



Training Manual

U C C
UNITED COMMUNITY CLINICS

VOLUNTEER MANUAL

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MISSION STATEMENT

The United Community Clinics is a collaborative effort from the University of Pennsylvania's Schools of Dental medicine, Medicine, Nursing, and Social Work. United Community Clinics draws upon the resources and expertise of diverse students and professionals to offer a wide range of services to the surrounding community. It is our goal to develop an understanding of the community's needs and respond to these needs by providing health care and social services, education programs, and other appropriate services.

CODE OF PRACTICE

In the spring of 2000, students from the dental, medical, nursing and social work clinics created a Code of Practice defining the standards guiding every interaction with UCC clients.

Our obligation to our clients is to:

- respect our clients' right to confidentiality, quality care, timely service, a comfortable environment, and sound referrals
- emphasize the strengths of our clients
- value cultural diversity
- provide an alternative experience to existing health care choices
- recognize the dignity and worth of all
- promote the independence and empowerment of our clients.

In fulfilling this obligation, each of us will strive to:

- collaborate with and learn from the colleagues, clients and professionals with whom we work
- conduct ourselves in a professional manner
- hold ourselves to the high standard of care that each individual deserves
- act as a resource and a partner in our clients' care
- focus on constant service improvement
- make good use of volunteers' time
- have the courage to challenge ourselves
- hold ourselves accountable to the UCC Code of Practice.

GETTING TO UCC

UCC is located in the East Parkside neighborhood of West Philadelphia, in the First African Baptist Church at 4159 Girard Avenue (at 42nd Street).

Shuttle

A Penn van leaves from between Johnson Pavilion and the Nursing Education Building every Monday evening at 5:30 pm and returns from clinic usually by 8:30 pm.

Directions

If you are driving, head west from Penn on Walnut or Market. Turn right (north) on 42nd Street. Take 42nd about 10 blocks until it dead-ends at Girard. Turn left on Girard, pass the church, then turn right onto Belmont Avenue. Take your next right onto Stiles Street then another right onto 42nd Street. The church entrance is on your left. Street parking is usually available there. Be sure to be at clinic by 5:45 pm.

CONTACTS

Website

For information about UCC, start here: <http://www.med.upenn.edu/ucclinic/>. This is where you will find the scheduler, coordinator contact information, special events, clinic schedule, this manual, and more.

Your coordinators can answer any other questions or concerns you may have. Feel free to contact them at any time and ****especially if you will not be able to make a scheduled visit to clinic.****

UCC Cell Phone

UCC has a cell phone that is used primarily to receive messages from clients. The voicemail message outlines when and where clinic is held. Clients can leave a message if they need more information. The voicemail is checked before clinic each week. The number is 215.704.2782.

UCC SERVICES

MEDICAL/NURSING CLINIC

The clinic operates primarily as a referral center providing basic screening tests and physical exams for school sports, employment, and driver's licenses. Each client will be given a full history and physical. Before you begin your history and physical, take a minute to peruse the form the client needs filled out to make sure we can provide what is needed. If you are unsure, run it by a coordinator first.

Services we provide:

- physicals for driver's license or permit except for bus or truck drivers
- sports physicals
- most employment physicals
- tuberculosis screening (a.k.a. PPD or Mantoux test)
- blood glucose screening
- hypertension screening
- free and anonymous HIV testing
- flu shots (in the fall)

Services we do not provide:

- bus driver's license physicals
- City of Philadelphia School District physicals for teachers
- physicals for disability declarations (Employment Assessment Forms, etc.)
- all other bloodwork (cholesterol, lead, toxicology screening, etc.)
- immunizations other than flu shots
- x-rays
- gynecological exams
- STI tests
- pregnancy tests

For more information on running the clinics, or the history and physical exam, see pages 6-14.

SOCIAL WORK CLINIC

The Social Work clinic provides counseling services and referral information regarding, among other areas, housing, child care, employment, domestic violence, substance abuse treatment, health insurance, and mental health and dental care.

DENTAL CLINIC

Students from the School of Dentistry come to UCC once a month and are supervised by Dr. Joan Glutch. Students can see approximately 6 patients each night. The dental clinic provides dental exams, dental referrals, oral health education, and free supplies (toothbrushes, toothpaste, and dental floss).

VISION CLINIC

Students from Penn's Scheie Eye Institute come to UCC once a month and provide eye exams and referrals. Patients seen at the vision clinic can follow up at Scheie to get glasses and a complete exam, which will be billed to their insurance if they are covered or are offered free of charge if the patient is uninsured

RUNNING THE CLINICS

The main objectives (and approximate order) for getting clinic started are:

- starting intake: this is done by social work students as soon as we arrive. They see each patient individually to determine what their needs are, then bring them downstairs to the waiting area with their intake form and blank chart.
- setting up carrels: this is done by medical and nursing students as soon as we arrive. Carrels consist of three screens set up in a U shape with three chairs inside. Fancy! We generally set up about six carrels, three on each side of the room, depending on how many students will be seeing patients. Carrels should be structured to maximize patient privacy and confidentiality: try to make sure the open part of the carrel is facing a wall, that the dividers are touching one another, and that the carrels are as far from the waiting area as possible.
- laying out supplies: blood pressure cuffs, stethoscopes, thermometers, penlights and other supplies are in bins in the locked closets and need to be laid out on the central table.
- as soon as a patient's chart is in the "To Be Seen" bin, a medical or nursing volunteer can begin their encounter. Just saunter over to the waiting area with the chart, find your patient, introduce yourself, and head back to a carrel to start your history and physical.
- when you have finished your history and physical, you need to present your patient to a physician. This may involve waiting for five to 10 minutes,

so it is a good time to leave your patient with some literature to peruse while s/he waits. While you wait, finish documenting the exam in the chart. When the physician is available, present your case (this will become easier as you get practice). Once you have discussed the case with the physician, you will see the patient together for a few minutes, and the physician will sign off on the chart. It is always a good idea to ask patients if they have any more questions before they leave. Once they are gone, sign the chart, leave it in the "To Be Filed" bin, and pick up the next chart!

DISPENSING MEDICATIONS & WRITING PRESCRIPTIONS

Occasionally, a volunteer and physician will decide together that a client needs a prescription medication. There are two ways to go about this:

- if we have the drug available in the med box at clinic, we can dispense it at no charge on the spot. Use the orange-tinted translucent prescription vials. Make sure you put a label on the vial (blank labels are available in the supply cabinet) indicating the doctor's name, patient's name, drug name, dosage, route, number of pills, and when to take them. We have stickers available with advisories for how to take the medicine (ie. with or without food). **In order to meet Pennsylvania state law, any medication dispensed must be recorded in the blue notebook on a sheet called "UCC Pharmacy Log."** If you have any questions, consult with the physician or a coordinator.
- If we do not have the drug, the doctor can write the patient a prescription using the prescription pad from his/her practice, or the UCC prescription pad, and the patient can get that prescription filled at a local pharmacy. **Be sure to record the prescription in the chart and the UCC blue notebook.**

Vitamins

The clinic currently dispenses multivitamins to any patient who requests them, whether they have seen or will see the doctor. We record how many are dispensed in our patient records and the UCC pharmacy log form. We can use bags provided by the pharmacy. Make sure you put a label on the bag that describes the contents and directions for taking the vitamins.

HISTORY & REVIEW OF SYSTEMS

Interview (education) guidelines

Clearly, in the majority of cases at UCC, this is the most important tool students have to gather information about their clients. It is critical because most of our patients are fairly healthy (i.e. their physical exam will be unremarkable) and the history will allow you to learn about their health and risk factors, and provide an excellent opportunity for patient education. During your interview you may discover that your patient needs specific services regarding job referrals, drug or alcohol counseling, housing help, domestic violence, or other issues. Just because you don't know where to send them, don't be afraid to ask them about these topics. The social work volunteers are there to deal with these issues. When you are finished with your patient, bring them to the social work table, where they can get further help.

Because all of you are currently, or will soon be, taking part in a formal interviewing and history taking class, the manual will defer to those resources regarding the specific skills involved in the history taking. The text below is meant to be used as a guideline to help you develop your own interview style.

Name, age, sex, date of birth, occupation, country of origin

Chief Complaint: Recorded in patients words (use quotations)

HPI (History of Present Illness):

For an acute incident: inquire about the location, time, quality, severity, timing, setting, modifying, radiation, impact on patient's life.

For a physical exam with a healthy patient: Restate client's age, and specify reason for visit (if a job physical, where is the job and what type of work will they be doing; for a sports physical, what sport, how long have they played, have they ever been injured).

PMH (Past Medical History):

heart problems, high blood pressure
breathing problems, pneumonia, asthma
stomach problems, liver/gall bladder problems, kidney problems, bladder infections
sexual health, gonorrhea, syphilis, chlamydia, herpes, HIV
arthritis, aches, pains
anemia
cancer
diabetes
thyroid or other gland problems
emotional problems, stress, depression

Surgery: date of operation, hospital, complications

Hospitalizations (be sure to ask if the patient has ever visited the ED)
Significant injuries (make sure you ask about injuries if they are there for a sports or work physical)
Pregnancies: total number, number alive, miscarriages, abortions, other problems
Medications: including vitamins, herbals, OTC drugs
Allergies: food, medications, seasonal
Exposures: chemicals, blood transfusions, travel outside US

Family History: Inquire about all first degree relatives. Draw a family tree if possible. Ask specifically about diabetes, heart disease, hypertension, cancer, stroke, kidney disease.

Social history:

Occupation or where they go to school, who lives with them at home, marital status, children

Lifestyle risk factors: This is often the most difficult line of questioning but given the screening and education mission of the clinic, this is a true opportunity for education and possible intervention.

