The University of Texas at Arlington
College of Nursing
N5306 Pediatric Management
Summer 2014

<u>**Instructors:**</u>

Sharolyn Dihigo, DNP, RN, CPNP-PC
Clinical Assistant Professor
Office Number: Pickard Hall Office # 625
Office Telephone Number: (817) 272-2776
Email Address: sdihigo@uta.edu
Faculty Profile: https://www.uta.edu/mentis/profile/?392

Mindi Anderson, PhD, RN, CPNP-PC, CNE, CHSE-A, ANEF
Assistant Professor
Office Number: Pickard Hall Office #624
Office Telephone Number: (817) 272-2776
Email Address: manderso@uta.edu
Faculty Profile: https://www.uta.edu/mentis/profile/?1617

Debbie Boger, MSN, RN, CPNP-PC
Clinical Instructor
Office Number: Pickard Hall Office # 626
Office Telephone Number: (817) 272-2776
Email Address: dboger@uta.edu
Faculty Profile: www.uta.edu/profiles/deborah-boger

Mary Jane (Janie) Haskew, MSN, RN, CPNP
Clinical Instructor
Office Number: Pickard Hall Office # 626
Office Telephone Number: (817) 272-2776
Email Address: haskew@uta.edu

Linda Grande, DNP, RN, CPNP
Clinical Instructor
Office Number: Pickard Hall Office # 626
Office Telephone Number: (817) 272-2776
Email Address: grande@uta.edu
Faculty Profile: http://www.uta.edu/mentis/profile/?13238

Howard McKay, MSN, RN, FNP-C, CPNP-AC
Clinical Instructor
Office Number: Pickard Hall Office # 626
Office Telephone Number: (817) 272-2776
Email Address: mckay@uta.edu
Faculty Profile: https://www.uta.edu/profiles/howard-mckay

Sara Moore, MSN, RN, CPNP-AC & PC
Clinical Instructor
Office Number: Pickard Hall Office # 626
Office Telephone Number: (817) 272-2776
Email Address: moores@uta.edu
Faculty Profile: https://www.uta.edu/profiles/sara-moore

Nancy Wyrick, MSN, RN, CPNP
Clinical Instructor
Office Number: Pickard Hall Office # 626
Office Telephone Number: (817) 272-2776
Email Address: wyrick@uta.edu
Faculty Profile: https://www.uta.edu/mentis/profile/?367

Fax Number: (817) 272-5006
Office Hours: By Appointment

Section Information:
NURS 5306 Sections 001-011

Time and Place of Class Meetings:
Saturdays 9 am-5 pm, Pickard Hall Room #204
Class will meet June 7, June 28, July 19, August 2, and August 9

Description of Course Content: 2 Lecture Hours, 3 Lab Hours
Foundations of advanced clinical practice in the primary care of children, birth to 21 years with a family centered approach on growth and development, health promotion and management of common health problems.

Other Requirements:
Prerequisites: NURS 5418, 5334

Student Learning Outcomes:
Upon completion of the course, the student will be able to:
1. Analyze the empirical and theoretical knowledge of the unique anatomic structures, physiological and psychological process in the care of the pediatric and adolescent patient.
2. Apply family and developmental theory in the care of the pediatric and adolescent patient.
3. Demonstrate critical thinking and effective communication to assist children and their families in primary prevention to health promotion.
4. Demonstrate knowledge of basic management of the pediatric patient with common acute minor illness and appropriate referral.
5. Implement culturally sensitive care to the pediatric and adolescent patient and family.
6. Use current research in the management of health and illness in the pediatric patient role using research methodologies.

Required Textbooks and Other Course Materials:
1. Provence, S., & Apfel, N. H. (2001). *Infant-toddler and Family Instrument (ITFI).* (set of 15) Baltimore, MD: Paul H. Brookes Publishing Co., Inc. **ISBN: 978-1557664921**
2. Burns, C. E., Dunn, A. M., Brady, M. A., Barber Starr, N., & Blosser, C. G. (2013). *Pediatric primary care*. (5th ed.). Philadelphia, PA: Elsevier Saunders. **ISBN**: **978-0-323-08024-8**
3. Duncan, P. (2007). *Bright futures pocket guide: Guidelines for health supervision of infants, children, and adolescents.* (3rd ed.). American Academy of Pediatrics. **ISBN: 9781581102246**

4. Richardson, B. (2013). *Pediatric primary care: Practice guidelines for nurses.* (2nd ed.). Burlington, MA: Jones & Bartlett Learning. **ISBN: 978-1-4496-0043-3**

Recommended Textbooks:
1. Graham, M. V., & Uphold, C. R, (2004). *Clinical guidelines in child health.* (3rd ed.). Barmarrae Books, Inc. **ISBN: 9780964615175**
2. Uphold, C., R. & Graham, M. V. (2013). *Clinical guidelines in family practice.* (5th ed.). Barmarrae Books, Inc. **ISBN: 9780964615199**
3. Kliegman, R. M., Stanton, B., St. Geme, J., Schor, N., & Berhman, R. E. (2011). *Nelson textbook of pediatrics: Expert consult premium edition.* (19th ed.). Saunders. **ISBN: 9781437707557**
4. American Academy of Pediatrics. (2013). *Pediatric clinical practice guidelines & policies: A compendium of evidence-based research for pediatric practice.* (13th ed.). **ISBN: 9781581107661**

Descriptions of Major Assignments and Examinations with Due Dates:

Clinical Decision-Making (CDM) In-Class Exercises/Group Exercises (10%; Most Classes)
You will be doing several interactive exercises with a group working through clinical decision-making on the basic management of pediatric patients with common acute minor illnesses during most class days. You may also be participating in other group exercises related to the content areas. You will be graded on your attendance and participation in these exercises. **If you miss class, there will be a 10% deduction in your participation grade for each class day missed.**

Clinical Decision-Making (CDM) Papers (20% each X 2 [40%]; 07/05/14 and 07/26/14)
During the semester, you will be doing two formal CDM papers working through clinical decision-making on the basic management of pediatric patients with common acute minor illnesses. These papers are individual projects. Grading criteria for these papers can be found later in the syllabus.

Developmental Paper (Pass/Fail; 06/28/14)
You will choose one client (age 2 weeks to 3 years of age) to complete a developmental assessment on. You will complete an Infant-Toddler and Family Instrument (ITFI) (Provence & Apfel, 2001) and then write a 2-3 page typed paper presented in a Subjective, Objective, Assessment, and Plan (SOAP) format. This paper is an individual project. Grading criteria can be found later in the syllabus. You will receive 3.5 hours of clinical credit for your completing your developmental paper.

