

**The University of Texas at Arlington
College of Nursing
N5306 Pediatric Management
Summer 2012**

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Debbie Boger MSN, RN, CPNP

Clinical Instructor

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Section Information: N5306 Section 001-011

Time and Place of Class Meetings:

Time: **Saturday 9:00am -5:00pm**

Place: **Pickard Hall, Room 204**

Description of Course Content: 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.

Growth and Development, Common Dermatological Pediatric Problems, Common Respiratory Pediatric Problems, Common Orthopedic Pediatric Problems, Pathologic vs. Innocent Murmurs in Pediatrics, Common HEENT Pediatric Problems, Common GI and GU Pediatric Problems, Topics in Adolescence, Colicky Infants, Speech and Hearing Problems, Dental, Common Neurologic Pediatric Problems, Minor Emergencies in Pediatric

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 patientrole using research methodologies.

Required Textbooks and Other Course Materials:

1. Apfel, N.H. and Provence, S. (2001). *Infant-Toddler and Family Tool (ITFI) and Manual*. Baltimore: Brookes Publishing. **ISBN for the Manual is 1-5576-6493-5 ISBN for the Tool is 1-5576-6492-7**
2. Burns, C.E., Dunn, A.M., Brady, M.A., Starr, N.B., & Blosser, C. (2013). *Pediatric Primary Care: A Handbook for Nurse Practitioners*. (5th ed.). St. Louis: W. B. Saunders. **ISBN: 9781416040873- (Pedi, Family, & Psych)**
3. Clark, Eileen, Green, Morris, and Palfrey, Judith. (2008). *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*. (3rd Ed.). American Academy of Pediatrics. **ISBN-13: 9781581102246 (pocket)**
4. Richardson, Beth. (2011). *Pediatric Primary Care: Practice Guidelines for Nurses*. Jones & Bartlett Learning **ISBN: 978-1-4496-0043-3**

Recommended Textbooks and Other Course Materials:

1. Behrman, R.E., Kliegman, Stanton, Bonita M.D., St. Geme, Joseph, Schor, F, Nina, (2011). *Nelson Textbook of Pediatrics*. (19th ed.). St. Louis: W.B. Saunders. **ISBN-: 9781437707557**
2. Brazelton, T.B. and Sparrow, J.D. (2002). *Touchpoints: Your Child's Emotional and Behavioral Development, Birth to 3 -- The Essential Reference for the Early Years*. **ISBN: 9780201626902**
3. Tappero, E.P. and Honeyfield, M.E. (2003). *Physical Assessment of the Newborn*. Santa Rosa: Nicu Ink Publishers. **ISBN: 1-8875-7109-4**
4. Uphold, C.R., and Graham, M.V. (2003). *Clinical Guidelines in Child Health*. Gainesville: Barmarrae Books. **ISBN: 0-9646-1517-7**
5. Uphold, C.R., and Graham, M.V. (2003). *Clinical Guidelines in Family Practice* (4th ed.) Barmarrae Books **ISBN: 978-0964615168**

Please purchase the most current addition for the textbooks referenced above.

Course Topics:

- Growth and Development Theory
- Growth and Development across age groups infants to adolescents
- Texas Newborn Screening
- HEENT
- Cardiology
- GI
- GU
- Orthopedics
- Hepatitis A, B, C, and HIV
- Epilepsy and Febrile Seizures
- Headaches and Syncope
- Asthma and Respiratory Conditions
- Audiology and Newborn Hearing Screening
- Urgent Office Conditions
- Neonatal Sepsis
- Hyperbilirubinemia
- Dermatology

Requirements: Prerequisites: (See Graduate Catalog)

Clinical Logs

Evaluation Materials

Written Examinations-Exam #1 and Exam #2

Clinical Decision Making (5)

Developmental Observation Paper

Class Participation

Clinical Practicum

Class Attendance

Teaching Methods/Strategies:

Lecture/Discussions

Clinical Practice

Consultant Lectures

Examination

Application Case Studies

Descriptions of Major Assignments and Examinations with Due Dates:

N5306 Tentative Due Dates for Assignments

June 9, 2012 CDM #1 (in class graded group assignment)

June 30, 2012 TX Health Steps Certificates Due &
Developmental Paper/Assignment Due

July 7, 2012 CDM #2 Due Online (Individual Assignment)

July 13-15 Test #1 Online on Blackboard

July 21, 2012 CDM #3 (in class graded group assignment)

July 28, 2012 CDM #4 Due Online (Individual Assignment)

August 3-5, 2012 Final Exam Online
August 4th and 11th, 2012 Standardized Patient Check Offs (Required to attend 1 date)

Grading Policy:

Exam #1	20%
CDMs (5)	50%
Final Exam	20%
TOTAL Classroom:	90%
Clinical Practicum:	10%
	100%

Clinical Hours:

E-Logs	P/F
Developmental assignment/paper	5 hours
<u>Office clinical practice</u>	<u>40hours</u>
TOTAL:	45 hours

Course Grading Scale:

A = 92 to 100
B = 83 to 91
C = 74 to 82
D = 68 to 73
F = below 74 - cannot progress

Clinical Expectations

In order to pass a course containing both didactic and clinical requirements, the student must pass both the theoretical and clinical components of the course. A passing grade is considered 83% or greater. Students deemed unsafe or incompetent will fail the course and receive a course grade of "F." The following behaviors constitute clinical failure:

1. Demonstrates unsafe performance and makes questionable decisions.
2. Lacks insight and understanding of own behaviors and behavior of others.
3. Needs continuous specific and detailed supervision.
4. Has difficulty in adapting to new ideas and roles.
5. Fails to submit required written clinical assignments.

A "B" is required as a passing score in all clinical experiences.

Course Work

Late written assignments will not be accepted and will receive a grade of zero. Examinations will be taken on the assigned date or will receive a grade of zero. Arrangements can be made for emergencies.

Attendance Policy: Regular class attendance and participation is expected of all students. Students are responsible for all missed course information.

Drop Policy: Students may drop or swap (adding and dropping a class concurrently) classes through self-service in MyMav from the beginning of the registration period through the late registration period. After the late registration period, students must see their academic advisor to drop a class or withdraw. Undeclared students must see an advisor in the University Advising Center. 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 Financial Aid Office for more information.

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 Financial Aid Office for more information. The last day to drop a course is listed in the Academic Calendar available at <http://www.uta.edu/uta/acadcal>.

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) complete a Course Drop Form (available online http://www.uta.edu/nursing/MSN/drop_resign_request.pdf or Graduate Nursing office rooms 512 or 606); (2) obtain faculty signature and current course grade; and (3) submit the form to Graduate Nursing office rooms 512 or 606.
3. A student desiring to drop all courses in which he or she is enrolled is reminded that such action constitutes withdrawal (resignation) from the University. The student must indicate intention to withdraw and drop all courses by completing a resignation form in the Office of the Registrar or by: (1) Completing a resignation form (available online http://www.uta.edu/nursing/MSN/drop_resign_request.pdf or Graduate Nursing office rooms 512 or 606; (2) obtaining faculty signature for each course enrolled and current course grade; (3) Submitting the resignation form in the College of Nursing office room 512 or 606; and (4) The department office will send resignation form to the office of the Registrar.
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://www.grad.uta.edu/handbook>

<p><i>Census Date: June 7, 2012</i> <i>Last Day To Drop Or Withdraw July 19, 2012</i></p>

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: It is the philosophy of The University of Texas at Arlington that academic dishonesty is a completely unacceptable mode of conduct and will not be tolerated in any form. All persons involved in academic dishonesty will be disciplined in accordance with University regulations and procedures. Discipline may include suspension or expulsion from the University. According to the UT System Regents' Rule 50101, §2.2,

"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/tutorials/Plagiarism>

Student Support Services Available: The University of Texas at 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. These resources include tutoring, major-based learning centers, developmental education, advising and mentoring, personal counseling, and federally funded programs. For individualized referrals to resources for any reason, students may contact the Maverick Resource Hotline at 817-272-6107 or visit www.uta.edu/resources for more information.

Electronic Communication Policy: The University of Texas at Arlington has adopted the University “MavMail” address as the sole official means of communication with students. MavMail is used to remind students of important deadlines, advertise events and activities, and permit the University to conduct official transactions exclusively by electronic means. For example, important information concerning registration, financial aid, payment of bills, and graduation are now sent to students through the MavMail system. All students are assigned a MavMail account. ***Students are responsible for checking their MavMail regularly.*** Information about activating and using MavMail is available at <http://www.uta.edu/oit/email/>. There is no additional charge to students for using this account, and it remains active even after they graduate from UT Arlington.

To obtain your NetID or for logon assistance, visit <https://webapps.uta.edu/oit/selfservice/>. If you are unable to resolve your issue from the Self-Service website, contact the Helpdesk at helpdesk@uta.edu.

Librarian to Contact:

Helen Hough, *Nursing Librarian*

Phone: (817) 272-7429

E-mail: hough@uta.edu

Research Information on Nursing:

<http://libguides.uta.edu/nursing>

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. Problems, concerns or issues students may have will be discussed in front of the Family Nurse Practitioner faculty team.

