**CLINICAL SYLLABUS**

**THE UNIVERSITY OF TEXAS**

**AT ARLINGTON**

**SCHOOL OF NURSING**

**N5306 PEDIATRIC MANAGEMENT**

**Sections (001-008)**

**Summer 2009**

**Classroom: 204/206/209 Pickard Hall**

The University of Texas at Arlington School of Nursing

**Graduate Program**

# N5306 Pediatric Management In Advanced Nursing Practice

**(**3 credit hours, 2 class hours, 3 clinical hours**)**

**Summer 2009**

**Scheduled Saturdays**

**9:00 a.m. to 5:00 p.m.**

**Pickard Hall, Room 204-209**

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| **INSTRUCTOR(S):** | **Nancy Wyrick, RN, MSN, CPNP-PC**  ***Clinical Instructor***  Office #: 626 Pickard Hall  Office Hours: By Appointment  Office Phone: (817) 272-2776  Office Fax: (817) 272-5006  Work Phone: (817)467-1503  Email: [wyrick@uta.edu](mailto:wyrick@uta.edu)  **Sharolyn Dihigo, RN, MSN, CPNP-PC**  **Clinical Professor**  Office #: 626 Pickard Hall  Office Hours: By Appointment  Office Phone: (817) 272-2776  Office Fax: (817) 272-5006  Email: [sdihigo@uta.edu](mailto:sdihigo@uta.edu) or [ntxcolic@aol.com](mailto:ntxcolic@aol.com)  **Sara Moore, RN, MSN, CPNP-BC, CPNP-AC**  ***Clinical Instructor***  Office # 626 Pickard Hall  Office Hours: By Appointment  Office Phone: (817) 272-2776  Office Fax: ( 817) 272-5006  Email: smile4sara@aol.com  **Howard McKay, RN, MSN, FNP-C, CPNP-AC**  ***Clinical Instructor***  Office #: 626 Pickard Hall  Office Hours: By Appointment  Office Phone: (817) 272-2776  Office Fax: (817) 272-5006  Email: [howardmckay@sbcglobal.net](mailto:howardmckay@sbcglobal.net) |
| **COURSE WEB SITE OR WORLD WIDE WEB SITE:** | <http://www.uta.edu/nursing> |
| **COURSE PREREQUISITES:** | NURS 5334, 5418 |
| **REQUIRED TEXTBOOKS & 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   1. Boyton, R.W., Dunn E.S., Stephens, G.R., & Pulcini, J. (2003). *Manual of Ambulatory Pediatrics*. Philadelphia: Lippincott Williams & Wilkins. **ISBN:** 0-7817-4136-X. ***(Pedi)*** 2. Burns, C.E., Dunn, A.M., Brady, M.A., Starr, N.B., & Blosser, C. (2009). *Pediatric Primary Care*: *A Handbook for* *Nurse Practitioners*. St. Louis: W. B. Saunders. **ISBN:** 0-7216-0185-5. ***(Pedi, Family, & Psych)*** 3. Mertens, D. and Underwood, J. (2005). *SimClinic: Interactive Cases: Primary Care (CD-ROM)*. St. Louis: Mosby. **ISBN:** 0-3230-3423-3. 4. Clark, Eileen, Green, Morris, and Palfrey, Judith. (2007). *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents.* 2nd Edition. **ISBN-13: 9781581102246 (pocket)**   **RECOMMENDED TEXTBOOKS**   1. Behrman, R.E., Kliegman, R.M., and Jenson, H.B. (2004). *Nelson Textbook of Pediatrics*. St. Louis: W.B. Saunders. **ISBN:** 0-7216-9556-6. 2. Brazelton, T.B. and Sparrow, J.D. (2002). *Touchponts: The Essential Reference.* **ISBN:** 0-7382-0678-4. 3. Levine, M.D., Carey, W.B., and Crocker, A.C. (1999). *Developmental-Behavioral Pediatrics*. St. Louis: W.B. Saunders. **ISBN:** 0-7216-7154-3. 4. Uphold, C. and Graham, M. *Clinical Guidelines in Family Practice*. Gainesville: Barmarrae Books. **ISBN:** 0-9646-1516-9. 5. Uphold, C.R., and Graham, M.V. (2003). *Clinical Guidelines in Child Health*. Gainsville: Barmarrae Books. **ISBN:** 0-9646-1517-7. 6. Tappero, E.P. and Honeyfield, M.E. (2003*). Physical* *Assessment of the Newborn*. Santa Rosa: Nicu Ink Publishers. **ISBN:** 1-8875-7109-4. |
| **COURSE DESCRIPTION:** | 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. |
| **STUDENT LEARNING OUTCOMES:** | Upon completion of the course the student will  be able to:   1. Analyze the empirical and theoretical knowledge of the unique anatomic structures, physiological and psychological process in the care of the pediatric and adolescent patient. 2. Apply family and developmental theory in the care of the pediatric and adolescent patient. 3. Demonstrate critical thinking and effective communication to assist children and their families in primary prevention to health promotion. 4. Demonstrate knowledge of basic management of the pediatric patient with common acute minor illness and appropriate referral. 5. Implement culturally sensitive care to the pediatric and adolescent patient and family. 6. Use current research in the management of health and illness in the pediatric patient. |
| **ATTENDANCE AND**  **DROP POLICY:** | * Regular class attendance and participation is expected of all students. * Students are responsible for all missed course information.   A graduate student who wishes to change a schedule by either dropping or adding a course must first consult with Graduate Nursing Advisor. The following regulations pertain to adds and drops:   1. A student may not add a course after the end of the late registration. 2. A graduate student dropping a course or resigning from the university after the Census Date but before the final designated drop date for the enrolled semester will receive a grade of W only if at the time of dropping the student is passing the course (has a grade of A, B, or C); if the student has a D or F at the time of dropping, an F will be recorded. Students dropping a course must: (1) Complete a Course Drop Form (available online <http://www.uta.edu/nursing/MSN/forms.php> or MSN Office Room 605 and Rooms 623 & 624,); (2) obtain faculty signature and current course grade; and (3) Submit the form to MSN Office Room 605. 3. A graduate student who desires to drop all courses for which he or she is enrolled is reminded that such action constitutes a withdrawal from the University. The student should indicate intention to withdraw from all courses by: (1) Completing a Registration Form (available online <http://www.uta.edu/nursing/MSN/forms.php> or MSN Office Room 605 and Rooms 623 & 624); (2) Obtaining faculty signature for each course enrolled and current course grade; (3) Filing the registration form in the School of Nursing Office Room 605; and (4) Filing the Registration Form in the Office of the Registrar in Davis Hall Room 333. 4. Graduate students may drop a course up to 12 weeks in the fall or spring semester and up to 8 weeks in a 10-week summer session. Under extreme circumstances, the Dean of Graduate Studies may consider a petition to withdraw after the designated drop date, but in no case may a graduate student selectively drop a course after the drop date and remain enrolled in any other course.  Last Date Drop or Withdraw: July 16, 2009 |