Examinations (20% each X 2 [40%]; 07/11/13 to 07/13/13 and 08/09/14 to 08/11/14)
During the semester, you will complete two on-line, multiple-choice examinations. These examinations will be available only for a certain number of days, and the examinations will be timed. Examinations should be done individually and without any reading material/references. Further information about the examinations will be given on Blackboard and in class.

On-line Courses (Pass/Fail; 6/28/14)
You will complete four Texas Health Steps on-line courses, in which you will turn in the certificates received for these courses. For completion of the courses, you will receive 1.5 hours of clinical credit. More information will be discussed in class.

Clinical (Pass/Fail; Throughout Semester)
In this course, you will complete 40 hours of precepted clinical. In addition, you will receive hours for the four Texas Health Steps on-line courses and the developmental paper previously described. More information on clinical will be discussed in class.

Clinical Check-off/Clinical Practicum (10%; 08/02/14 or 08/09/14)
At the end of the semester, you will be doing a clinical check-off/clinical practicum with standardized patients. This will be an episodic/problem-focused examination, where you will be evaluated on your basic management of a pediatric patient with a common acute minor illness. More information about this will be given on Blackboard and in class.

Clinical Notebooks (Pass/Fail; 08/11/14)
Over the semester, you will keep a clinical notebook which will include: the precepted hours/signature page with total number of clinical hours you completed, your personal clinical objectives, a self-evaluation, an evaluation of your preceptor, a practicum evaluation, a copy of your CDMs and other graded assignments for this course, and a copy of your e-logs final printout. Further criteria can be found later in the syllabus.

Attendance: Regular class attendance and participation is expected of all students. A grade is received for in-class participation, and missing class will result in points deducted from the participation grade. Students are responsible for all missed course information and may be required to complete additional coursework to meet the course outcomes. See more information under "***Clinical Decision-Making (CDM) In-Class Exercises/Group Exercises."***

Grading Policy:

Due Dates	Assignment	% of Course Grade
Most class days	Clinical Decision-Making (CDM) In-Class Exercises/Group Exercises	10% of participation grade *Counted as didactic grade
06/28/14	Texas Health Steps On-line Courses X 4	Pass/fail *Counted as clinical grade
06/28/14	Developmental Paper (Paper and Tool)	Pass/fail *Counted as clinical grade
07/05/14 CDM #1 07/26/14 CDM #2	CDM Papers	40% (20% each X 2) *Counted as didactic grade
07/11/14 to 07/13/14	Exam #1 (On-line)	20% *Counted as didactic grade
08/09/14 to 08/11/14	Final Exam (On-line)	20% *Counted as didactic grade
08/02/14 or 8/09/14	Clinical Check-off/Clinical Practicum	10% *Counted as clinical grade
08/11/14	Preceptor Evaluation	Credit (pass/fail) *Counted as clinical grade
08/11/14	Student Evaluation of Preceptor	Credit (pass/fail) *Counted as clinical grade
08/11/14	Clinical Notebook (with E-logs)	Credit (pass/fail) *Counted as clinical grade
Total		100%

Both the didactic and clinical must be passed in order to pass the whole course. Both are combined into one course grade. See further information in syllabus.

Students are expected to keep track of their performance throughout the semester and seek guidance from available sources (including the instructor) if their performance drops below satisfactory levels.

Course Grading Scale
A = 92 to 100
B = 83 to 91
C = 74 to 82
D = 68 to 73 – cannot progress
F = below 68 – cannot progress

<u>Late written assignments will not be accepted and may receive a grade of zero.</u> Examinations will be taken on the assigned date or may receive a grade of zero. Arrangements can be made for emergencies IF made in **ADVANCE**.

Expectations for Out-of-Class Study:
Beyond the time required to attend each class meeting, students enrolled in this course should expect to spend at least an additional 9 hours per week on their own time in course-related activities, including reading required materials, completing assignments, preparing for exams, etc.

Make-up Exams:
Please contact your faculty for make-up approval and instructions.

Grade Grievances: Any appeal of a grade in this course must follow the procedures and deadlines for grade-related grievances as published in the current graduate catalog.
http://grad.pci.uta.edu/about/catalog/current/general/regulations/#gradegrievances

Test Reviews:
Contact your faculty for instructions.

Drop Policy: Graduate students who wish to change a schedule by either dropping or adding a course must first consult with their Graduate Advisor. Regulations pertaining to adding or dropping courses are described below. Adds and drops may be made through late registration either on the Web at MyMav or in person through the student's academic department. Drops can continue through a point two-thirds of the way through the term or session. It is the student's responsibility to officially withdraw if they do not plan to attend after registering. **Students will not be automatically dropped for non-attendance**. Repayment of certain types of financial aid administered through the University may be required as the result of dropping classes or withdrawing. Contact the Office of Financial Aid and Scholarships at
http://wweb.uta.edu/aao/fao/ . The last day to drop a course is listed in the Academic Calendar available at http://www.uta.edu/uta/acadcal.php?session=20141

1. A student may not add a course after the end of late registration. June 2- June 3, 2014.
2. A student dropping a graduate course after the Census Date but on or before the end of the 10th week of class may with the agreement of the instructor, receive a grade of W but only if passing the course with a C or better average. A grade of W will not be given if the student does not have at least a C average. In such instances, the student will receive a grade of F if he or she withdraws from the class. Students dropping a course must:
   (1) Contact course faculty to obtain permission to drop the course with a grade of "W".
   (2) Complete the form, sign electronically, (available at http://www.uta.edu/nursing/msn/msn-forms/) email to the course faculty for their electronic signature using the envelope located in the toolbar at the top of your screen and copy your graduate program advisor using the appropriate email: MSN-NP – sdecker@uta.edu
   (3) Contact the graduate program advisor to verify the approved form was received from the faculty, the course drop was processed and schedule an appointment to revise student degree plan.