Student Requirement For Preceptor Agreements/Packets:

1. All Preceptor Agreements must be signed by the first day the student attends clinical (may be signed on that day).
2. **Student** is responsible to ensure that all of his/her preceptor agreements are signed before beginning clinical experience and those agreements are given to Lori Riggins by the **third week** of the semester. (This means that even if a student doesn’t start working with a particular preceptor until late in the semester, s(h)e would contact that preceptor during the **first 3 weeks of the semester**.)
3. Lori Riggins or designated support staff will enter the agreement date into *Partners* database. The Agreement Date” field in *Partners* is the data that the Preceptor signed the Agreement. (This date must be on or before the student’s first clinical day in order for the student to access *E-logs*). 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 and submit it with his/her Curriculum Vitae.
4. The signed preceptor agreement is part of the clinical clearance process. Failure to submit it in a timely fashion will result in the inability to access the E-log system.

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.

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).

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 their Associate Dean for the MSN Program, Department of Advanced Practicum Dr. Schira. The complete policy about encumbered licenses is available online at: www.bon.state.tx.us

MSN Graduate Student Dress Code: Policy: 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:
www.uta.edu/nursing.

UTA Student Identification: 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/handbook/toc.php>

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/handbook/toc.php>

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: http://www.uta.edu/nursing/scholarship_list.php 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.

Bomb Threats: If anyone is tempted to call in a bomb threat, be aware that UTA will attempt to trace the phone call and prosecute all responsible parties. Every effort will be made to avoid cancellation of presentations/tests caused by bomb threats. Unannounced alternate sites will be available for these classes. Your instructor will make you aware of alternate class sites in the event that your classroom is not available.

Course Evaluation: Course evaluation is a continuous process and is the responsibility of both the faculty and the students. Ongoing feedback (formative evaluation) is the only way to improve the course and to assure that it meets your needs and those of the discipline of nursing. It is your responsibility to give immediate, constructive feedback regarding class structure and process.

Formal evaluation of the course and the instructor occurs at the end of the course. You will receive instructions at your University of Texas at Arlington e-mail address about how to complete the course

evaluations online. Your ratings and comments are sent to a computer not connected to the College of Nursing, and faculty members do not receive the results until after they have turned in course grades.

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.

Departmental Office/Support Staff

Department of Advanced Nurse Practice

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Associate Dean and Chair; Graduate Advisor
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Required Reading Assignments

Burns, C.E., Dunn, A.M., Brady, M.A., Starr, N.B., & Blosser, C. (2004). *Pediatric Primary Care: A Handbook for Nurse Practitioners*. St. Louis: W. B. Saunders. ISBN: 0-7216-0185-5. (*Pedi, Family, & Psych*)

Chapters in Burns and/or Nelson's that correspond with the topics listed in the Class Schedule. Nelson's is not a required textbook except for Pedi Majors.

Please read the chapters that coincide with the topic prior to class.

Web Sites to visit:

<http://generalpediatrics.com/CommonProbProf.html#Emergency%20Medicine>

<http://www.hawaii.edu/medicine/pediatrics/pedtext/s01c03.html>

<http://www.peds.umn.edu/divisions/pccm/teaching/acp/burns.html>

<http://www.peds.umn.edu/divisions/pccm/teaching/acp/poison.html>

<http://www.peds.umn.edu/divisions/pccm/teaching/acp/officeprep.html>

<http://www.peds.umn.edu/divisions/pccm/teaching/acp/seize.html>

<http://www.bonetumour.org/book/APTEXT/index.html>

<http://www.unmc.edu/Community/comsep/modules/known110b.htm>

http://www.hc-sc.gc.ca/fnihb/ons/nursing/resources/pediatric_guidelines/chapter_10.htm

<http://www.faughnan.com/medref/peds.html>

<http://www.icodata.com/health/pedbase/pedlynx.htm>

ASSIGNMENTS/GRADE SUMMARY

<u><i>Clinical Assignments</i></u>	<u><i>Due Date</i></u>	<u><i>Score</i></u>
1. Preceptor Evaluations		Credit _____
2. Student Evaluation of Preceptor		Credit _____
3. Clinical Practicum	TBA	10% _____
4. E-Logs		Credit _____
5. Developmental Assignments (Paper plus Developmental Scenarios)		P/F

<u><i>Didactic Assignments</i></u>	<u><i>Due Date</i></u>	<u><i>Score %</i></u>
1. CDMs (5)	TBA	50% _____
2. Exam #1	TBA	20% _____
3. Final Exam	TBA	20% _____
TOTAL:		100 % _____

FINAL GRADE: _____

PRECEPTOR PACKETS

**Now Available
On line**

Via Adobe Acrobat Reader

<http://www.uta.edu/nursing/msn/>

**Please utilize this page when you need preceptor
packets**

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. collect 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 may not make any decisions requiring medical management. Your clinical preceptor is responsible to see EVERY patient that you see.

