**(CLINICAL)**

**The University of Texas at Arlington**

**College of Health Innovation**

**N5441 Acute Care Pediatric**

**Fall 2014**

**Instructor(s):**

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| **Lindy Moake, , RN, MSN, PCCNPC*****Clinical Instructor***Office Number: Pickard Hall #626Office Telephone Number: 817-272-4885Email Address: Moake@uta.edu Faculty Profile: <https://www.uta.edu/mentis/profile/1672> Office Hours**:** By Appointment |
| **Howard McKay, MSN, RN, FNP-C, CPNP-AC*****Clinical Instructor***Office Number: Pickard Hall #626Office Telephone Number: 817-272-4885Email Address: Mckay@uta.edu Faculty Profile: TBAOffice Hours: By Appointment |
| **Sara Moore, RN, MSN, PNP, PNP-BC, CPNP-AC*****Clinical Instructor***Office Number: Pickard Hall #626Office Telephone Number: 817-272-4885Email Address: Moores@uta.edu Faculty Profile: [https://www.uta.edu/mentis/profile/4858](https://www.uta.edu/mentis/profile/?4858) Office Hours**:** By Appointment |

**Section Information:**

NURS 5441 Sections 001-004

**Time and Place of Class Meetings:**

Friday, 9am-5:00pm Pickard Hall Room # 223

**Description of Course Content:**

Focus is on advanced, interdisciplinary practice to assess, diagnose, and manage acute and critical, single and multi-system health problems of children birth to 21 years in secondar7y and tertiary care settings.

**Other Requirements:**

NURS 5306; 5314 and N5442 or concurrent enrollment; or Certificate Program standing. 2 Lecture Hours, 6 Lab hours.

**Student Learning Outcomes:**

Upon completion of the course, the student will be able to:

1. Assess, diagnose, and manage children birth to 21 years with acute and critical, single and multi-system health problems using evidence-based knowledge.
2. Use technology to provide therapeutic management of children with complex acute and critical illnesses.
3. Collaborate with other health professionals to promote quality health outcomes for acutely and critically ill children and their families.
4. Use research to examine outcomes of Acute Care Pediatric Nurse Practitioner (ACPNP) practice.

**Required Textbooks and Other Course Materials:**

1. Reuter-Rice, K. and Bolick, B. (2011). *Pediatric Acute Care: A Guide to Interprofessional Practice.* Jones and Bartlett **ISBN: 9780763779719**
2. AACN. (2007). *AACN Procedure Manual for Pediatric Acute and Critical Care.* Saunders **ISBN: 9780721606408**
3. American Heart Association and the American Academy of Pediatrics. (2012)
4. *Pediatric Advanced Life Support Provider Manual.* Dallas, TX:American Heart Association **ISBN: 9781616691127**
5. Lieh-Lai, M., Ling-McGeorge, K., Asi-Bautista, M., Reid, C. (2001)
6. *Pediatric Acute Care: (Core Handbooks in Pediatrics)* (2nd ed.).Philadelphia, PA: Lippincott Williams and Wilkins **ISBN:** **9780781728522**