3. Students who drop all coursework at UTA must check the RESIGN box. Students staying in a least one course and dropping other coursework will check the DROP COURSE(S) box.
4. In most cases, a student may not drop a graduate course or withdraw (resign) from the University after the 10th week of class. Under extreme circumstances, the Dean of Graduate Studies may consider a petition to withdraw (resign) from the University after the 10th week of class, but in no case may a graduate student selectively drop a course after the 10th week and remain enrolled in any other course. Students should use the special Petition to Withdraw for this purpose. See the section titled Withdrawal (Resignation) From the University for additional information concerning withdrawal.
   http://grad.pci.uta.edu/faculty/resources/advisors/current/

> **Census Day: June 19, 2014**
> **Last day to drop or withdraw July 17, 2014 by 4 pm**

Americans with Disabilities Act: The University of Texas at Arlington is on record as being committed to both the spirit and letter of all federal equal opportunity legislation, including the *Americans with Disabilities Act (ADA)*. All instructors at UT Arlington are required by law to provide "reasonable accommodations" to students with disabilities, so as not to discriminate on the basis of that disability. Any student requiring an accommodation for this course must provide the instructor with official documentation in the form of a letter certified by the staff in the Office for Students with Disabilities, University Hall 102. Only those students who have officially documented a need for an accommodation will have their request honored. Information regarding diagnostic criteria and policies for obtaining disability-based academic accommodations can be found at www.uta.edu/disability or by calling the Office for Students with Disabilities at (817) 272-3364.

Academic Integrity: All students enrolled in this course are expected to adhere to the UT Arlington Honor Code:

> *I pledge, on my honor, to uphold UT Arlington's tradition of academic integrity, a tradition that values hard work and honest effort in the pursuit of academic excellence.*
>
> *I promise that I will submit only work that I personally create or contribute to group collaborations, and I will appropriately reference any work from other sources. I will follow the highest standards of integrity and uphold the spirit of the Honor Code.*

Per UT System Regents' Rule 50101, §2.2, suspected violations of university's standards for academic integrity (including the Honor Code) will be referred to the Office of Student Conduct. Violators will be disciplined in accordance with the University policy, which may result in the student's suspension or expulsion from the University.

"Scholastic dishonesty includes but is not limited to cheating, plagiarism, collusion, the submission for credit of any work or materials that are attributable in whole or in part to another person, taking an examination for another person, any act designed to give unfair advantage to a student or the attempt to commit such acts."

As a licensed registered nurse, graduate students are expected to demonstrate professional conduct as set forth in the Texas Board of Nursing rule **§215.8. in the event that a graduate student holding an RN license is found to have engaged in academic dishonesty, the college may report the nurse to the Texas BON using rule §215.8 as a guide.**

Plagiarism: Copying another student's paper or any portion of it is plagiarism. Copying a portion of published material (e.g., books or journals) without adequately documenting the source is plagiarism. Consistent with APA format, if five or more words in sequence are taken from a source, those words must be placed in quotes and the source referenced with author's name, date of publication, and page number of publication. If the author's ideas are rephrased, by transposing words or expressing the same idea using different words, the idea must be attributed to the author by proper referencing giving the author's name and date of publication. If a single author's ideas are discussed in more than one paragraph, the author must be referenced, according to APA format. Authors whose words or ideas have been used in the preparation of a paper must be listed in the references cited at the end of the paper. Students are expected to review the plagiarism module from the UT Arlington Central Library via http://library.uta.edu/plagiarism/index.html

Student Support Services: UT Arlington provides a variety of resources and programs designed to help students develop academic skills, deal with personal situations, and better understand concepts and information related to their courses. Resources include tutoring, major-based learning centers, developmental education, advising and mentoring, personal counseling, and federally funded programs. For individualized referrals, students may visit the reception desk at University College (Ransom Hall), call the Maverick Resource Hotline at 817-272-6107, send a message to resources@uta.edu, or view the information at www.uta.edu/resources.

Electronic Communication: The University of Texas at Arlington has adopted "MavMail" as its official means to communicate with students about important deadlines and events, as well as to transact university-related business regarding financial aid, tuition, grades, graduation, etc. All students are assigned a MavMail account and are responsible for checking the inbox regularly. There is no additional charge to students for using this account, which remains active even after graduation. Information about activating and using MavMail is available at http://www.uta.edu/oit/cs/email/mavmail.php. If you are unable to resolve your issue contact the Helpdesk at helpdesk@uta.edu. *Students are responsible for checking their MavMail regularly.*

Student Feedback Survey: At the end of each term, students enrolled in classes categorized as lecture, seminar, or laboratory shall be directed to complete a Student Feedback Survey (SFS). Instructions on how to access the SFS for this course will be sent directly to each student through MavMail approximately 10 days before the end of the term. Each student's feedback enters the SFS database anonymously and is aggregated with that of other students enrolled in the course. UT Arlington's effort to solicit, gather, tabulate, and publish student feedback is required by state law; students are strongly urged to participate. For more information, visit http://www.uta.edu/sfs.

Final Review Week: A period of five class days prior to the first day of final examinations in the long sessions shall be designated as Final Review Week. The purpose of this week is to allow students sufficient time to prepare for final examinations. During this week, there shall be no scheduled activities such as required field trips or performances; and no instructor shall assign any themes, research problems or exercises of similar scope that have a completion date during or following this week *unless specified in the class syllabus*. During Final Review Week, an instructor shall not give any examinations constituting 10% or more of the final grade, except makeup tests and laboratory examinations. In addition, no instructor shall give any portion of the final examination during Final Review Week. During this week, classes are held as scheduled. In addition, instructors are not required to limit content to topics that have been previously covered; they may introduce new concepts as appropriate.

Emergency Exit Procedures: Should we experience an emergency event that requires us to vacate the building, students should exit the room and move toward the nearest stairwell. When exiting the building during an emergency, one should never take an elevator but should use the stairwells. Faculty members and instructional staff will assist students in selecting the safest route for evacuation and will make arrangements to assist handicapped individuals.

Librarian to Contact:

> **PEACE WILLIAMSON**
> **STEM LIBRARIAN**
> CENTRAL LIBRARY
> 702 Planetarium Place
> Office #216, Arlington, TX 76019
> http://www.uta.edu/library/ | peace@uta.edu
> Research Information on Nursing:
> **http://libguides.uta.edu/nursing**

Library Home Page .... http://www.uta.edu/library
Subject Guides .... http://libguides.uta.edu
Subject Librarians .... http://www.uta.edu/library/help/subject-librarians.php
Database List.................................... http://www.uta.edu/library/databases/index.php
Course Reserves................................ http://pulse.uta.edu/vwebv/enterCourseReserve.do
Library Catalog .... http://discover.uta.edu/
E-Journals .... http://liblink.uta.edu/UTAlink/az
Library Tutorials .... http://www.uta.edu/library/help/tutorials.php
Connecting from Off- Campus .... http://libguides.uta.edu/offcampus
Ask A Librarian .... http://ask.uta.edu

UTA College of Nursing Additional Information:

Clinical Evaluations:
Students must pass both the didactic and clinical portions of a clinical course in order to pass the course. In order to pass the clinical portion, the student must receive a passing grade (minimum of 83%) on the faculty evaluation of the student's clinical performance (Nurse Practitioner Clinical Evaluation). Students who fail a faculty evaluation have a one-time option to retake the practicum. A second faculty member will be present during the clinical performance retake. If the student passes the clinical performance retake (minimum of 83%), the **maximum** grade the student can receive for the exam for purposes of grade calculation is 83%. If the student fails the retake, the student will receive a grade of "F" for the course.