Inquiries should include:

alcohol (how much, how often)

tobacco (pack years)

recreational drugs

sexual history

safety at home and school

stress levels and support at home

Review of Systems

It is helpful to note pertinent positives or negatives, and is overall a very good tool for eliciting a more complete history. Starting out you will want to do this part of the exam during the history, but eventually you may incorporate the specific questions into your physical exam.

General: vital signs, overall appearance, weight loss/gain, sleep patterns, change in appetite, fever, chills, sweats, fatigue, exercise tolerance, dizziness

Skin: rashes, itching, mole changes, changes in pigmentation

Head: headache, fainting, seizures, hx of head injury

Eyes: glasses/contacts, blurry vision, double vision, flashing lights, red eye, pus, yellow eye, cataracts, glaucoma

Ears: change in hearing, pain, discharge, ringing in ears (tinnitus), sense that room is spinning (vertigo)

Nose: running, congestion, frequent sneezing, sense abnormal odors

Throat: soreness, change in voice, hoarseness, goiter

Breasts: monthly exam, presence of masses, pain, discharge

Cardiovascular: chest pain/pressure, difficulty breathing while lying flat (orthopnea), sudden shortness of breath while sleeping (PND, paroxysmal nocturnal dyspnea), edema, cyanosis, fast or irregular heart beat (palpitations), murmur, pain in legs that increase when walking (intermittent claudication)

Pulmonary: shortness of breath (dyspnea), cough: productive (color), non-productive, wheezing

Gastrointestinal: cavities, missing teeth, toothache, ulcers, sore tongue, difficulty swallowing (dysphagia), if so with solids, liquids, painful swallowing (odynophagia), nausea, vomiting, change in bowel habits: diarrhea, black or clay colored stool, constipation, abdominal pain, jaundice, liver problems

Endocrine: increase appetite (polyphagia), increase thirsty (polydipsia), increase urination (polyuria), menstruation (age at of first period/ or menopause), cycle, duration, date of last period, associated pain), impotence

Allergies: hives (urticaria), hay fever, asthma, food, pets

Musculoskeletal: pain, swelling, stiffness, limits in movement, fractures or sprains

Neurological: paralysis, weakness, loss of mass (atrophy), tremor, spastic movements, involuntary movements, loss of coordination, tingling in peripheral limbs, bowel or bladder incontinence

Psychiatric: mood changes, anxiety, phobia, sleep patterns, memory loss, hallucinations

PHYSICAL EXAM

This is a pretty detailed explanation of how to do many parts of the physical exam. It was written primarily for the first and second year medical students who will formally learn many of these techniques after they have started seeing patients. This section is provided not because of an expectation that any or all of these exams should be completed, but there are some essential aspects of the examination (ie. blood pressure, pulse, auscultation of the heart and lungs, neuromuscular exam) that should be completed by all students. Many people are very nervous about doing these exams, but practice is the only way to improve. So after you have tried the specific exam on a friend a couple of times, bring those skills to your interaction with the client. The main intention behind this section is to increase your comfort level and facilitate your willingness to try what you have learned, by providing you with a brief reminder of the skills and techniques you have already learned. It is also geared to give you a general idea of how to document your findings.

While it is obvious that different aspects of the physical exam are more or less appropriate given a particular patient's reason for coming to the clinic (i.e. a sport physical vs. abdominal pain), as mentioned above there are basic components of the exam that should be performed on every client who comes to the medical/nursing clinic. A section has been included with some brief examples of how to document normal findings on the physical exam. If you have abnormal findings, discuss the documentation with the attending physician or your colleagues.

Outline for order of exam for the clinic: (A good pattern to follow is moving from head to toe)

- General appearance
- Vital signs
- HEENT
- Lungs
- Heart
- Musculoskeletal
- Neurological

General inspection

The physical exam should begin with an assessment of the overall appearance of the patient (do this during your interview). The write up should include enough detail that they patient could be identified in a crowd. Describe their general state of health: how they are dressed (disheveled vs. well groomed, and their general appearance). Level of distress: no acute distress or distressed (if distressed try to identify nature and case of distress). Level of consciousness: awake, somnolent, lethargic, obtunded, comatose.

Vital Signs

These are non-invasive, quick, cheap, and vital to any physical exam. Do these if nothing else in your physical exam. Every UCC patient should have their blood pressure measured and their pulse checked.

Blood pressure

Procedure for Blood Pressure Measurement at UCC

1. Patient must be given several minutes of quiet rest before the blood pressure measurement.
2. The patient should be seated with both feet on the floor and his or her back fully supported.
3. The cuff size should be matched to the arm size of the individual. Do not use a cuff that is too small for a larger individual. As a rule of thumb, use the largest cuff for males over 200lbs and females weighing more than 160 lb.
4. Have the patient expose the upper arm on his or her dominant arm and place the blood pressure cuff on the upper part of the arm, with the bottom edge of the cuff at the crease of the elbow.
5. Line the artery mark on the cuff with the location of the brachial artery at the center of the elbow (ie. to the medial side, or inside of the biceps tendon).
6. Place the bell of the stethoscope lightly under the cuff at the brachial artery and form a seal.
7. Close the pressure gauge and pump up the cuff until total occlusion of the brachial artery (around 160 for most patients, if you hear noises at pressures around 160, you must continue to pump the pressure until the artery is completely occluded and you hear no sounds).
8. Slowly release the pressure of the cuff until you begin to hear the first sound. This is the systolic pressure. Let the pressure out very slowly after hearing the first sound. Let four beats out for each 10 mmHg.
9. Continue to let the pressure out at this rate until the sounds disappear. Note the pressure at which this occurs. This is the diastolic pressure.
10. Let the remainder of the pressure out.
11. If screening for high blood pressure, wait another five minutes and repeat the procedure then average the two pressures to determine the systolic and diastolic pressure.