| **TENTATIVE LECTURE/TOPIC SCHEDULE (COURSE CONTENT):** | 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 |
| **SPECIFIC COURSE REQUIREMENTS:** | Clinical Practicum/Site Visits  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:** | **Teaching/Learning**:  Lecture/Discussions  Clinical Practice  Consultant Lectures  Examination  Clinical Seminar  **Clinical Agencies:** Selected ambulatory practice sites |
| **GRADE CALCULATION**  **(COURSE EVALUATION &**  **FINAL GRADING):**  **CLINICAL EVALUATIONS:** | Exam #1 20%  Sim Clinic CDMs (5) 50%  Final Exam 20%  **TOTAL Classroom:** **90%**  **Clinical Practicum: 10%**  **100%**  **Clinical Hours:**  E-Logs P/F  Developmental assignment/paper 5 hours  Office clinical practice 40hours  **TOTAL: 45 hours**  **Course Grading Scale**:  A = 92 – 100  B = 83 – 91  C = 74 – 82  D = 68 – 73  F = below 68  **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.  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 on the faculty evaluation of the students’ 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 fails the retake, the student will receive a grade of “F” for the course. |
| **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 Linda Adams 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. Linda Adams 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. |
| **STATUS OF RN LICENSURE:** | All graduate nursing students must have an unencumbered license as designated by the Board of Nurse Examiners (BNE) to participate in graduate clinical nursing courses. It is also imperative that any student whose license becomes encumbered by the BNE must immediately notify the Interim Associate Dean for the MSN Program, Dr. Mary Schira. Failure to do so will result in dismissal from the Graduate Program. The complete policy about encumbered licenses is available online at: <http://www.bne.state.tx.us> |
| **MSN GRADUATE STUDENT DRESS CODE:**  **CLINICAL SETTINGS REQUIRING UNIFORMS:**  **LEARNING RESOURCE SKILLS LAB/SIMULATION LAB ATTIRE:**  **UTA STUDENT IDENTIFICATION:**  **CLINICAL SETTINGS REQUIRING STREET CLOTHES:** | Policy: The University of Texas at Arlington School of Nursing expects students to reflect professionalism and maintain high standards of appearance and grooming in the clinical setting. **Clinical faculty have 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.**  **General Guidelines**   1. **Jewelry**  * Watches, wedding rings only, earrings (one small stud per earlobe) may be worn. * Necklaces are not permitted unless maintained under clothing and not visible. * Except for one stud earring per earlobe, no other body piercing jewelry is permitted. Nose piercing jewelry must be removed or covered. No exceptions.   **2. Hair**   * + Hair is to be clean, neat, and well groomed. Shoulder length hair or longer must be pulled back behind the ears off the neck when in the clinical, learning resource or simulation lab settings.   + Males are expected to be clean-shaven or facial hair/moustache and beards neatly trimmed.   + Hair must be of a color found in nature (no pink, blue, etc.).   **3. Nails**   * + Nails are to be clean, groomed, and manicured.   + Artificial nails are prohibited in the clinical setting.   + Nails are to be cut to the tip of the finger and groomed.   + Only clear nail polish may be worn. No fingernail jewelry.   **4. Other**   * + Makeup will be subdued. Personal hygiene including oral care, daily showering/bathing, and the use of deodorant is expected.   + No perfume or scented lotions are to be worn.   + Gum chewing is not permitted.   + Personal beepers, cell phones, and other such technology shall be utilized only during breaks from patient care. Cell phones must be turned off during clinical and left in the student’s purse or backpack. * Tattoos must be covered and not visible. * Refrain from smoking in uniform as the smoke can cling to clothes and be an irritant to patients.   Current UTA undergraduate student uniforms are navy blue scrubs with a UTA insignia patch sewn on the left upper sleeve of scrub top. White long or short sleeved turtleneck or crew neck T-shirts without logo’s or advertisements may be worn under scrub shirts.   * Uniforms are to be clean and not wrinkled * No sweaters with hoods may be worn with the uniform. * Head coverings must be a solid color (white, navy blue or black) and without adornment. The covering may not include the face. * A thigh-length white lab coat with a UTA insignia patch sewn on the left upper sleeve may be worn with the scrubs. * Undergarments and/or cleavage should not show when leaning or bending over. Low-rise scrub pants and rolling down the waist band of scrub pants is prohibited. * Shoes are to be closed toed, closed heel, clean and in good repair. Shoes must be made of a material that will not absorb bio-hazardous materials and that can be cleaned. Therefore, they must be white leather or rubber. White hose/socks (that come above the ankle) are required. Clog type shoes are prohibited for safety concerns.   