Clinical Clearance:
All students must have current clinical clearance to legally perform clinical hours each semester. If your clinical clearance is not current, you will be unable to do clinical hours that are required for this course and this would result in course failure.

Student Requirement For Preceptor Agreements/Packets:
1. Preceptor Agreements must be **signed and dated** by the student and the preceptor the first day the student attends clinical (may be signed on that day), scanned and emailed to npclinicalclearance@uta.edu.
2. **Student** is responsible to ensure that all of his/her preceptor agreements are signed and complete including their student 1000 number and course number before beginning clinical experience and those agreements are scanned and emailed to Kim Hodges @ npclinicalclearance@uta.edu or Janyth Arbeau at arbeau@uta.edu by the third week of the semester. (For instance, if a student starts working with a particular preceptor late in the semester, he/she would contact that preceptor during the first 3 weeks of the semester.
3. If this is the first time a preceptor is precepting a graduate nursing student for The University of Texas at Arlington, please have him/her complete the Preceptor Biographical Data Sheet. If he/she is a returning preceptor have them fill out the phone number and email address section of the preceptor agreement.
4. The signed/completed preceptor agreement is part of the clinical clearance process. Failure to submit in a timely fashion will result in the inability to access the E-log system.
5. All communications to the NP Clinical Coordinator should be made to the following email address: npclinicalclearance@uta.edu. This includes scanned copies of preceptor agreements, preceptor evaluations of the student, and student evaluations of the preceptor.

Clinical E-Logs:
Students are required to enter all patient encounters into the E-Log system. E-Log is both a student learning opportunity and an evaluation method for clinical courses. Patient encounters include patients the student assesses, diagnoses, and manages as part of their clinical coursework. Individual clinical courses may have additional guidelines/requirements related to their specific course and will be noted in the course syllabus (e.g. types of encounter required, number of patients required during course).

Students can access their Elogs by entering their own unique Elogs username and password which will be accessible their first clinical semester. http://totaldot.com/ The username consists of the student's first, middle, and last initials (in CAPS) with the last four digits of their 1000#. Example: Abigail B. Cooper, 1000991234 is ABC1234. If the student does not have a middle initial, then only two initials will be used. The student's password is simply their last name. Example: Cooper (note first letter is a capital letter).

The student's E-Log data provides a description of the patients managed during the student's clinical experience, including the number of patients, diagnoses of patients, and the type of interventions initiated. As a result, E-Log data are an essential requirement of the student's clinical experience and are used to evaluate student clinical performance. The data are used to meet course requirements and to evaluate student clinical performance. Upon completion of the Program, students will receive an executive summary of their E-Log entries for their professional portfolio.

Students are expected to enter information accurately so that (if needed) faculty may verify/validate the information provided. Falsifying and/or misrepresenting patient encounter data is considered academic dishonesty.

<u>**Status of RN Licensure**</u>**:**
All graduate nursing students must have an unencumbered license as designated by the Texas Board of Nursing (BON) to participate in graduate clinical nursing courses. It is also imperative that any student whose license becomes encumbered by the BON must immediately notify Dr. Mary Schira, Associate Dean, Department of Advanced Practice Nursing. The complete policy about encumbered licenses is available online at: www.bon.state.tx.us

<u>**MSN Graduate Student Dress Code**</u>**:**
The University of Texas at Arlington College of Nursing expects students to reflect professionalism and maintain high standards of appearance and grooming in the clinical setting. **Clinical faculty has final judgment on the appropriateness of student attire and corrective action for dress code infractions. Students not complying with this policy will not be allowed to participate in clinical.**

Please View the College of Nursing Student Dress Code on the nursing website: http://www.uta.edu/nursing/msn/msn-students .

<u>**UTA Student Identification**</u>**:**
MSN Students MUST be clearly identified as UTA Graduate Students and wear a UTA College of Nursing ID in the clinical environment.

Unsafe Clinical Behaviors:
Students deemed unsafe or incompetent will fail the course and receive a course grade of "F".
Any of the following behaviors constitute a clinical failure:

1. Fails to follow standards of professional practice as detailed by the Texas Nursing Practice Act * (available at www.bon.state.tx.us)
2. Unable to accept and/or act on constructive feedback.
3. Needs continuous, specific, and detailed supervision for the expected course performance.
4. Unable to implement advanced clinical behaviors required by the course.
5. Fails to complete required clinical assignments.
6. Falsifies clinical hours.
7. Violates student confidentiality agreement.

*Students should also be aware that violation of the Nursing Practice Act is a "reportable offense" to the Texas Board of Nurse Examiners.

Blood and Body Fluids Exposure:
A Health Verification form was signed by all MSN students at start of the program documenting personal health insurance coverage. All MSN students have mandatory health insurance and will need to manage exposure to blood and fluids. Current CDC guidelines can be found at:
http://www.cdc.gov/

Confidentiality Agreement:
You signed a Confidentiality Form in orientation and were provided a copy of the form. Please take your copy of this Confidentiality Form with you to your clinical sites. Please do not sign other agency confidentiality forms. Contact your faculty if the agency requires you to sign their confidentiality form.

Graduate Student Handbook:
Students are responsible for knowing and complying with all policies and information contained in the Graduate Student handbook online at: http://www.uta.edu/nursing/msn/msn-students

Student Code of Ethics:
The University of Texas at Arlington College of nursing supports the Student Code of Ethics Policy. Students are responsible for knowing and complying with the Code. The Code can be found in the student handbook online: http://www.uta.edu/nursing/msn/msn-students

No Gift Policy:
In accordance with Regent Rules and Regulations and the UTA Standards of Conduct, the College of Nursing has a "no gift" policy. A donation to one of the UTA College of Nursing Scholarship Funds, found at the following link: is http://www.uta.edu/nursing/student-resources/scholarship would be an appropriate way to recognize a faculty member's contribution to your learning. For information regarding Scholarship Funds, please contact the Dean's office.