Pulse (if regular taken over 15 seconds, if irregular taken over 60 seconds)

Respiratory Rate Should be measured for 60 seconds, right after taking pulse (without releasing) wrist

Weight (measure on our scale)

Height (measure on our scale)

Temperature Only take the patient's temperature of there is an indication (complaint of fever, signs or symptoms of infection, etc.)

HEENT (Head, eyes, ears, nose, and throat)

Head

Inspect face for symmetry and trauma.
Inspect for closure of skull fissure in children

In the chart: If normal record as: no temporal wasting, AT/NC (atraumatic, normocephalic)

Eyes

Outline of exam:

Gross Inspection of the eyes
Visual Acuity
Visual Fields by Confrontation
Functional Assessment of the eyes
Ophthalmoscopic exam

Gross inspection of eyes:

Look for symmetry and position of eyelid
Examine the eyes for position within socket: check for depression or protrusion of one or both eyes
Exam alignment of the eyes (convergent or divergent strabismus)
Note eye color
Look at the sclera (white of the eye) for redness (inflammation), jaundice (yellowing) and for any lesions
Exam for symmetry of pupils. Note size, shape, symmetry (anisocoria, or asymmetry is present in 20% of people)
 In the chart: Unless there is an abnormality, no record is needed.

Visual acuity:

Distance vision: The patient should be 10 feet away from the chart, with the 20/20 line at eye level. If the patient wears glasses or contact lenses for distance vision, they should wear them for the test. Ask the patient to keep both eyes open and cover one eye. Then ask the patient to read the smallest row he or she can. (Some charts show a series of symbols. In this case, ask the patient to indicate with one hand the direction in which the symbol points. These charts are preferable for young children and patients who have trouble reading letters.) Record the number of the smallest line that was correct. Repeat with the other eye.

Near vision: Again, if glasses are worn for reading, the patient should wear them for the test. Hold the near vision test chart about 14 inches from the patient's eyes. Have them cover one eye with a card and read the letters from the smallest line they can. A line from which they can read more than half the letters is considered a positive

reading. Keep moving them down the chart until they can no longer get 50% correct. Repeat having them cover the other eye. Make sure there is enough light for them to read the chart well.

- **In the chart:** Record results for each eye according to the line with the smallest letters read. Written as 20/(some number) depending on their results. Right eye 20/40, left eye 20/20.

Pupillary exam:

Reaction to light:

Ask the patient to look straight forward. Shine a pen light obliquely into each eye. Look for the examined pupil to constrict (direct response). Then, repeat procedure this time looking for constriction of the non-lit eye while shining light into the opposite pupil (consensual response)

Convergence: Ask the patient to follow your finger or pencil as you move in toward the bridge of the nose. The eyes should converge within 5 to 8 cm of the nose.

- **In the chart:** If normal, the exam is recorded as PERRLA (Pupils equally reactive and responsive to light and accommodation). Record diameter of pupils and asymmetry. 3mm, bilaterally.

Extraocular exam:

Standing about 3 feet in front of the patient:

- Ask the patient to track your moving finger or a pencil without turning their head.
- From center move your finger to the extreme right about 1 and 1/2 ft. Then move it directly upward and then downward.
- Then sweep your finger back through the center to the extreme left. Move your finger upward and then downward. The pattern makes an H.
- You should be a few steps further back for middle age individuals and older.

You are looking for nystagmus or non-conjugate (i.e. asymmetric) tracking of the eyes

- **In the chart:** Results are recorded as part of the cranial nerve exam (CN III, IV, VI)

Ophthalmoscopic Examination

This need only be done when indicated. Generally you should remove your glasses unless you are very nearsighted or astigmatic. If you or your patient have severe enough visual problems, the examination may have to be performed with your and/or their glasses on.

Patients are examined with your right eye to their right eye and your left eye to their left eye.