Students entering the skills or simulation labs must be in uniform.   * The UTA Student Picture ID is to be worn above the waist and in clear view when in uniform. * No other ID should be attached to the UTA School of Nursing ID, nor should the UTA ID be worn in settings other than clinical. The School of Nursing ID must be worn in all clinical and lab settings. * Professional attire is expected. Jeans/western cut pants, sweatshirts, shirts of underwear type, see-through clothing, sleeveless shirts or any clothing which exposes a bare midriff, back, chest or underwear are prohibited. Tattoos must be covered. Skirt length must be knee length or longer. Appearance must be clean and neat. Students in agencies where scrubs are provided should follow the above standards prior to changing into scrubs. * Students involved in pre-planning activities at a clinical site must wear a lab coat and UTA ID. |
| **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.bne.state.tx.us](http://www.bne.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/> |
| **CONFIDENTALITY 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> |
| **AMERICANS WITH**  **DISABILITIES ACT:** | The University of Texas at Arlington is on record as being committed to both the spirit and letter of federal equal opportunity legislation; reference Public Law 93112 -- The Rehabilitation Act of 1973 as amended. With the passage of new federal legislation entitled Americans With Disabilities Act - (ADA), pursuant to section 504 of The Rehabilitation Act, there is renewed focus on providing this population with the same opportunities enjoyed by all citizens.  As a faculty member, I am required by law to provide "reasonable accommodation" to students with disabilities, so as not to discriminate on the basis of that disability. Student responsibility primarily rests with informing faculty at the beginning of the semester and in providing authorized documentation through designated administrative channels. |
| **STUDENT SUPPORT SERVICES:** | The University of Texas at Arlington supports a variety of student success programs to help you connect with the University and achieve academic success. They include learning assistance, developmental education, advising and mentoring, admission and transition, and federally funded programs. Students requiring assistance academically, personally, or socially should contact the Office of Student Success Programs at 817-272-6107 for more information and appropriate referrals. |
| **STUDENT CODE OF ETHICS:** | The University of Texas at Arlington School 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> . |
| **ACADEMIC DISHONESTY:** | 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.  "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." (Regents' Rules and Regulations, Part One, Chapter VI, Section 3, Subsection 3.2, Subdivision 3.22) |
| **PLAGIARISM:** | Copying another student’s paper or any portion of it is plagiarism. Additionally, copying a portion of published material (e.g., books or journals) without adequately documenting the source is plagiarism. 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 at the end of each paragraph. 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 encouraged to review the plagiarism module from the UT Arlington Central Library via <http://library.uta.edu/tutorials/Plagiarism> |
| **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. |
| **E-CULTURE POLICY:** | The University of Texas at Arlington has adopted the University email address as an official means of communication with students. Through the use of email, UT-Arlington is able to provide students with relevant and timely information, designed to facilitate student success. In particular, important information concerning department requirements, registration, financial aid and scholarships, payment of bills, and graduation may be sent to students through email. All students are assigned an email account and information about activating and using it is available at [www.uta.edu/email](http://www.uta.edu/email). Students are responsible for checking their email regularly. |
| **NO GIFT POLICY:** | In accordance with Regent Rules and Regulations and the UTA Standards of Conduct, the School of Nursing has a “no gift” policy. A donation to one of the UTA School of Nursing Scholarship Funds, found at the following link:  [Nursing Scholarship List](http://www.uta.edu/nursing/schol-list) 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. |
| **GRADUATE COURSE SUPPORT STAFF:** | **Brittany Bazile, *Senior Office Assistant***  Office # 624 – Pickard Hall (817) 272-2043, ext 24798  Email: [bazile@uta.edu](mailto:bazile@uta.edu) |
| **LIBRARY INFORMATION:** | **Helen Hough, *Nursing Librarian***  (817) 272-7429, Email: [hough@uta.edu](mailto:hough@uta.edu)  Research Information on Nursing:  <http://www.uta.edu/library/research/rt-nursing.html> |
| **MISCELLANOUS INFORMATION:** | Inclement Weather (School Closing) Inquiries:  *Metro (972) 601-2049*  Fax Number - UTA School of Nursing: (817) 272-5006  Attn: Graduate Nursing Programs Office  UTA Police (Emergency Only): (817) 272-3003  **Mailing Address for Packages**:  UTA School of Nursing  C/O Nancy Wyrick or Sharolyn Dihigo  411 S. Nedderman Drive, Pickard Hall  Arlington, Texas 76019-0407 |