Online Conduct:
The discussion board should be viewed as a public and professional forum for course-related discussions. Students are free to discuss academic matters and consult one another regarding academic resources. The tone of postings should be professional in nature.
It is not appropriate to post statements of a personal or political nature, or statements criticizing classmates or faculty. Inappropriate statements/language will be deleted by the course faculty and may result in denied access to the Discussion boards. Refer to UTACON Student Handbook for more information.

For this course Blackboard communication tools, discussion boards, and UTA MAV email will be used extensively and should be checked often.

Writing Center:
The English Writing Center, Room 411 in the Central Library, provides support to UT-Arlington undergraduate and graduate students and instructors. Undergraduate and graduate student consultants in the Writing Center are trained to help student writers at any stage in their writing processes. Consultants are trained to attend to rhetorical and organizational issues that instructors value in student writing. Although consultants will assist students in identifying and correcting patterns of grammatical or syntactical errors, they are taught to resist student entreaties to become editors or proofreaders of student papers.

The Writing Center offers tutoring for any assigned writing during enrollment at UT-Arlington. Individuals may schedule appointments online by following directions available at www.uta.edu/owl, or by visiting the Writing Center.

The Writing Center Director, Assistant Director, or tutors are available to make classroom presentations describing Writing Center services. The Writing Center also offers workshops on topics such as documentation and will design specialized workshops at the request of instructors. To schedule a classroom visit or inquire about a workshop, please e-mail or call Tracey-Lynn Clough, Writing Center director, at clought@uta.edu or (817) 272-2517.

Department of Advanced Practice Nursing Office/Support Staff

Mary Schira, PhD, RN, ACNP-BC
Associate Dean and Chair; Graduate Advisor
Email Address: schira@uta.edu

Sheri Decker, Assistant Graduate Advisor
Office # 606-Pickard Hall, (817) 272-0829
Email Address: sdecker@uta.edu

Luena Wilson, Academic Advisor I
Office #: TBA
Email Address: lvwilson@uta.edu

Rose Olivier, Administrative Assistant I
Office # 605-Pickard Hall, (817) 272-9517
Email Address: olivier@uta.edu

Janyth Arbeau, Clinical Coordinator
Office # 610- Pickard Hall, (817) 272-0788
Email Address: Arbeau@uta.edu or npclinicalclearance@uta.edu

Kimberly Hodges, Support Specialist I
Office #610 Pickard Hall, (817) 272-9373
E-mail Address: khodges@uta.edu or npclinicalclearance@uta.edu

Timara Spivey, Admissions Assistant
Office # 602, Pickard Hall (817) 272-4796
Email Address: tnspivey@uta.edu

Required Reading Assignments

Burns, C. E., Dunn, A. M., Brady, M. A., Barber Starr, N., & Blosser, C. G. (2013). *Pediatric primary care*. (5th ed.). Philadelphia, PA: Elsevier Saunders. **ISBN**: **978-0-323-08024-8** *(Pedi, Family, & Psych)*

Chapters in Burns et al. (2013) and/or Nelson's (Kliegman et al., 2011) that correspond with the topics listed in the Class Schedule. Nelson's (Kliegman et al., 2011) is not a required textbook, except for Pedi Majors. Please read the chapters that coincide with the topic prior to class.

ASSIGNMENTS/GRADE SUMMARY

Clinical Assignments	*Due Date*	*Score or %*
1. Developmental Assignments (Paper & ITFI)	June 28 (3.5 Hrs.)	P/F
2. Texas Health Steps On-line Courses	June 28 (1.5 Hrs.)	P/F
3. Clinical Check-off/Clinical Practicum	August 2 or 9	10% _____
4. Preceptor Evaluation	August 11	Credit _____
5. Student Evaluation of Preceptor	August 11	Credit _____
6. E-Logs	August 11	Credit _____
7. Clinical Notebook	August 11	Credit _____

Didactic Assignments	*Due Date*	*Score %*
1. CDMs (Interactive group activities in class) Participation grade	Each class	10% _____
2. CDMs (Individual) 20% each x 2	July 5; July 26	40% _____
3. Exam #1	July 11-13	20% _____
4. Final Exam	August 9-11	20% _____
TOTAL:		**100%**_____

FINAL GRADE:_____

CLINICAL GUIDELINES

&

EVALUATION FORMS

NURSE PRACTITIONER CLINICAL OBJECTIVES

1. Provide evidence of clinical skills in performing advanced health assessments to include:

   a. collecting a complete health history
   b. examining all body systems
   c. performing functional assessments to determine ability for self-care and independent living
   d. collecting additional data as needed (ECG, vision and hearing screening, urinalysis, blood sugar determination, hematocrit, pap-smear, wet-mount, hanging drop smear, nose and throat culture, and others)
   e. making appropriate decisions regarding priority needs for episodic data collection (subjective and objective)
   f. determining which problems/data collection can be deferred until later
   g. making an appropriate and accurate assessment of client's health status (rule outs, differential diagnoses, nursing diagnoses, etc.)
   h. presenting pertinent data to preceptor in a succinct manner
   i. presenting a cost-effective, clinically sound plan of care which may include:
      1) advanced nursing management
      2) medical intervention
      3) pharmacotherapeutics
      4) diagnostic testing
      5) teaching/counseling
      6) follow-up plan
   j. discussing with preceptor personal strengths and needed areas of improvement

2. Show increasing evidence of ability to develop, implement and evaluate an appropriate management plan for common episodic, acute, chronic, and rehabilitative health concerns for clients.

3. Show increasing evidence of ability to develop, implement and evaluate an appropriate plan for health maintenance and health promotion of clients.

4. Show evidence of ability to integrate health promotion/disease prevention activities into each client encounter.

5. Provide evidence of advanced nursing activities to promote and maintain health of children.

6. Demonstrate ability to provide quality, culturally sensitive health care for individuals of diverse cultural and ethnic backgrounds.

7. Provide evidence of the ability to formulate and administer advanced nursing care and medical therapeutics in a variety of setting.

8. Integrate current research findings into the development and implementation of health care for children and their families.

9. Continue personal development of the various roles of the nurse practitioner as evidenced by didactic and clinical work.

