University of Nevada, Las Vegas
School of Nursing
FNP Adult and Women's Health

NURS 740R
FNP Adult and Women's Health
Credits: 6 (2 theory, 4 clinical = 180 hours in primary care setting)
Semester: Spring 2016

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Prerequisite: NURS 701 and NURS 703

Course Description
This course provides the FNP student with the knowledge and skills necessary to manage patients in the primary care setting. Specific content relates to primary care needs of adults, including adolescent through older adults, in screening for, preventing, and/or managing common acute and chronic conditions.

Course Objectives	MSN Program Outcomes
1. Synthesize history and physical examination data to develop management plans of common acute and chronic conditions.	7. Employ culturally appropriate skills in communicating and collaborating with interdisciplinary teams to achieve positive outcomes in clinical or educational settings.
2. Apply the concepts of diagnostic reasoning/clinical decision making in the formulation of differential diagnoses of common acute and chronic conditions.	3. Apply continuous quality improvement measures to achieve positive outcomes in clinical or educational settings.
3. Establish evidence-based practice into the management plan of common acute and chronic conditions by integrating current research and clinical practice guidelines.	3. Apply continuous quality improvement measures to achieve positive outcomes in clinical or educational settings.
4. Demonstrate knowledge of assessment and management of common acute and chronic conditions for persons from adolescence through older adulthood.	1. Integrate scientific findings from health and educational fields to include but not limited to nursing, social sciences, and humanities.
5. Display the professional behaviors required for and expected of the advanced practice registered nurse.	9. Model the professional role of an advanced practice nurse or nurse educator in daily practice.

Required Texts

Dunphy, L.M., & Winland-Brown, J.E. (2015). *Primary care: The art and science of advanced practice nursing* (4th ed.). F.A. Davis. ISBN: 9780803638013

Pagana, K.D., Pagana, T.J. & Pagana, T.N. (2015). *Mosby's diagnostic and laboratory test reference* (12th ed.). Mosby Elsevier. ISBN: 9780323225762.

Unbound Medicine Resources at http://www.unboundmedicine.com/ucentral

- 5-Minute Clinical Consult
- Clinical Evidence
- Davis's Lab & Diagnostic Tests
- Evidence-Based Medicine Guidelines
- The Merck Manual Professional Edition

Shadow Health (2015) [software].
PIN [September 2015-5803-8693-8031-5393].

For registration, follow the guide at
https://shadow.desk.com/customer/portal/articles/980991-how-to-register-with-

shadow-health. You will need to copy and paste the unique PIN above to register in this course.

Shadow Health recommends using headphones to access the assignments in which you will practice identifying normal and abnormal sounds.

Shadow Health Technical Requirements – https://shadow.desk.com/customer/portal/articles/963290-dce-recommended-system-specifications

Shadow Health Support
If at any time you have any questions or encounter any technical issues regarding the DEC, contact 24/7 support at http://support.shadowhealth.com

Recommended Texts

Buttaro, T.M., Trybulski, J., Bailey, P.P. & Sandberg-Cook, J. (2012). *Primary care: A collaborative practice* (4th ed.). Elsevier: Mosby. ISBN: 9780323075015

Ferri, F. (2016). *Ferri's clinical advisor 2016*. Elsevier: Mosby. ISBN: 9780323280471

Goolsby, M.J. & Grubbs, L. (2015). *Advanced assessment: interpreting findings and formulating differential diagnoses* (3rd ed.). Philadelphia, PA: F.A. Davis. ISBN: 9780803643635.

Hawkins, J.W., Roberto-Nichols, D.M., & Stanley-Haney, J.L. (2016). *Guidelines for nurse practitioners in gynecologic setting* (11th ed.). Springer Publishing Company. ISBN: 9780826122827 (Highly Recommended)

Papadakis, M.A. & McPhee, S. J. (2015). *CURRENT medical diagnosis and treatment 2016* (55th ed.). McGraw-Hill. ISBN: 9780071845090

Teaching Strategies

This course is delivered via online platform but may incorporate face-to-face meetings as determined by faculty. The methods of instruction will include but not limited to assigned readings, lectures, online discussions, and written case study. Students are expected to read selected materials according to the enclosed weekly tentative class schedule, in addition to readings posted within WebCampus weekly modules. Weekly on-line learning modules may be augmented by seminars strategically placed throughout the semester.