**Recommended Textbooks:**

1. Kliegman, R. Stanton, B., Geme, J., Schor, N., Behrman, R. (2011). *Nelson Textbook of Pediatrics,* (19th ed.). St. Louis, MO: Saunders **ISBN: 9781437707557**
2. Perkin, R., Swift, J., Newton, D., Anas, N. (2007) *Pediatric Hospital Medicine***: *Textbook of Inpatient Management.* (2nd ed.).**Philadelphia, PA: Lippincott Williams and Wilkins **ISBN: 9780781770323**
3. Johns Hopkins Hospital, Arcara K., Tschudy, M. (2011). *Harriet Lane Handbook.* (19th ed.). St Louis, MO: Elsevier Mosby **ISBN: 9780323079426**
4. Tobias, J.D. (1999). *Pediatric Critical Care: The Essentials.* Wiley-Blackwell I**SBN: 9780879934286**
5. Allen, P., Vessey, J., Schapiro, N. (2009). *Primary Care of the Child with a Chronic Condition* (5th ed.).St. Louis, MO: Mosby Elsevier **ISBN: 9780323058773**
6. Walsh, E., Saul, J., Triedman, J. (2001) *Cardiac Arrhythmias in Children and Young Adults* Philadelphia, PA: Lippincott Williams and Wilkins **ISBN: 9780397587445**
7. Nichols, D. (2008). *Rogers’ Textbook of Pediatric Intensive Care.* (4th ed*.*). Baltimore, MD: Lippincott, Williams & Wilkins **ISBN: 9780781782753**
8. Gilbert-Barness, E., Barness, L. (2009).*Clinical Use of Pediatric Diagnostic Tests.* (2nd ed.). IOS Press **ISBN: 9781586039936**
9. Park, M., Guntheroth, W., (2006). *How to Read Pediatric ECG’s.* (4th ed.). **ISBN: 9780323035705**
10. American Academy of Pediatrics (2013). *Caring for the Hospitalized Child: A Handbook of Inpatient Pediatrics***.**  **ISBN: 9781281107548**

**Descriptions of major assignments and examinations with due dates:**

**DIDACTIC CONTENT EVALUATION**

|  |  |  |
| --- | --- | --- |
| Clinical Case IPE Project and Poster | 10% | **11/14/2014**  |
| CDM #1 | 15% | **10/10/2014** |
| CDM #2 | 15% | **11/21/2014** |
| Multiple Choice Exam #1 | 25% | **10/25/2014** |
| Multiple Choice Exam #2 | 25% | **12/05/2014** |

**CLINICAL EVALUATION**

|  |  |
| --- | --- |
| Preceptor Evaluation | Credit |
| Mid-clinical Site Visit if indicated | Credit |
| At mid-point of clinical hours |  |
| Final Clinical Practicum | 10% |
| Clinical - E-Logs | Credit |
|  |  |

**Grading Policy:**

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

**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>

**Expectations of 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 6-9 hours per week on their own time in course-related activities, including reading required materials, completing assignments, preparing for exams, etc.

**Attendance Policy:**

At The University of Texas at Arlington, taking attendance is not required. Rather, each faculty member is free to develop his or her own methods of evaluating students’ academic performance, which includes establishing course-specific policies on attendance. As the instructor of this section, **Regular class attendance and participation is expected of all students. Students are responsible for all missed course information.**

**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=20146>

1. A student may not add a course after the end of late registration.
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) Contact your graduate advisor to obtain the form and further instructions.

**Census Day: September 8, 2014**

**Last day to drop or withdraw October 29, 2014**

**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](http://www.uta.edu/disability) or by calling the Office for Students with Disabilities at (817) 272-3364.

**Title IX:**

The University of Texas at Arlington is committed to upholding U.S. Federal Law “Title IX” such that no member of the UT Arlington community shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity. For more information, visit [www.uta.edu/titleIX](http://www.uta.edu/titleIX).

**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.*

UT Arlington faculty members may employ the Honor Code as they see fit in their courses, including (but not limited to) having students acknowledge the honor code as part of an examination or requiring students to incorporate the honor code into any work submitted

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](http://www.uta.edu/resources).

**Electronic Communication:**

UT 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.

**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 exit. 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 individuals with disabilities.

**Librarian to Contact:**

**Peace Williamson**, *Nursing Librarian*

Phone: (817) 272-7433

E-mail: peace@uta.edu

Research Information on Nursing:

[**http://libguides.uta.edu/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](http://ask.uta.edu/)

The following URL houses a page where we have gathered many commonly used resources needed by students in online courses: <http://www.uta.edu/library/services/distance.php>

**UTA College of Health Innovation - 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.**

**Status of RN Licensure:** 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](http://www.bon.state.tx.us)

**MSN Graduate Student Dress Code:** The University of Texas at Arlington College of Health Innovation 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 Health Innovation Student Dress Code on the nursing website:<http://www.uta.edu/nursing/msn/msn-students> **.**