- Ask the patient to stare slightly upward, over your shoulder, into the distance.
 - Make sure that the scope is grossly focused already for your vision.
 - Start 15 inches from the patients eye and shine the beam into their pupil. You should see an orange light.
 - Move closer in, placing your other hand on their eyebrow to give you better sense of depth.
 - When you see a blood vessel, follow the blood vessel laterally towards the optic disk (which looks oval and yellow to pink)
 - Sharply focus the disc by adjusting the lens.
 - If you and the patient have no refractive errors, the "0" setting should work.
 - For a myopic patient, rotate the lens disc counterclockwise to the minus side.
 - For a hyperopic patient, rotate clockwise.
 - Follow vessels peripherally vertically and horizontally noting their size and any lesions.
 - The fovea should be medial to the optic disk
- In the chart:** While there are many possible descriptors with pathology, in a patient with healthy eyes you should be able to see the red reflex (record as red reflex response) and visualize the fundus (fundus visualized and normal)

Ears

Inspect ears for sores, discharge, or swelling

Palpate the pre-auricular and post-auricular nodes (in front of and behind the ears)

- In the chart:** No pre-auricular and post-auricular nodes palpable

Otoscopic exam (if indicated):

Change the head of the ophthalmoscope to the otoscopic head and place a disposable tip on the otoscope (use medium size tip).

Pull the patient's ear posteriorly and superiorly at a 45°.

Advise the patient that you will be moving slowly and that they can tell you to stop at any point if the exam becomes uncomfortable.

With the scope nearest your 5th finger, place speculum in ear with the speculum pointing slightly anteriorly. Move very gently

Using the rest of your hand, steady your hand against the patient's head to prevent sudden movements.

Examine the tympanic membrane. You should see a reflective line of light (cone of light) indicating intact membrane and likely absence of inflammation.

Inspect ear canal for tenderness, redness, or discharge

- In the chart:** For normal: tympanic membranes intact and reflective to light

Nose

Using a new otoscopic tip, inspect the nasal cavities. Identify the inferior turbinate. Observe the mucosal lining for swelling, inflammation.

Oral Cavity

Ask the patient to open their mouth:

Using a pen light, inspect the oral cavity for any signs of redness, white patches (ulcers), nodules, or tumors

Individually exam the lips, buccal mucosa, hard and soft palates, gums and teeth, tongue, floor of mouth, uvula and tonsils, pharynx.

Ask the patient to stick out their tongue and move it side to side (Cranial nerve XII)

- In the chart:** For normal, Poor/good dentition. No erythema, lesions, or tonsillar adenopathy.

Neck

Inspect the neck region for symmetry, masses, or goiter.

Palpate:

Trachea: Note if midline

Thyroid: normal may be palpable or non-palpable

If palpable describe size, consistency (smooth, nodular)

Cervical lymph nodes: Behind angle of the mandible, anterior to the sternocleidomastoid muscle, in the posterior triangle (behind the sternocleidomastoid muscles), suboccipital.

Note size (<1 cm is nml), consistency (hard, firm, rubbery, fluctuant), tenderness, if they are distinct or enmeshed, and if they are mobile or fixed.

Carotid pulse noting contour (one upstroke or two) and amplitude (strong or weak) and symmetry

Auscultation: Listen over both carotid arteries for bruits.

- In the chart:** If normal-> non/palpable thyroid gland or cervical lymph nodes. No bruits. If nodes are present describe them in terms of size, consistency, and mobility.

Pulmonary

Auscultate the lungs by asking the patient to take deep breaths while moving in a Z shaped pattern from apex to lung base.

Listen for rales (discontinuous sounds like Velcro indicating fluid in the lungs), wheezes (high pitched continuous sounds usually heard during expiration indicating airway obstruction), rhonchi (low pitched continuous sounds usually heard during inspiration), or rubs (sounds like the movement of leather heard during ins/expiration indicating pleural inflammation).

- **In the chart:** If normal: lungs clear to auscultation bilaterally. Note presence and location of any abnormalities.

Cardiac

Inspect for visual pulsations of heart (heaves)

Auscultation:

S1 (systole) and S2 (diastole). Either may be split.

S1 is closure of mitral and tricuspid valves

S2 is closure of the aortic and pulmonic valves

PMI occurs with S1 as does the carotid upstroke

- **In the chart:** If exam was normal: no gallops, rubs, or murmurs (w/o G/R/M). RRR (regular rate and rhythm). If S2 noted and normal: Physiologic S2.

Abdominal

For logistical reasons, this exam is only done at the clinic if the patient presents with a GI-related complaint.

Neurological

Sensation: Assess the symmetry of sensation to light touch on face, arms, and legs. Test vibratory sensation on hands, forearms, feet, and shins.

Cerebellar coordination:

- Hold your finger out at arm's length from the patient. Have the patient touch his/her nose, then your finger.

- Move your finger across their visual field starting at the right and moving left.

Repeat with other hand. Inaccuracy, tremor, or non-fluidity of movement should be noted.

- Dysdiadochokinesis: Ask the patient to place one hand, palm up, into their opposite hand. Ask them to turn the top hand over and back again as quickly as they can.

- If the patient is young and/or in reasonable shape you can also test gross coordination by ask them to squat down and walk 4 to 5ft in a crouched position.

- For a sense of their gross function, you can ask the patient to crouch down at the knees and walk (like a duck) for 5 or 6 steps.

- **In the chart:** Finger to Nose (F->N) normal. Cerebellar reflexes grossly intact.