GRADUATE NURSING WEBSITES

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| **Description** | **Website** |
| University of Texas Home Page | <http://www.uta.edu> |
| Graduate Catalog & Faculty | <http://www.uta.edu/gradcatalog/nursing> |
| Graduate Nursing Programs | <http://www.uta.edu/nursing/MSN/administration.php>  <http://www.uta.edu/nursing/MSN/practitioner.php> |
| Graduate Nursing Courses & **Syllabi** | <http://www.uta.edu/nursing/MSN/grad-courses1.php> |
| Faculty and Staff Email Contacts and Biosketches | <http://www.uta.edu/nursing//faculty.php> |
| Graduate Student Handbook | <http://www.uta.edu/nursing/handbook/toc.php> |
| * **Miscellaneous Graduate MSN Forms:**   + Banking Clinical Hours   + Code of Ethics   + Drop Request   + E-log Consent Form   + Liability Policy   + Master’s Completion Project Forms   + Nurse Admin Preceptor Package   + Nurse Practitioner Preceptor Package   + Personal Insurance Verification Form   + Petition to Graduate Faculty   + Resignation Request   + Student Confidentiality Statement   + Traineeship Statement Forms | <http://www.uta.edu/nursing/MSN/forms.php> |
| * **Clinical Evaluation MSN Forms:**   + Educator Evaluation   + Faculty Evaluation of Preceptor   + NP Clinical Evaluation (Practicum Tools)   + Nurse Admin Faculty Eval of Preceptor   + Nurse Admin Preceptor Eval of Student   + Preceptor Evaluation of Student   + Psych Therapy Preceptor Eval of Student   + Student Evaluation of Preceptor   + Student Self Evaluation |
| Clinical Online Submission (Elogs) | <http://www.totaldot.com/> |
| Criminal Background Check (Group One) | <http://www.dfwhc.org/GroupOne/> |
| **Instructions for E-Reserves** | <http://www.uta.edu/library/>  Select under Library Catalogs  ([UTA Library Catalogs](http://pulse.uta.edu/))  Select Course Reserves  Look for Instructor’s Name, Click Search, Select Article  Password is course abbreviation and course number.  ALL CAPS no spaces (ex. NURS5340). |