**UTA Student Identification: MSN Students MUST be clearly identified as UTA Graduate Students and wear a UTA College of Health Innovation 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](http://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 Health Innovation 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 Health Innovation has a “no gift” policy. A donation to one of the UTA College of Health Innovation 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 UTACHI 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 Writing Center provides the workshops below to help guide graduate students through the demands of writing at the graduate level. In order to sign up for workshops, students must register with the Writing Center at http://uta.mywconline.com/. Workshops are listed on the regular appointment schedule. If you experience any difficulty signing up for any of these, please call (817) 272-2601 and one of our staff will be happy to assist.

All Workshops hosted by the Writing Center are held in 411 Central Library and are offered at 6 p.m. on Mondays, Tuesdays, Wednesdays or Thursdays. These are not recorded and are not available online.

**Department of Advanced Practice Nursing**

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| --- | --- |
| **Mary Schira,** PhD, RN, ACNP-BCAssociate Dean and Chair; Graduate AdvisorEmail: sCollege of Health Innovationra@uta.edu  | **Rose Olivier**, Administrative Assistant IOffice # 605-Pickard Hall, (817) 272-9517Email: olivier@uta.edu  |
| **Sheri Decker**, Assistant Graduate AdvisorStudents: A-JOffice # 611-Pickard Hall, (817) 272-0829Email: s.decker@uta.edu  | **Janyth Arbeau,** Clinical CoordinatorOffice # 610- Pickard Hall, (817) 272-0788Email: Arbeau@uta.edu or npclinicalclearance@uta.edu  |
| **Luena Wilson**, Graduate Advisor IStudents: K-ZOffice # 613-Pickard Hall, (817) 272- 4798Email: lvwilson@uta.edu  | **Kimberly Hodges,** Support Specialist IIOffice #612 Pickard Hall, (817) 272-9373E-mail: khodges@uta.edu or npclinicalclearance@uta.edu |
| **Sonya Darr**, Support Specialist IOffice # 609-Pickard Hall, (817) 272-2043 Email: sdarr@uta.edu  | **Timara Spivey**, Admissions AssistantOffice # 606, Pickard Hall (817) 272-4796Email: tnspivey@uta.edu or npadmasst@exchange.uta.edu |

**Emergency Phone Numbers:** In case of an on-campus emergency, call the UT Arlington Police Department at 817-272-3003 (non-campus phone), 2-3003 (campus phone). You may also dial 911.

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**READING ASSIGNMENTS**

**Reading assignments coincide with scheduled lectures. If there are any specific reading assignments we will post on BB.**

**UNIVERSITY OF TEXAS AT ARLINGTON**

**COLLEGE OF NURSING**

**N 5441 - Pediatric Acute Care**

### Fall 2014 Grade Summary

**Didactic Content Evaluation Score**

Exam 1 25% \_\_\_\_\_\_\_

Exam 2 25% \_\_\_\_\_\_\_

IPE project

and poster 10% \_\_\_\_\_\_\_

CDM #1 15% \_\_\_\_\_\_\_

CDM #2 15% \_\_\_\_\_\_\_

**Clinical Evaluation**

Preceptor Evaluation Credit \_\_\_\_\_\_\_

Final Clinical Practicum 10% \_\_\_\_\_\_\_

Clinical Evaluation Scantrons Credit \_\_\_\_\_\_\_

**Total** **100% \_\_\_\_\_\_\_**

**IPE Assignment: Clinical Case Presentation and Poster**

**Assignment Part I: Poster (70%)**

Purpose of assignment: To exhibit results of group work on each scenario

The poster should contain the following sections: Assessment, Plan, Evaluation, and Group Process

We will be discussing generic rubric for posters at IPE day (09/13/2013), Grading rubrics for your CDM’s may be found on pages 18-20 of this syllabus.