GUIDELINES FOR CLINICAL EXPERIENCES

1. **Use of Protocol Manuals:**
   Occasionally, students encounter preceptor sites that do not use formal protocols. It is recommended that students select a published protocol book to use in these circumstances. The selected reference should be discussed with and reviewed by the clinical preceptor. If agreeable, the protocols will be the basis for your care with appropriate modifications as necessary in that clinical site.

2. **Documentation of Care:**
   The UTA College of Nursing Nurse Practitioner Program requires a wide variety of clinical hours which necessitates the student to obtain experiences in numerous settings. The student is expected to appropriately, thoroughly, and accurately document each client encounter on the client's health record, i.e., SOAP notes, clinical summaries, etc. All entries made by the student in the client's health record should be reviewed by the preceptor. Documentation will be co-signed by the preceptor as appropriate for the clinical site. If you are in a site using an Electronic Medical Record, you may be required to do SOAP notes in the clinical setting to document your care at the request of your clinical faculty and/or preceptor.

3. **Clinical Preceptors:**
   Students are encouraged to utilize several preceptors throughout their nurse practitioner coursework. Guidelines for the selection of preceptors are included in the "Preceptor Agreement Packet." Please note that the "Letter of Agreement" in the packet MUST be signed and on file at UTA BEFORE clinical experiences commence at the site. {Students are expected to negotiate their clinical objectives and number of hours with each preceptor.} If for any reason, the primary preceptor is absent i.e., not physically in the practice setting, the student <u>may not make any decisions requiring medical management. Your clinical preceptor is responsible to see EVERY patient that you see.</u>

4. **Site Visits:**
   The Nurse Practitioner Faculty may evaluate the student's clinical abilities at his/her clinical site and/or an appointed clinical site at regular intervals and/or for the final clinical practicum. The student will be evaluated according to criteria on the "Faculty Site Visit Form" or "Clinical Practicum Form."

5. **Preceptor Evaluations:**
   Preceptor evaluations are required each semester and indicate the student's clinical performance **over time** as opposed to the site visit and/or practicum evaluation, which evaluates clinical performance on <u>one</u> client. Evaluations can be obtained from those preceptors that spend <u>16 hours or more</u> in clinical with the student. The student is encouraged to ask the preceptor to <u>discuss the evaluation</u> with him/her before mailing it to the student's clinical advisor.

6. **Clinical Notebook:**
   A notebook will be kept of all the student's clinical experiences throughout the NP Program. (See "Clinical Notebook Guidelines.")

7. **Professional Attire:**
   Students should dress professionally and appropriately according to the clinical practice setting. <u>A name pin must be worn at all clinical sites at all times and a lab coat</u> identifying the student as a nurse practitioner student may be worn in client encounters <u>as appropriate</u>.

8. **Clinical Conferences With Faculty:**
   At various intervals throughout the NP Program, the student and faculty advisor may meet to discuss the student's progress towards obtaining clinical objectives, the student's overall performance in the program and other areas of concern. During these conferences, it is expected that the student share information with the clinical advisor that will help the advisor evaluate the quality and scope of the clinical experiences. On occasion, these conferences may be conducted via telephone, particularly for student's living out of the Metroplex area.

9. **E-LOGs:**
   Students are responsible for maintaining accurate clinical documentation in the e-log. These must be up-to-date.

Clinical Notebook
Guidelines

The Clinical Notebook should be organized an electronic notebook with appropriate files saved on a flash drive.

1. Precepted Hours/Signature Page

    a. Must have preceptor sign each day of clinical experience in the appropriate space attesting to the number of patients you have seen and the hours you were present. This page also includes the total number of patients seen that day and your hours for the day. Make sure you show a lunch break in accordance with BON rules.

2. At the end of your clinical, please total this page showing the total number of clinical hours completed with each preceptor.

3. Personal Clinical Objectives

    a. How and Why—personalize these to you and your learning needs
    b. Evaluate each one as to Met, Partially Met, Not Met - give brief description

4. Self-Evaluation—form provided on nursing website

5. Student Evaluation of Preceptor-- form provided on nursing website

6. Preceptor Evaluation-- form provided on nursing website; keep a copy for your records and turn in a copy to the CON Graduate Office at npclinicalclearance@uta.edu.

7. Practicum Evaluation

    a. Midterm, as applicable
    b. Final

8. CDMS and Other Graded Assignments

9. E-logs Final Printout (Print the Total Hours Page and/or copy and save this file)

Developmental Paper
Pediatric Management

Due: TBA

Guidelines:

The paper is a summary of your findings from ITFI Tool and Developmental Assessment presented in a Subjective, Objective, Assessment, and Plan (SOAP) format and is required to be 2-3 typed pages. Please provide one copy to hand in, and keep one copy in your file at home. We are looking for quality not quantity, good grammar, and correct spelling. Be sure to use a SOAP note outline, but with a narrative format. Include all subjective information in one section, i.e., anything you are told by the family. Include all objective information in another section, i.e., things you observe and record, particularly those issues related to the developmental map. You may also include things you directly observe in the session related to parent – child interaction, temperament of the child, etc. Finally, you need to include your assessment or your impression, which clearly states how you see the child and family at this point in time, and summarizes all the data you have gathered about the child and family. Your last paragraph will address your plan, and clearly is a "road map" for dealing with the items outlined in your assessment/impression.

Suggested Readings
Developmental Assignment
Pediatric Management

Burns, C. E., Dunn, A. M., Brady, M. A., Barber Starr, N., & Blosser, C. G. (2013). *Pediatric primary care*. (5th ed.). Philadelphia, PA: Elsevier Saunders. **ISBN**: **9780323080248**
(Pedi, Family, & Psych)
Chapters 7, 8, 9, 22

National Research Council Institute of Medicine, From Neurons to Neighborhoods

Frailberg, Clinical Studies in Infant Mental Health The First Years of Life

Apfel and Provence, Manual for the Infant-Toddler and Family Instrument (LRC/UTA)

Zero To Three Bulletin of National Center for Infants, Toddlers and Families

Green, Bright Futures: Guidelines for Health Supervision

The University of Texas at Arlington
College of Nursing
N5306 Pediatric Management in Advanced Nursing Practice

TIPS FOR DEVELOPING YOUR CDM:

1. If you have a positive complaint, it must be addressed in the physical exam, assessment, and plan.

2. It is not necessary to do a comprehensive review of systems (ROS) but pertinent systems must be included for the episodic visit. You should complete a ROS with information pertinent to the presenting problem, current medications (indicate why patient is taking the medication, i.e., Amoxicillin 250 mg po bid for otitis media, etc.), and status of concurrent health problems only. Pertinent past medical history, family history, and social history should be addressed. Your history should be focused.