Motor Strength

- 5/5 = complete range of motion against gravity and with full resistance
- 4/5 = complete range of motion against gravity and with some resistance
- 3/5 = complete range of motion against gravity only
- 2/5 = complete range of motion, with gravity eliminated
- 1/5 = evidence of slight contractility-no joint motion
- 0/5 = no contractility

In the chart:

List muscles tested (including right vs left) and results of each test.
Ex. Biceps L/R 5.

OR

Draw a stick figure and include results beside the appropriate limb.

Reflexes

Test reflexes at: biceps, triceps, brachioradialis, patella, and achilles

Responses is graded on a 4/4 scale

- In the chart:** Individual limbs may be listed or stick figure can be used

Cranial nerves

- I → Olfactory: (smell) not routinely tested.
- II → Optic: (vision) gross vision and pupillary light reflex
- III → Oculomotor: (most eye movements) constriction of pupil, accommodation.
- IV → Trochlear: (depression, intortion, abduction of eye) extraocular eye movement exam
- V → Trigeminal: (sensation on the face)
- VI → Abducens: (abducts the eye) extraocular eye movement exam
- VII → Facial: (taste, salivation, facial expression) patient should try to hold eye shut against your efforts to open them.
- VIII → Vestibulochochlear: (balance and hearing)
- IX → Glossopharyngeal: (taste, sensation, swallowing) gag reflex
- X → Vagal: (sensation and vocalization) vocalization without hoarseness
- XI → Accessory: (movement of head and shoulders) shoulder shrug
- XII → Hypoglossal: (movement of tongue) have the patient move their tongue side to side. Look for deviation to one side when patient attempts to stick tongue straight out.

Musculoskeletal/Extremities

Inspect the skin, nails and joints for edema or erythema.

Palpate for pulses in the lower extremities (dorsalis pedis, post. tib, popliteal, and inguinal).

Manually move the shoulder, elbows, wrist, ankle, knee, and forefoot through full range of motion.

DOCUMENTATING A PATIENT ENCOUNTER

It is very important to document ALL tests and examinations even if the results are normal. Never record the result of an exam you have not performed.

General inspection

Comment on ability to communicate and overall appearance. Did they look ill, alert, depressed.

The patient did not appear in acute distress (was in mild/moderate/severe distress).

Vital Signs

Pulse	Record rate and describe if pattern regular or irregular and faint to strong
Blood Pressure	Systolic/Diastolic. Note arm used to take BP
Respiratory Rate	Record number
Temperature	Record number in degrees Fahrenheit
Weight	Record weight in pounds
Height	Record height in total inches and feet and inches

Skin

Comment on overall appearance of skin, presence of lesions. Describe any lesions.

HEENT

Head	AT, NC (atraumatic normo-cephalic)
Eyes	Visual Acuity Test: record results of visual acuity test Pupillary light reflex: PERRLA (pupils equally reactive and responsive to light and accommodation)
Ears	No pain on palpation. Tympanic membranes intact and reflect light
Nose	Septum without deviation
Oral Cavity	Poor/good dentition. No erythema, lesions, or tonsillar adenopathy
Neck	Non-palpable thyroid gland or cervical lymph nodes. No bruits. If nodes are present, describe them in terms of size, consistency, and mobility. Carotid pulse ?/2 on R/L

Pulmonary

Lungs clear to auscultation bilaterally. Note presence and location of any abnormalities.

Cardiac

RRR (regular rate and rhythm). No gallops, rubs, or murmurs (w/o G/R/M).

Abdominal

Presence/absence of bowel sounds, tenderness, rebound, or guarding

Neurological

Reflexes

Out of 4. Use stick figure

Muscle strength

Out of 5. Use stick figure

Cranial Nerves

Cranial nerves II - XII grossly intact

Sensory

Normal sensation to touch, vibration, temp

Cerebellar

Cerebellar reflexes grossly intact

HEALTH EDUCATION

Simply approach the patient, introduce yourself and tell him/her who you are in the clinic. It is a good idea to learn his/her name also.

Tips on talking to patients about health topics

Put yourself on the same physical level as the patient.

Ask the patient if they have any general questions (specific health issues, concerns, etc.). Address these questions and concerns *first*.

Find out what they already know and where they are coming from.

Acknowledging their knowledge helps to put you on a more equal level. In particular, pay special attention to different personal and cultural concepts of health and disease.

Address your health education to the patient “where they are.” The conversation should be geared towards the patient’s individual stage of change.

Acknowledge larger structural and societal factors that the patient can’t change that hinder his/her health. Work with the patient on how to work within his/her present home, work, and socioeconomic environment.

Don’t assume literacy. Rather than simply giving the patient a brochure, offer to look it over with them and answer any questions they might have. All printed material for patients created by UCC should be no higher than a 4th grade reading level.

Work *with* the patient - keep the conversation open.

Don’t use medical jargon. Learn to talk about any issue with plain and direct language.

Continually assess the patient’s interest and your material’s pertinence to his/her life.