|  |  |  |  |
| --- | --- | --- | --- |
| **Category** | **Criteria** | **Points****Possible** | **Points****earned** |
| Assessment | Primary medical diagnosis(es) identified (10 points)Primary psychosocial problem(s) identified (10 points) | 20 |  |
| Plan | Appropriate interventions identified for each primary diagnosis/problem  | 30 |  |
| Evaluation | How will the effectiveness of the plan be evaluated (what’s next)? | 10 |  |
| General | Poster appearance (organized, free of errors, creativity)List of references in APA format | 10 |  |
|  |  | 70 |  |

Comments:

**Assignment Part II: Group Process Document (30%)**

|  |  |  |
| --- | --- | --- |
| **Criteria** | **Points****possible** | **Points****earned** |
| List of group activities with dates, venues, and participants | 10 |  |
| Evaluation of group process (what worked, what didn’t?) | 10 |  |
| What did you learn about your own and other discipline? | 10 |  |
|  | 30 |  |

Comments:

**The University of Texas at Arlington**

###### College of Nursing

**N5441 Acute Care Pediatrics**

**TIPS FOR DEVELOPING YOUR Clinical Decision Making (CDM) papers**

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 complete review of systems for an interval visit. You should do a ROS for the presenting problem; current medications (indicate why patient is taking the medication, i.e., Amoxicillin 250 mg po tid for otitis media. Include the day of antibiotic therapy if necessary, i.e. Day 7/10.), and status of concurrent health problems only. Pertinent past medical history, family history, and social history should be addressed. Your history shouldbe 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 one that you consider as you are taking the history, and doing the physical exam. It may or may not be addressed in the plan depending on the data you gather in the “S” and “O”.

1. You may not cite a handbook as your reference for the pathophysiology or rationale for your plan. All sources must be referenced according to APA format. It is recommended that you check web sites (i.e. AAP, CDC, NHLBI, NIH, etc) for the latest guidelines on common diseases as reference to your plan. If there is a recent article, recommendation, clinical practice guideline, or a specific protocol, then cite whichever is appropriate. Your text should be the last option to cite as a reference for your plan. REMEMBER, most texts are out-of-date by the time they get to the publisher.

<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 such as fever, malaise, fatigue, night sweats, and weight change. It does not include any objective information such as “alert”, “oriented”, “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 and Expanded SOAP/Patient Encounter. If a category is not applicable, simply put NA.

**N5441 Acute Care Pediatrics**

**CLINICAL DECISION MAKING GUIDE/SOAP NOTE GUIDE**

* 1. **SUBJECTIVE DATA**
		1. Chief complaint
		2. History of Present Illness

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.

Begin the present illness with "the patient was in good health until . ..." or, if the patient has a chronic illness, with "the patient was in his usual state of health until . . ." Then begin the story of the present illness with the earliest relevant facts, and proceed in chronological order.

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.

**Address the following only as appropriate:**

* + 1. 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)
		2. Past Medical History
			1. Illnesses / trauma
			2. Hospitalizations
			3. OB History
			4. Sexual History
			5. Emotional/Psychiatric History
		3. Family History
		4. Personal/Social History
		5. Review of Systems (appropriate to clinical scenario)
	1. **OBJECTIVE DATA**
1. Examination of appropriate systems, laboratory or diagnostic test (if results are available.)
	1. **ASSESSMENT**
	2. Primary Diagnosis(es) – ICD 9 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***.
	3. Differential Diagnosis- ICD-9 Codes with explanation of why you think this is a possible diagnosis based on subjective and/or objective data provided. ***This is not to be a “laundry” list of ALL diagnosis, only those that fit the data you are given.*** If you are absolutely sure of the primary diagnosis there will not be a list of differential diagnosis.
	4. Nursing diagnosis(es)
	5. **PLAN**
2. Write a plan of care for the patient described in the case. Include a **detailed, scientific and when possible, an evidence based rationale for each intervention you 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.
3. 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 differential diagnosis listed. If you are absolutely sure of the primary diagnosis there will not be a list of differential diagnosis.
4. Medical therapeutics/Nursing therapeutics, prescriptions with rational for each treatment and appropriate references
5. Patient education with references
6. Counseling (when appropriate)
7. Health promotion/health maintenance (when appropriate)
8. Referral (when appropriate)
9. Consults (when appropriate)
10. Follow-up appointments
	1. **DOCUMENTATION**
		1. Should reflect ***pertinent*** normal and abnormal findings
		2. Use appropriate terminology
		3. Write-up should be organized and complete

**FORMAL CLINICAL DECISION MAKING (CDM) ASSIGNMENT**

**EVALUATION GUIDE/GRADE SHEET**

Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Possible Actual**

**Points Points**

20 \_\_\_\_\_\_ A. Completed subjective and objective database, as appropriate to scenario.