3. "Rule out" diagnoses are those diagnoses that are most probable, and must be addressed in the plan (Ex: What do I need to do to rule this out?). A differential diagnosis is merely one that you consider as you are taking the history, and doing the physical exam. It is not addressed in the plan as it is not one of your "most likely."

4. Use multiple sources as you reference the pathophysiology. Use National Guidelines to develop your plan and rationale for the management portion. All sources must be referenced according to <u>APA</u> format. It is **required** that you check web sites (i.e. AAP, CDC, NHLBI, NIH, etc.) for **the latest practice guidelines** on common diseases.

    Some examples include:
    http://www.nhlbi.nih.gov/index.htm
    http://www.aap.org/default.htm
    http://www.cdc.gov/

When you are doing your review of systems, the "general" category includes symptoms (subjective) such as fever, malaise, fatigue, night sweats, and weight change. It does not include any objective information such as "alert", "oriented", or "good historian."

When you are giving the rationale for medication usage, please explain the drug's category and action (i.e., third generation cephalosporin antibiotic and is used primarily for gram positive organisms), and why the patient has been prescribed the particular medication.

PLEASE use the following format when preparing your CDM (see next page).

N5306 Pediatric Management
CLINICAL DECISION MAKING (CDM) GUIDE

I. SUBJECTIVE DATA
   A. Chief complaint.
   B. History of Present Illness with 7 variables as used in the UT Arlington Advanced Assessment Course (N5418).

The present illness should include all positive historical findings, as well as pertinent negatives, regardless of where in the history the information normally would be placed. For example, the immunization history should be mentioned here for a patient suspected of having measles, even though immunizations usually are mentioned in the past history. Similarly, a family history of sickle cell anemia should be mentioned in a patient admitted for evaluation of anemia, even though it usually is discussed in the family history.

Remember physical examinations, laboratory evaluations, assessments, and treatments that occurred before this presentation are now part of the history and should be included now, at the appropriate chronological point in the history. Avoid giving your assessment at this point; this belongs later, in the assessment section.

   C. Current health data is obtained
      1. Current medications
      2. Allergies
      3. Last physical examinations
      4. Immunization status
      5. LMP and type of birth control (if applicable)
   D. Past Medical History
      1. Illnesses / trauma
      2. Hospitalizations
      3. OB History (may be N/A) or include Birth History for a newborn or young child
      4. Sexual History
      5. Emotional/Psychiatric History
   E. Family History
   F. Personal/Social History
   G. Review of Systems (appropriate to clinical scenario)

II. OBJECTIVE DATA
   A. Examination of appropriate systems, laboratory or diagnostic test (if results are available.)

III. ASSESSMENT
   A. Primary Diagnosis(es) – ICD 9 and/or ICD 10 Codes with pathophysiology that correlates with the patient data for major diagnosis. Include references. This is not to be an "excerpt" from a medical text, rather a rationale for choosing this diagnosis that is related back to your patient. You may want to list "**pertinent positives"** (why you think what you think). At times, a secondary diagnosis may also be present.

B. Rule-Out Diagnosis- ICD-9 and/or ICD-10 Codes with **explanation of why** ("**pertinent positives"**) you think this is a possible diagnosis based on subjective and/or objective data provided. List at least 1 rule out diagnosis.
C. Differential Diagnosis – this may be a "laundry" list of ALL possible diagnosis that could fit the data you are given. List at least 1 differential diagnosis.

IV. **PLAN**
A. Write a plan of care for the patient described in the case. *Include a detailed, scientific, evidence-based rationale for each intervention you plan.* **Search the current literature and find a national guideline to guide your management plan**. *If you plan a new, controversial, or not widely used intervention, provide specific references and a discussion of the literature supporting the use of the intervention.* If you noted something during the Subjective or Objective part of the H&P, you have to mention it in your plan.
B. Cost Effectiveness of your Plan – please discuss the cost effectiveness, pricing for medications, formula changes, labs, or other testing, etc.
C. Diagnostic studies and/or laboratory tests with rationale for each treatment in the management plan and appropriate references. The plan should include how you will "rule-out" or "rule-in" your primary diagnosis and each of the diagnosis listed.
D. Medical therapeutics/Nursing therapeutics, prescriptions with rationale for each treatment and appropriate references.
E. Patient education with references
F. Counseling (when appropriate)
G. Health promotion/health maintenance (This is NOT patient education related to the diagnosis; this is information to keep your patient safe and well.)
H. Referral(s) (when appropriate)
I. Consult(s) (when appropriate)
J. Follow-up appointments

V. **GENERAL DOCUMENTATION GUIDELINES**
K. Use appropriate terminology, proper spelling, and grammar.
L. Write-up should be organized and complete.
M. References should be in APA format.

PLEASE ATTACH A GRADING SHEET WITH ANY WORK YOU TURN IN. THANK YOU

FORMAL CLINICAL DECISION MAKING (CDM) ASSIGNMENT
EVALUATION GUIDE/GRADE SHEET

Student:_____   Date:_____

Faculty:_____   Grade:_____

Possible Points	**Actual Points**	
20	_____	A. Completed subjective and objective database, as appropriate to scenario. Data prioritized, with pertinent positives established.
20	_____	B. Assessments, rule-out diagnoses, and differential diagnoses stated appropriately with the ICD-9 or ICD-10 Code(s).
20	_____	C. Physiological and pathological process leading to diagnosis(es) are documented and referenced.
20	_____	D. Plan is sound, logical, cost-effective and includes both medical and nursing management and is referenced. Should put initial tests that are indicated – order these tests first and if additional tests are required, briefly discuss what might be needed at a later time or visit. Should include a section entitled Health Promotion/Health Maintenance.
20	_____	E. Rationale and **references are provided for each step in the management plan**. **Reference and Provide** the front page of a **National Guideline** to guide and reference your plan. Also include a grading sheet.