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 one client. 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 him/her before mailing it to the student's clinical advisor.

6. Clinical Experiences Journal:

A journal will be kept of all the student's clinical experiences throughout the NP Program. (See "Clinical Experiences Journal Guidelines.")

7. Professional Attire:

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

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-LOG

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 with appropriate tabbed sections:

A. Tally Sheets

Current total preceptor hours for Pedi Mgmt

B. Personal Clinical Objectives

How and Why—personalize these to you & your learning needs

Evaluate each one as to Met, Partially Met, Not Met - give brief description

C. Client Encounter Record(s)/

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

D. Self Evaluation—form provided on WEB

E. Student Evaluation of Preceptor-- form provided on WEB

F. Preceptor Evaluation-- form provided on WEB

G. Practicum

Midterm, as applicable

Final

H. CDMS

I. Elogs Final Printout

Developmental Paper Pediatric Management

Due: TBA

Guidelines:

The paper is a summary of your findings from Apfel Tool and Developmental Assessment presented in a SOAP format and is required to be 2-3 typed pages. Please provide one copy to hand in, keep one copy in your file at home. I am looking for quality not quantity, good grammar and spelling. Use a SOAP note outline, but 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, 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, Brady, Dunn, and Starr Ch. 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 for an interval 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 tid 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 APA 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”, “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.

N5306 Pediatric Management

CLINICAL DECISION MAKING GUIDE

I. SUBJECTIVE DATA

- A. Chief complaint
- B. History of Present Illness with 7 variables as used in the UTA Advanced Assessment Course.

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 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).
- B. Rule-Out Diagnosis- ICD-9 Codes with **explanation of why** (“**pertinent positives**”) 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. (differential diagnosis only if applicable)
- C. Nursing diagnosis(es) X2

PLAN

- A. 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. 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. 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.
- C. Medical therapeutics/Nursing therapeutics, prescriptions with rational for each treatment and appropriate references
- D. Patient education with references
- E. Counseling (when appropriate)
- F. Health promotion/health maintenance (when appropriate)
- G. Referral (when appropriate)
- H. Consults (when appropriate)
- I. Follow-up appointments

IV. DOCUMENTATION

- A. Should reflect pertinent normal and abnormal findings
- B. Use appropriate terminology
- C. Write-up should be organized and complete

PLEASE ATTACH AN EVALUATION FORM WITH ANY WORK YOU TURN IN FOR A GRADE. THANK YOU

FORMAL CLINICAL DECISION MAKING ASSIGNMENT EVALUATION GUIDE/GRADE SHEET

Student: _____

Date: _____

Faculty: _____

Grade: _____

**Possible
Points**

**Actual
Points**

- | | | |
|----|-------|---|
| 20 | _____ | A. Completed subjective and objective data base as appropriate to scenario. Data prioritized, with pertinent positives established. |
| 20 | _____ | B. Assessments, rule-out diagnoses, differential diagnoses, and nursing diagnoses X2 complete and stated appropriately, ICD-9 Code(s). |
| 20 | _____ | C. Physiological and pathological process leading to diagnosis(es) are documented and referenced. |
| 20 | _____ | D. Plan is sound, logical, <u>cost-effective</u> and includes both medical and nursing management and 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 management plan. Reference and Provide the front page of a National Guideline to guide and reference your plan. |

Total Points: _____

COMMENTS:

FORMAL CLINICAL DECISION MAKING ASSIGNMENT EVALUATION GUIDE/GRADE SHEET

Student: _____

Date: _____

Faculty: _____

Grade: _____

**Possible
Points**

**Actual
Points**

- | | | |
|----|-------|---|
| 20 | _____ | A. Completed subjective and objective data base as appropriate to scenario. Data prioritized, with pertinent positives established. |
| 20 | _____ | B. Assessments, rule-outs diagnoses, differential diagnoses, and nursing diagnoses X2 complete and stated appropriately, ICD-9 Code(s). |
| 20 | _____ | C. Physiological and pathological process leading to diagnosis(es) are documented and referenced. |
| 20 | _____ | D. Plan is sound, logical, <u>cost-effective</u> and includes both medical and nursing management and 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 management plan. Reference and Provide the front page of a National Guideline to guide and reference your plan. |

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 at Arlington College of Nursing
N5306 Pediatric Management
Summer 2012

Student:_____

Advisor:_____

Clinical Major:_____

Type of hours	Hours	# of Patients	Agency	Preceptor Signature
Developmental Assessment	5			
Primary Care				
Primary Care				
Primary Care				
Primary Care				
Primary Care				
	45			