* + - * + 7 variables (5 points)

-2 if not put into 7 variables

* + - * + PMH (2 points), FH (2 points), SH (1 point)
				+ ROS (3 points)
				+ Objective (5 points)

Growth percentiles (1 point out of the 5 points for objective)

BMI (1 point out of the 5 points for objective)

* + - * + Additional questions written that would be asked (not provided in scenario) (2 points)

20 \_\_\_\_\_\_ B. Data prioritized, with pertinent positives established. Assessments, rule-out diagnoses, and differential diagnoses stated appropriately with the ICD-9 or ICD-10 Code(s).

* Pertinent positives (2 points)
* Diagnosis/diagnoses – include all diagnoses (10 points)
* Rule-outs (2 points)
* Differentials (3 points)
* ICD-9 or ICD-10 codes (3 points)

20 \_\_\_\_\_\_ C. Physiological and pathological (patho) process leading to diagnosis(es) are documented and referenced. Patho must be completed on EACH main diagnosis.

* Includes judgment and references (10 points)
* Must relate to patient (10 points)

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.

* Plan (12 points)
* Cost effectiveness (4 points)
* Health Promotion/Health Maintenance (4 points)

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.

* Rationale (5 points)
* References in plan (5 points)
* National Guideline Used (10 points)
	+ -5 points if not provided but referenced

**Total Points**:\_\_\_\_\_\_\_\_\_\_\_

**COMMENTS:**

**University of Texas at Arlington College of Nursing**

**N5441 Pediatric Acute Care**

**Fall 2014**

**Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Advisor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Clinical Major:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

| **Type of hours** | **Hours** | **# of Patients** | **Agency** | **Preceptor Signature** |
| --- | --- | --- | --- | --- |
| **Daily/Routine**  |  |  |  |  |
| **Daily/Routine**  |  |  |  |  |
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| **Admission** |  |  |  |  |
| **Discharge** |  |  |  |  |
| **Post-op** |  |  |  |  |
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**ACUTE CARE PEDIATRIC NURSE PRACTITIONER**

**CLINICAL OBJECTIVES**

1. Provide evidence of clinical skills in performing advanced health assessments to include:
2. Collecting a complete health, family, and developmental history
3. Examining all body systems, identifying physiological and pathological processes.
4. Collecting additional data as needed (EKG, laboratory, radiologic)
5. Making appropriate decisions regarding priority needs for episodic data collection (subjective and objective)
6. Determining which problems/data collection can be deferred until later
7. Making an appropriate and accurate assessment of client's health status (rule outs, differential diagnoses, nursing diagnoses, etc.)
8. Presenting pertinent data to preceptor in a succinct manner
9. Presenting a cost-effective, clinically sound plan of care which may include:
* advanced nursing management
* medical intervention
* pharmacotherapeutics
* diagnostic testing
* family and developmental care
* teaching/counseling
* follow-up plan
1. Discussing with preceptor personal strengths and needed areas of improvement
2. Follow up plan and consultation for transition of care and discharge planning
3. Demonstrate increasing evidence of ability to develop, implement and evaluate an appropriate management plan for common episodic acute and chronic health concerns for children and families.
4. Demonstrate increasing evidence of ability to develop, implement and evaluate an appropriate plan for ongoing health maintenance and promotion of children and families.
5. Demonstrate evidence of ability to integrate health promotion/disease prevention activities into child and family encounters.
6. Provide evidence of advanced nursing plans to promote and maintain the health of children and families in order to promote self-care.
7. Demonstrate ability to provide sensitive, quality health care for individuals and families representative of diverse cultural and ethnic backgrounds.
8. Provide evidence of the ability to formulate and administer advanced nursing care and medical therapeutics in the acute care setting.
9. Integrate current research findings into the development and implementation of health care for children and families.
10. 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/Clinical Pathways:**

