

# Blood Pressure Protocol Training EVALUATION

## Pre-Test

1. Which of the factors may effect a patient's blood pressure reading?
  - a. Smoking within 30 minutes of measurement
  - b. Placing the blood pressure cuff over clothing during measurement
  - c. Talking during measurement
  - d. Distended bladder during measurement
  - e. All of the above
2. Hypertension is the most common chronic condition in primary care settings?
  - a. True
  - b. False
3. Which of the following lifestyle modifications, has the largest impact potential on high blood pressure?
  - a. Weight loss reduction
  - b. Reduction in dietary sodium
  - c. DASH diet
  - d. Increased physical activity to 30 minutes per day
  - e. None of the above

## Post-Test

1. Which of the factors may effect a patient's blood pressure reading?
  - a. Smoking within 30 minutes of measurement
  - b. Placing the blood pressure cuff over clothing during measurement
  - c. Talking during measurement
  - d. Distended bladder during measurement
  - e. All of the above
2. Hypertension is the most common chronic condition in primary care settings?
  - a. True
  - b. False
3. Which of the following lifestyle modifications, has the largest impact potential on high blood pressure?
  - a. Weight loss reduction
  - b. Reduction in dietary sodium
  - c. DASH diet
  - d. Increased physical activity to 30 minutes per day
  - e. None of the above

Please fill in marks completely using a pen or pencil

Correct: ●      Incorrect: ⊗ ⊘

**Please rate how well the presentation fulfilled each of the following objectives:**

	Very Good	Good	Fair	Poor	Very Poor
Explain why accuracy in BP measurement is critical in management of hypertension.	<input type="radio"/>				
Identify the prevalence of HTN in North Dakota.	<input type="radio"/>				
Identify basic lifestyle recommendations to lower blood pressure	<input type="radio"/>				
Recommend tools for education, workflow and an approved protocol for use to improve identification and management of people with elevated blood pressure.	<input type="radio"/>				
Demonstrate proper sizing of a BP cuff and how to take a blood pressure.	<input type="radio"/>				
Discuss alternate blood pressure measurement sites.	<input type="radio"/>				

	Advanced	Intermediate	Basic	None
How would you rate your level of knowledge about training content <b>before</b> you attended this training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How would you rate your level of knowledge about training content <b>after</b> you attended this training?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Yes	No
<b>Will the information presented cause you to make any changes in your practice?</b>	<input type="radio"/>	<input type="radio"/>
If <b>yes</b> , what changes do you plan to make?		

Please indicate if today's training will have an impact on your knowledge, competence, and performance as it relates to patient outcomes.	Yes	No	If Yes, please describe:
This activity increased my knowledge. (knowing what to do)	<input type="radio"/>	<input type="radio"/>	
This activity increased my competence. (knowing how to do something)	<input type="radio"/>	<input type="radio"/>	
This activity will improve my performance. (ones actual behavior in practice)	<input type="radio"/>	<input type="radio"/>	

	1 – Not at all Committed	2	3	4	5 – Highly Committed
If <b>yes</b> , how committed are you to making these changes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If <b>no</b> , what barriers exist to prevent you from making changes? (check all that apply)					
<input type="radio"/> Clinical application	<input type="radio"/> Management priorities	<input type="radio"/> Reimbursement			
<input type="radio"/> Fundamental delivery system redesign necessary	<input type="radio"/> Time constraint	<input type="radio"/> Resistance to change			
<input type="radio"/> Resource availability (staff, funding, etc.)	<input type="radio"/> Need for training	<input type="radio"/> Other			
If other, please explain:					

Professional Designation:			
<input type="radio"/> CNA	<input type="radio"/> OT	<input type="radio"/> PT	<input type="radio"/> Student
<input type="radio"/> LRD	<input type="radio"/> PA, NP	<input type="radio"/> RN, LPN	<input type="radio"/> Other
<input type="radio"/> MD, DO	<input type="radio"/> PharmD, RPh	<input type="radio"/> RT, RRT	
<input type="radio"/> Med Tech	<input type="radio"/> PhD		

How did you hear about this training? (check all that apply)			
<input type="radio"/> Email	<input type="radio"/> Newsletter	<input type="radio"/> Social Media (Facebook)	<input type="radio"/> Other
<input type="radio"/> Flyer	<input type="radio"/> Website	<input type="radio"/> Word of Mouth	If other, please explain:

**In order to receive credit for this educational activity, please complete and return this evaluation form. Thank you.**