II-XII
* Checks motor strength (upper and lower for tone, bulk, power)
* Checks sensation of light touch (& as appropriate: pinprick, vibration, position)
* Checks reflexes (biceps, triceps, brachioradialis, patella, ankle)
* Checks coordination as appropriate(Romberg, heel shin, FNF, RAFM)
* Assesses gait
* Cites familiarity with cognitive exam tools (e.g MMSE, MOCA or mini-cog)

**Extremity Exam**

* Inspects for discoloration, deformity, muscle atrophy
* Palpates and name bones, muscles, tendons, spaces
* Checks active range of motion in all directions
* Checks strength
* Checks for vascular compromise (pulses and skin color)

**Advanced Communication**

**Establish Rapport**

* Allows patient to express reason for visit
* Shows attentive listening by reflecting, summarizing, not interrupting
* Identifies patient’s chief concern within his/her life story
* Demonstrates non-verbal communication w/warm tone and posture
* Elicits patient’s beliefs, concerns, and expectations about illness
* Names patient’s strongest emotions and asks patient to expand
* Asks, “Is there something else you would like to discuss?”

**Oral Case Presentation**

* Begins with one-sentence summary (name, age, cc)
* Continues w/HPI (pertinent positives/negatives related to illness)
* Briefly lists relevant PMH/FH/SH
* Includes focused physical exam findings
* Offers a provisional diagnosis/diagnoses with rationale
* Offers a therapeutic or diagnostic plan
* Presents information in the proper order

**Office Skills**

**Intro/Room Patients with MA/RN**

* Identifies the roles of the healthcare team
* Calls patient from waiting room as instructed to by office staff
* Student gives own first & last name, identifies self as student
* Asks how patient wishes to be addressed
* Directs patient to room
* Obtains and documents vital signs
* Notifies doctor patient is ready/asks patient if ok to interview
* Works alongside another member of the healthcare team

**Information Mastery**

* Can formulate PICO (patient, intervention, control, and outcome) question
* Identifies patient-oriented evidence
* Lists evidence-based information sources (dynamed, BMJ, cochrane)
* Accesses evidence to answer a clinical question in real time

**Documentation**

**SOAP Note**

* Subjective: Documents each concern in patient’s words
* Objective: Documents vitals, pertinent exam, labs/tests
* Assessment: List each problem with ddx and rationale if needed
* Plan: Documents management plan for each problem
* Each concern in subjective section has associated plan

**Medication Reconciliation**

* Elicits list of medications from patient
* Verifies doses and timing
* Verifies indication for each med with patient
* Inquires about meds from other prescribers
* Inquires about herbs/supplements
* Removes meds no longer taken
* Determines medication adherence