Use visuals! Brochures, posters, displays, etc. If you need something the clinic does not have, talk to the coordinators about getting it.

Pay attention to body language, both your own and the patient’s.

Remember that patients may be tired, stressed, rushed etc - don’t take it personally.

Concluding the Health Education Interaction:

Work with the patient to make *concrete action steps*. Include in the discussion how the patient can use his/her support system to help him/her with the action steps.

Provide resources if available and appropriate. Refer to social work for more resources and expertise.

Conclude with phrases that keep communication open, “Is there anything else you’d like to talk about? Thanks. If you want to talk further, I’ll be available”, etc.

HISTORY & ORGANIZATION OF UCC

The following account of UCC was provided by Eric Fleegler [and lifted verbatim from the last volunteer manual]:

The purpose of the following is to place in writing the details and chronology of the events that have led to the development of United Community Clinics:

Through the Bridging the Gaps program, summer 1995, Rachel Werner and Liza Presser developed ideas to improve and expand the UCHC Clinic which had operated within the Church of Our Savior for the previous six years on a slim budget provided by the University City Hospitality Coalition, the Medical School Government of the School of Medicine, and glove sales each year. Their energies focused on soliciting funds, furthering the multidisciplinary nature of the clinic, and expanding a multidisciplinary clinic to another location.

At the same time, Eric Fleegler, another rising second year medical student was coordinating medical student volunteers through **Lift A Hammer** at the Habitat for Humanity site on Stiles Street in West Philadelphia. While working there, Eric realized that health services, as well as housing, were a major need in the community and began exploring avenues to increase medical student involvement in this area. Eric submitted a proposal to Gail Morrison (Vice-Dean of the University of Pennsylvania School of Medicine) outlining, among other things, a proposal that the University sponsor a home for a family and support the development of a weekly student-run free clinic at this location. After speaking with Rachel and Liza, the three decided to combine their efforts and launched the process of organizing a second student-run, free clinic at the Habitat site. Eric also initiated discussions with the School of Medicine Administration (Adam Houtz and Chris Allen, Director of Ambulatory Care, University of Pennsylvania Health System) and Marla Davis (Director of Community Relations, University of Pennsylvania Health System) regarding the possibility of the School of Medicine adopting a building at the Habitat site for a physician's office that could be used in the evenings for a new free clinic.

Rachel and Liza wrote a proposal detailing the core concepts of the UCHC Clinic and the possible location of a new site for a second clinic, at Habitat for Humanity. This proposal was sent to two associations, The Philadelphia Foundation and the Bryn Mawr Presbyterian Church. The Philadelphia Foundation awarded a \$7000.00 grant to be used by the UCHC Clinic (magnitudes above their average \$1500.00 yearly budget). The Bryn Mawr Presbyterian Church initially awarded \$2000.00 for the concept of a 'new' clinic, and later announced they were willing to offer an additional \$8,000.00 to be distributed at the church's discretion, as monetary needs arose.

Following the initial proposal, students spearheaded further fundraising efforts. First, at Adam Houtz' suggestion, Eric submitted a proposal to the Wharton Undergraduate Management 100 Class to sponsor 12 freshman in a community project that would raise funds and community awareness of the project. Through a direct mailing solicitation of 101 local companies, Wharton

students raised \$3250.00 for the clinic. In addition, they coordinated a disco-night at Sloppy Joe's that raised \$450.00. The Social Work Society donated \$200. Eric and another medical student, Colleen Monaghan, gave a presentation to GAPSA to elicit their support. Susan Elliott, Koli *****, and David Etzioni worked together to follow-up on this presentation. Their efforts resulted in an allotment of \$5,000.00 from GAPSA for the multidisciplinary clinic.

Eric began contacting students and the Deans from other graduate schools in the summer of 1995. The trio also made a presentation about the clinic project to interested members of their medical school class to solicit their support. Colleen Monaghan, who was one of the managers of the UHC clinic, became interested in the project and worked with Eric to create a formal presentation, for September, to the Deans of the various graduate schools, interested faculty, and student leaders. At that time, students felt that the clinic would be ready to open on October 16, 1995 in a Habitat building. The Deans offered their support, but were concerned that the planned opening day was premature. Recommendations included the completion of a formal needs assessment for the community and reevaluation to ensure that all other preparations should be completed before opening.

Interested students from the dental, law, nursing, and medical schools formed a steering committee to guide clinic development, eventually involving social work and veterinary students as well. The committee met weekly to write a mission statement, plan services that would be offered, and discuss strategies for involving the community. Eric and Colleen served as co-chairs for the committee. Several subcommittees were formed to address various tasks, including education, community relations, fundraising, and student training.