Students may encounter preceptor sites that do not use formal protocols or clinical pathways. Selected references used for protocols/pathways should be discussed with and reviewed by the clinical preceptor. If agreeable, the references will be the basis for your care with appropriate modifications as necessary.

1. **Documentation of Care:**

The student is expected to appropriately, thoroughly, and accurately document each client encounter on the client's health/medical record (i.e. SOAP notes, clinical summaries, etc.) unless facility policy prohibits. All entries made by the student in the client's record must be reviewed by the preceptor. Documentation will be cosigned by the preceptor as appropriate for the clinical site.

1. **Clinical Sites/Preceptors:**

Students are encouraged to use several preceptors throughout their nurse practitioner coursework. Clinical experiences and sites will be negotiated among the student, clinical faculty, and the preceptor. Guidelines for the selection of preceptors are included in the "Preceptor Agreement Packet" on the UTA Nursing website. 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 may FAX a signed copy of the preceptor agreement the first day of clinical experience. The FAX must be sent to the attention of their clinical faculty.

1. **Clinical Schedules:**

Students are expected to discuss their clinical objectives with the preceptor and negotiate a clinical schedule. The students must provide a copy of their proposed clinical schedule to their faculty advisor. **If for any reason, the preceptor is absent (i.e. not physically present in the practice setting), the student may not make any decisions requiring medical management**.

1. **Invasive Procedures:**

All invasive procedures performed by the student require direct supervision by the preceptor. Direct supervision means that the clinical preceptor is physically present in the patient’s room.

1. **Site Visits:**

The Acute Care Nurse Practitioner faculty will evaluate the student's clinical abilities at his/her clinical site and/or an appointed clinical site at regular intervals throughout the NP program. In some cases, the site visit may be conducted by telephone for those students gaining clinical experiences out of the Metroplex area. The student should be prepared to conduct episodic/follow-up/consult visits with clients and have selected several clients before the faculty arrives at the facility.

1. **Preceptor Evaluations:**

Preceptor evaluation of the student is required each semester and indicates the student's clinical performance **over time** as opposed to the site visit and/or practicum evaluation, which evaluates clinical performance on a limited number of clients. Evaluations can be obtained from those preceptors that spend 16 hours or more in clinical with the student. The student is encouraged to ask the preceptor to discuss the evaluation with them before mailing it to the student's clinical advisor.

1. **Clinical Experiences Journal:**

A journal will be kept of all the student's clinical experiences throughout the NP program. The journal must include a copy of the e-log data summary, clinical hour tally sheet, and sample client documentation. (See Guidelines)

1. **Professional Attire:**

Students should dress professionally and appropriately according to the clinical practice setting. A lab coat and Photo ID identifying the student as a nurse practitioner student should be worn in client encounters as appropriate.

1. **Clinical Conferences With Faculty:**

At regular intervals throughout the NP program, the student and faculty advisor will 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 students living out of the Metroplex area.

**CLINICAL EXPERIENCES JOURNAL GUIDELINES**

The Clinical Experiences Journal is a compilation of the student's experiences in all clinical settings and will be maintained throughout Acute Care. Using the provided format, the journal should reflect the following:

1. The ability to apply and integrate didactic/theoretical information into common acute care clinical situations.
2. All client encounters and specific information regarding advanced nursing management and medical therapeutics.
3. Increasing evidence of the student's critical decision making ability in acute health care settings.
4. The student's personal clinical objectives for each clinical site and their subsequent evaluation.
5. Application and integration of the various roles of the nurse practitioner in acute care settings.