Topic Outline

Unit 1: APRN Role and Responsibility in Acute and Chronic Conditions: Meaning and Implementation

- Health Promotion
- The Art of Diagnosis and Treatment
- Evidence-Based Practice

Unit 2: APRN Role and Responsibility in Acute and Chronic Conditions: Assessment and Management

- Assessment and Management of Cardiovascular Disorders
- Assessment and Management of Endocrine and Metabolic Disorders
- Assessment and Management of EENT Disorders
- Assessment and Management of Pulmonary Disorders
- Assessment and Management of Gastrointestinal Disorders
- Assessment and Management of Renal Disorders
- Assessment and Management of Neurologic and Mental Health Disorders
- Assessment and Management of Hematologic and Immune Disorders
- Assessment and Management of Musculoskeletal and Arthritic Disorders
- Assessment and Management of Men and Women Health Problems
- Assessment and Management of Skin Disorders

Evaluation Methods

Students will be evaluated and graded through the following methods:	**PERCENT OF FINAL GRADE**
Syllabus Contract	PASS/FAIL
Exam #1 (Midterm)	25%
Exam #2 (Final Comprehensive)	30%
Online Discussions (total of 2 worth 7.5% each)	15%
Case Study	20%
Shadow Health DCE Focused Exam Assignment	10%
Clinical Requirements (180 hours, in addition to clinical requirements 1-6)	PASS/FAIL
	100%

Exams (55% of final grade):

There will be two (2) examinations scheduled in this course (see tentative weekly class schedule). Questions may include but not limited to multiple choice, matching, essays, short answer, and/or true-false. Each examination will be completed without use of references. Make-up examinations will not be provided unless a valid emergency excuse exists. Please refer to the policy below regarding make-up exams for further information. Refer to the tentative weekly schedule regarding when the midterm examination and final comprehensive examination is scheduled. You will have a total of 2 hours to complete the midterm and final comprehensive examination. Bring your NSHE identification number and #2 pencil with you.

Online Discussions (15% of final grade):
Open class discussion is an important and significant part of an online course. The purpose of online discussions is for students to reflect thoughtfully and exchange ideas on the main concepts covered in this course. Students will be assigned, by the instructor, to small groups of 4-6 students at the beginning of the course (Example: Online Discussion Group 1, 2, 3, etc.). With each scheduled online discussion (see tentative weekly class schedule), each group will reflect on and respond to the online discussion question(s) posted in the module. Your contribution to the topic should be clear, complete, and accurate.

As a class, you should benefit from this assignment only as much as you put into it. Last minute posts that are inaccurate, unorganized, and unclear help no one. If you find that a post is unclear or inaccurate, it is your role to ask your peer for further clarification or to point out the inaccuracy. If someone replies to your post with a question, you owe him/her the courtesy of a response. You are also responsible for posting your answers and replies on time. While class discussion whether online or face-to-face, can be characterized by free flowing conversation, there are identifiable characteristics that distinguish exemplary contributions to class discussion from those of lesser quality. The criteria found in below online discussion grading rubric will be used to assess the quality of your initial postings and responses to the postings and comments of peers during class discussion. **Each scheduled online discussion is worth a total of 100 points.**

Note: Initial postings are your comments based on the discussion prompt posted by the instructor. Responses to others are your replies to your peers' initial postings. The instructor will comment, when appropriate, on those posts or discussion threads that contain inaccuracies or where there seems to be some confusion. The instructor will point out those posts or discussions which are particularly thoughtful, insightful, and well written.

Criteria	Novice	Competent	Proficient
Quantitative	**0 points** Reads messages in the small-group discussion forums on a weekly or more frequent basis but does not post messages. Initial post made late in the week.	**12.5 points** Accesses small-group discussion forum at least twice a week on two separate days. Reads most messages. Posts constructive messages. Initial post made by midweek.	**25 points** Accesses small-group discussion forum 3 or more days a week. Reads all messages. Posts three or more constructive messages. Initial post made early in the week.
Content	**0 points** Messages tend to address peripheral issues and/or ramble. Content is generally accurate; however, with omissions and/or errors. Tendency to recite facts.	**17.5 points** Messages tend to provide good general answers but may not always directly address discussion topics. Assertions are not always supported by evidence. Avoids unsupported opinions.	**35 points** Messages are characterized by conciseness, clarity of argument, depth of insight into theoretical issues, originality of treatment, relevancy as supported by scientific evidence and sometimes include unusual insights.