One of the most important initial tasks was finding an appropriate location for the clinic. Eric, Colleen, and Marla made several visits to the Cathedral Park neighborhood to visit potential sites as well as to build relationships with community members. They met on several occasions with Ms. Minis, the president of the Cathedral Park Association to discuss the project and solicit her input. A variety of potential locations for the clinic were discussed including a local gym and several Habitat buildings. Colleen and David presented to the board of directors of Habitat for Humanity a petition to use of one of their buildings for the clinic. The board decided that they could not provide a site for the clinic. Instead, they offered to facilitate discussions between one of the local churches, the Union Tabernacle Church, the Medical Center, and their insurance company, because this church had no liability insurance. The medical school's legal department advised that while professional liability is covered by the hospital policy, physical liability must be provided by the site. Reverend Gaines from the Union Tabernacle expressed interest in obtaining liability insurance but stated that he been unsuccessful finding a company willing to insure his building.

During this time, several students from the School of Nursing performed a community assessment of the Cathedral Park community as part of a class assignment. They analyzed

demographic data and interviewed residents, eventually outlining the churches and schools in the area. They presented their completed assessment to the steering committee to help guide the development of clinical services. The Reverend from Mother of our Sorrows church heard about the clinic and contacted Marla Davis to ask that his church be considered as a potential site. This church is located outside the boundaries of Cathedral Park, but is only several blocks away, and would still be accessible to the people of that neighborhood. Thus, after several months of visiting sites and investigating two sites in depth, the search was expanded to include areas outside of Cathedral Park.

In January of 1996, while pursuing other potential sites, Adam Houtz contacted Eric to recommend the First African Presbyterian Church in the East Parkside community. Reverend Pinkney from First African expressed great interest in the clinic and thought he could get quick approval from the board of elders, allowing the clinic to open soon. In addition, the church had liability insurance, adequate space and storage, and was willing to arrange transportation and security.

A group of students from the steering committee, along with Marla Davis, visited the First African Presbyterian Church to present the clinic concept to the Reverend and to ask for his feedback and opinion about having the clinic at the church. After the elders accepted the initial presentation, the Reverend arranged for students to come to the church to present the clinic project to the church elders and other community leaders. Representatives from each school came to the church and approximately 50 people from the church, other local churches, and the community were present to listen to the presentation. Questions from the church elders and community members addressed faculty supervision, malpractice, and continuity, among other concerns.

The University then began the process of negotiating a legal contract outlining the relationship of the University, the School of Medicine, and the church. This process took about two months to complete. During that time, students went out into the community with a community needs questionnaire as part of a formal community needs assessment. A sub-committee of students worked to design a comprehensive training program for all students interested in volunteering at the clinic. They planned a school-wide training seminar, invited guest speakers, made pamphlets, and conducted the seminar which was attended by approximately 100 students from all of the graduate schools involved. Because summer was approaching, the opening of the clinic was delayed until the fall.

Finally in the fall of 1996 the clinic opened and has served thousands of community members during its operation.

UCC AND EPWP (EAST PARKSIDE WELLNESS PROJECT)

The East Parkside Wellness Project (EPWP) started three years ago when a few students from the UCC clinic applied for a grant distributed through AMSA with funds from the Kellogg Foundation. The grant program was called ICHFP (Interdisciplinary Community Health Fellowship Program) and was designed to facilitate collaboration between university's and their students (specifically students from different disciplines) to address community health issues. These students' proposal to AMSA was, "Through a multi-faceted approach the ICHFP team will look to expand the current role of UCC to provide a more holistic preventive and educational approach towards addressing the issues that are facing this community."

During the first year of the project the students working on the project had meetings with community residents and discovered that the priorities and needs of the community fell in four different areas: health, recreation, youth, and environment. Since that time the various team members have been working hard to initiate interventions and build community capacity in these quadrants by training community members in relevant areas, and working together to start programs that in which the community is interested. This year's team has continued this mission. In the last year and a half we have been working on several projects, including:

- Collaboration with the UCC clinic to improve care, particularly in the area of Sexual and Reproductive Health
- Starting an after-school gymnastics program at the Leidy Elementary School in East Parkside
- Supporting existing programs in East Parkside:
 - Positive's Sunlight Mentoring Group
 - East Parkside Residents Association
 - United Block Captains Association
 - Obtaining city funding and working to start an after-school homework and recreation program at Leidy Elementary
 - Operating a summer Youth Community Development Corps

The relationship with UCC has changed over the last two years. The members of the first team were also the main leaders of the different clinics at UCC. In this years team, all EPWP members have played active roles in UCC, but they were not the main coordinators of the clinic. For this reason the relationship between the two programs is not as clear. We would like the future leaders of UCC to know about EPWP, where it came from, and realize that the student members of EPWP are very interested in improving the overall health of the East Parkside area. EPWP members are good resources for discussion about new programming that the clinic may hope to initiate and have a good sense of what is going on in the community around the clinic, including what the residents might need or want. They would also be very good people to work with when doing outreach to the community. We hope that the mutually supportive relationship between the two programs will continue in the future years.



UCC Mailing Address

United Community Clinics
University of Pennsylvania School of Social Work
3701 Locust Walk
Philadelphia , PA 19104-6214

Clinic Location

United Community Clinics
First African Presbyterian Church
42nd and Girard Avenue
Philadelphia , PA 19104

Clinic Contact Information

Phone: (215) 704-2782