Total Points:_____

COMMENTS:

FORMAL CLINICAL DECISION MAKING (CDM) ASSIGNMENT
EVALUATION GUIDE/GRADE SHEET

Student:_____   Date:_____

Faculty:_____   Grade:_____

Possible Points	**Actual Points**	
20	_____	A. Completed subjective and objective database, as appropriate to scenario. Data prioritized, with pertinent positives established.
20	_____	B. Assessments, rule-out diagnoses, and differential diagnoses stated appropriately with the ICD-9 or ICD-10 Code(s).
20	_____	C. Physiological and pathological process leading to diagnosis(es) are documented and referenced.
20	_____	D. Plan is sound, logical, cost-effective and includes both medical and nursing management and is referenced. Should put initial tests that are indicated – order these tests first and if additional tests are required, briefly discuss what might be needed at a later time or visit. Should include a section entitled Health Promotion/Health Maintenance.
20	_____	E. Rationale and **references are provided for each step in the management plan**. **Reference and Provide** the front page of a **National Guideline** to guide and reference your plan. Also include a grading sheet.

Total Points:_____

COMMENTS:

PREVENTION OF ACADEMIC DISHONESTY GUIDELINES

Special Instructions Regarding Assignments

Unless otherwise instructed, all course (class & clinical) assignments are to follow the following guidelines:

1. Each student is expected to do each assignment independently. This means no consultation, discussion, sharing of information, or problem-solving to complete any component of the assignment. This includes your preceptor – do not ask the preceptor to advise you on an assignment.
2. It is your ability and clinical decision-making that we are assessing through the assignments – not your colleagues.
3. Any violation of these instructions will result in academic dishonesty a violation of UTA's Academic Dishonesty Policy. The penalties can range from failure on the assignment, course failure and/or expulsion from the program.
4. The student will turn in the original and 1 copy of each written assignment. One copy will be maintained in a permanent file after a faculty assesses all class papers. The graded copy will be returned to the student and will be maintained in the clinical notebook.
5. If at any time a student is aware of academic dishonesty committed by a classmate, the student is expected to inform the faculty.
6. Academic dishonesty is cheating and will not be tolerated in this program. RNs are expected to conform to professional ethics whether in the classroom or in the clinical setting.

You are asked to sign below to indicate that you understand the above guidelines.

_____
Name

_____
Date

University of Texas Arlington College of Nursing
N5306, N5442, N5444, N5631/5631 Courses Hours Log
Patient Encounters Record

Student: _____   Facility/Preceptor: _____

Date	# of Patients Seen	Time In	Lunches/Breaks	Time Out	Total Hours	Preceptor Signature

Date	# of Patients Seen	Time In	Lunches/Breaks	Time Out	Total Hours	Preceptor Signature

N5306 Summer 2014   Tentative Course Schedule:

Class	Topics	Readings/Podcasts	Assignments/Due Dates
Class 1 (June 7)	1. Orientation to the Course 2. Immunizations 3. HEENT	1. Prior to class, watch the following lectures (podcasts) on Blackboard: a. Immunizations b. HEENT 2. Read the chapters in Burns et al. (2013) and/or Nelson's (Kliegman et al., 2011) that corresponds with the topics listed for class BEFORE you attend class. Nelson's (Kliegman et al., 2011) is not a required textbook except for Pedi Majors. 3. Other lectures (podcasts) to be watched include: a. Developmental lectures across age groups (plus YouTube videos) b. Growth and development theory c. Torticollis and plagiocephaly webcast & images (under YouTube & Supplemental Learning) d. Colic 4. Read the chapters in Burns et al. (2013) and/or Nelson's (Kliegman et al., 2011) that corresponds with the topics listed for other lectures (podcasts). Nelson's (Kliegman et al., 2011) is not a required textbook except for Pedi Majors.	1. Clinical Decision-Making (CDM) In-Class Exercises/Group Exercises
Class 2 (June 28)	1. Cardiology 2. Asthma	1. Prior to class, watch the following lectures (podcasts) on Blackboard: a. Respiratory 2. Read the chapters in Burns et	1. Prior to class, complete the Texas Health Steps on-line courses and print certificates for your clinical instructor (due 06/28/14) 2. Prior to class, complete and

Class	Topics	Readings/Podcasts	Assignments/Due Dates
		al. (2013) and/or Nelson's (Kliegman et al., 2011) that corresponds with the topics listed for class BEFORE you attend class. Nelson's (Kliegman et al., 2011) is not a required textbook except for Pedi Majors. 3. Other lectures (podcasts) to be watched include: a. HIV and Hepatitis b. Urgent Office Conditions 4. Read the chapters in Burns et al. (2013) and/or Nelson's (Kliegman et al., 2011) that corresponds with the topics listed for other lectures (podcasts). Nelson's (Kliegman et al., 2011) is not a required textbook except for Pedi Majors.	submit on-line the Developmental Paper (due 06/28/14) 3. Clinical Decision-Making (CDM) In-Class Exercises/Group Exercises 4. Test 1 (on-line) from 07/11/14-07/13/14 5. CDM #1 (Asthma; Individual) due on-line 07/05/14
Class 3 (July 19)	1. Headaches 2. Syncope 3. GI	1. Prior to class, watch the following lectures (podcasts) on Blackboard: a. GI 2. Read the chapters in Burns et al. (2013) and/or Nelson's (Kliegman et al., 2011) that corresponds with the topics listed for class BEFORE you attend class. Nelson's (Kliegman et al., 2011) is not a required textbook except for Pedi Majors. 3. Other lectures (podcasts) to be watched include: a. Audiology b. Adolescent Lecture (Health Maintenance) c. Hyperbilirubinemia	1. Clinical Decision-Making (CDM) In-Class Exercises/Group Exercises 2. CDM #2 (Newborn; Individual) due on-line 07/26/14 3. On-line Final Exam from 08/09/14-08/11/14 4. Clinical Notebooks due to Clinical Faculty by 08/11/14 (plus all that needs to be included)

Class	Topics	Readings/Podcasts	Assignments/Due Dates
		(Jaundice) d. Neonatal sepsis e. Orthopedics f. Febrile seizures & epilepsy g. GU h. Dermatology 4. Read the chapters in Burns et al. (2013) and/or Nelson's (Kliegman et al., 2011) that corresponds with the topics listed for other lectures (podcasts). Nelson's (Kliegman et al., 2011) is not a required textbook except for Pedi Majors.	
Class 4 (August 2 or 9)	1. Clinical Check-off/Clinical Practicum		1. Clinical Check-off/Clinical Practicum with Standardized Patients

*Please see Blackboard for a more detailed schedule for class days.

"As the instructor for this course, I reserve the right to adjust this schedule in any way that service the educational needs of the students enrolled in this course". – Sharolyn Dihigo, DNP, RN, CPNP-PC