***Last Revision: May 20, 2009***

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 Nelson’s that correspond with the topics listed in the Class Schedule:

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

Web Sites to visit:

[**http://generalpediatrics.com/CommonProbProf.html#Emergency%20Medicine**](http://generalpediatrics.com/CommonProbProf.html#Emergency%20Medicine)

[**http://www.hawaii.edu/medicine/pediatrics/pedtext/s01c03.html**](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/burns.html)

[**http://www.peds.umn.edu/divisions/pccm/teaching/acp/poison.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/officeprep.html)

[**http://www.peds.umn.edu/divisions/pccm/teaching/acp/seize.html**](http://www.peds.umn.edu/divisions/pccm/teaching/acp/seize.html)

[**http://www.bonetumour.org/book/APTEXT/index.html**](http://www.bonetumour.org/book/APTEXT/index.html)

[**http://www.unmc.edu/Community/comsep/modules/knowl10b.htm**](http://www.unmc.edu/Community/comsep/modules/knowl10b.htm)

[**http://www.hc-sc.gc.ca/fnihb/ons/nursing/resources/pediatric\_guidelines/chapter\_10.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.faughnan.com/medref/peds.html)

[**http://www.icondata.com/health/pedbase/pedlynx.htm**](http://www.icondata.com/health/pedbase/pedlynx.htm)

**ASSIGNMENTS/GRADE SUMMARY**

***Clinical Assignments Due Date Score***

1. Preceptor Evaluations Credit \_\_\_\_\_\_
2. Student Evaluation of Preceptor Credit \_\_\_\_\_\_
3. Clinical Practicum TBA 10% \_\_\_\_\_\_
4. E-Logs Credit \_\_\_\_\_\_
5. Developmental Paper P/F

***Didactic Assignments Due Date Score %***

1. Sim Clinic CDM (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/forms.php**](http://www.uta.edu/nursing/MSN/forms.php)

**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:
   1. collecting a complete health history
   2. examining all body systems
   3. performing functional assessments to determine ability for self-care and independent living
   4. 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)
   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:
      1. advanced nursing management
      2. medical intervention
      3. pharmacotherapeutics
      4. diagnostic testing
      5. teaching/counseling
      6. follow-up plan
   10. 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.

1. **Documentation of Care:**

The UTA School 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.

1. **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.

1. **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.”

1. **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.

1. **Clinical Experiences Journal:**

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

1. **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.

1. **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 theses 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.

1. **E-LOG**

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

**Clinical Experiences Journal**

**Guidelines**

The Clinical Experiences Journal should be organized with appropriate tabbed sections:

A. Tally Sheets

Current 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

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

F. Preceptor Evaluation-- form provided on WEB

G. Practicum

Midterm, as applicable

Final

H. Course SOAP Notes

I. Course Mini CDMs

J. Course Major CDMS

K. 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.

Be prepared to present and discuss your paper with the class. Your grade will be calculated based on the following:

**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**

**School 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 **complete** review of systems for an interval visit. You should do a ROS 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 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 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. You may not cite Boynton as your reference for the pathophysiology. You may cite it as 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.

<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. If a category is not applicable, simply put NA.

**N5306 Pediatric Management**

**CLINICAL DECISION MAKING 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 or use the HPI format you learned in Assessment class.

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.

* + 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.)
2. **ASSESSMENT**
   1. 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).
3. 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)
4. Nursing diagnosis(es) X2
5. **PLAN**
   1. 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. If you noted something during the Subjective or Objective part of the H&P, you have to mention it in your plan.
   2. 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.**
   3. Medical therapeutics/Nursing therapeutics, prescriptions with rational for each treatment and appropriate references
   4. Patient education with references
   5. Counseling (when appropriate)
   6. Health promotion/health maintenance (when appropriate)
   7. Referral (when appropriate)
   8. Consults (when appropriate)
   9. Follow-up appointments
6. **DOCUMENTATION**
   1. Should reflect pertinent normal and abnormal findings
   2. Use appropriate terminology
   3. 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 Actual**

**Points 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, cost-effective 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 Actual**

**Points 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, cost-effective 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 School of Nursing**

**N5306 Pediatric Management**

**Summer 2009**

**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** |  |  |  |