**The Clinical Experiences Journal must include the following:**

1. **Client Encounters/Log**

For every clinical experience the student will enter the data into the e-log system, will summarize at 40 and 90 hours, and a copy placed in the clinical journal. E-log entries must be kept up to date. Data will be re-reviewed by the faculty at 40 and 90 hours. Students may not continue in clinical experiences unless the e-log encounters and Clinical Experience Patient Encounter Notes have been submitted to their clinical faculty. If the e-log does not apply to a clinical day, a brief narrative may be included to document the clinical day (e.g. day with Radiologist reading x-rays).

1. **Clinical Hour Tally Sheet**

The Clinical Hour Tally Sheet will be used to validate and summarize the completion of student clinical hours. Preceptor signature(s) must be included.

1. **Client Encounter Documentation**

Documentation samples are kept in the Clinical Experiences Journal and are representative of practice experiences. Notes should accurately reflect client encounters; diagnoses made, and recommended nursing/medical management. Standardized chart forms, checklists, SOAP notes, consult notes, admission history and physical exams, etc., may be used, and/or the student may include examples of documentation from the client’s medical record **as long as identifying patient information is removed and permitted by the clinical facility.**  The student is expected to include one documentation sample for each clinical day.

**N. 5441 Pediatric Acute Care**

**Class Schedule Fall 2014**

**Class Hours 9AM-5PM**

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| --- | --- | --- |
| **September 4, 2014** | **On Campus** | **IPE TBA** |
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| **September 5, 2014** | **On Campus** |  |
| **9:00- 10:00** | **Orientation and review of syllabus**  | **Faculty** |
| **10:00-10:45** | **SIADH/DI/CSW** | **Eichler** |
| **11:00-12:00** | **Acute Liver Failure**  | **Eichler** |
| **12:00-1:00** | **Diagnosis and Mgmt of acute renal problems/dialysis** | **Eichler** |
| **1:00-2:00** | **Lunch** |  |
| **2:00-3:00** | **Sepsis/shock/MOSF and Asthma/Hospital Management** | **Knapp** |
| **3:00-5:00** | **Pneumonia/Respiratory failure/ARDS** | **Knapp** |
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| **October 10, 2013** | **On Campus** |  |
| **9:00-10:00** | **Tumor lysis and other Cancer Crisis** | **Pavlock** |
| **10:00-11:00** | **Fluid and Electrolyte** | **Lund** |
| **11:00-12:00** | **Neonatal Emergencies** | **Leflore** |
|  | **CDM # 1 Due** | **ONLINE SUBMISSION** |
| **1:00-5:00pm** | **Smart Hospital scenarios** |  |
|  |  |  |
| **October 25, 2013** | **Test I (Test will be open from 10/25-10-27)** | **ONLINE SUBMISSION** |
|  |  |  |
| **November 14, 2014** | **On Campus** | **Poster Presentation Due** |
| **9:00-17:00** | **ABUSE SYMPOSIUM**  | **TBA** |
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| **VOD** | **Trauma** | **Brown** |
| **VOD** | **ID** | **Garcia** |
| **VOD** | **Toxicology** | **Jessica Williams** |
| **VOD** | **Congenital Heart Disease** | **Moake** |
| **VOD** | **Heart Disease, Congenital and Acquired; Diagnosis and Management/( Review)** | **Moake** |
| **VOD** | **PAH** | **Zawodniak** |
| **VOD** | **Cardiac Post Op Care** | **Ryan** |
| **VOD** | **Heart Failure, introduction**  | **Moake** |
|  |  |  |
| **November 21, 2014** | **CDM #2 due** | **ONLINE SUBMISSION** |
|  |  |  |
| **December 5, 2014** | **On Campus** |  |
| **09:00-15:00** | **Smart Hospital Clinical Check off’s** | **Clinical Instructor** |
|  | **Final Exam – On Line (Test will be open from 12/5-12/7)** | **ONLINE SUBMISSION** |
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***\*\*\*As the instructor for this course, I reserve the right to adjust this schedule in any way that serves the educational needs of the students enrolled in this course- Lindy Moake***