Questions	**0 points** Rarely includes questions that promote discussion. Rarely responds to questions.	**7.5 points** Sometimes includes questions that stimulate discussion. Sometimes responds to questions raised by others, including instructor.	**15 points** Often includes good questions that stimulate discussion. Frequently responds to questions from others, including instructor.
Collaboration	**0 points** Shows little evidence of collaborative learning. Most comments are directed to the instructor. Does not respond to any student posts.	**7.5 points** Shows some evidence of collaborative learning with a few comments directed to student-to-student (1-2 students) but the majority are student-to-instructor. There is little evidence of support and encouragement exchanged between students, nor a willingness to critically evaluate the work of others with constructive comments.	**15 points** Collaborative learning is evidenced by comments directed primarily to student-to-student (more than 2 students) rather than student-to-instructor. Evidence of support and encouragement is exchanged between students, as well as a willingness to critically evaluate the work of others with constructive comments.
Tone	**0 points** Aggressive and unprofessional postings.	**2.5 points** Members are empathetic rather than aggressive in tone but are not always respectful or professional in their postings.	**5 points** Members are empathetic rather than aggressive in tone and are always respectful or professional in their postings.
Mechanics	**0 points** Messages contain numerous errors in spelling, grammar, and/or APA formatting.	**2.5 points** Messages contain few if any errors in spelling, grammar, and/or APA formatting (indicating proofreading). Messages are well-formatted with spacing and are easy to read.	**5 points** Messages contain no errors in spelling, grammar, and/or APA formatting (indicating proofreading). Messages are well-formatted with spacing and are easy to read.

Case Study (20% of final grade):

Each student will complete one case study provided by the instructor. ***This is a required document for submission to your NP portfolio.*** The case study is designed to assist in mastery of course content and to serve as a mechanism to begin developing clinical judgment skills, integrating content, and application of didactic information to clinical situations. Objectives for the case study include the following: 1) concisely present a common health care situation to be covered this semester, 2) accurately cover signs and symptoms, history and physical exam findings, including pertinent negatives as appropriate to the case, 3) integrate current knowledge and research to analyze the problem conceptually and theoretically, 4) integrate the data gained from subjective and

objective approaches while proposing differential diagnoses, 5) discuss methods/criteria to include/exclude potential diagnoses with further work-up, and 6) discuss recommendations and/or treatments using evidence-based standards when appropriate. Answers must be in complete sentences and organized in a logical manner. In addition, responses should be consistent with current clinical practice standards and placed in the context of a primary care setting.

The final case study will be submitted via the assignment tab located within WebCampus. The final case study submission should include at least three (3) peer reviewed research journals no greater than three (3) years old. The maximum page limit should not exceed five (5) pages (excluding title page and reference page) and written in 6th edition APA format. **The case study is worth a total of 100 points.**

Each student will be evaluated based on below Case Study Grading Rubric.

Category	5 points	10 points	15 points	20 points
Identification of Main Issue/Problem and Supporting Information	Identifies, labels, and understands the main issue/problem and at least 2 points which support the main issue/problem.	Identifies, labels, and understands the main issue/problem and at least 3 points which support the main issue/problem.	Identifies, labels, and understands the main issue/problem and at least 4 points which support the main issue/problem.	Identifies, labels, and understands the main issue/problem and at least 5-7 points which support the main issue/problem.
Analysis of the Issue/Problem	Incomplete analysis of the main issue/problem.	Superficial analysis of the main issue/problem.	Thorough analysis of most of the main issue/problem.	Insightful and thorough analysis of the main issue/problem (including correct diagnosis).
Answers each Question Completely and Accurately	Superficial answers which are at times inappropriate and the link between answers to questions and didactic materials are incorrect/incomplete.	Superficial answer to questions with limited research and link between answers to questions and didactic materials.	Appropriate and well thought out answers with good research and documented link between answers to questions and didactic materials.	Well documented, accurate, and reasoned approach to answers with excellent link to didactic materials.
References and Format	A mix of appropriate and less appropriate references is used that are < 5 years old. APA format with > 5 format errors.	References are appropriate with occasional use of less reputable citations that are < 3 years old. APA format with	References are appropriate and are < 5 years old. APA format with 1-2 format errors.	References are appropriate and are < 3 years old. APA format is correct throughout the

		3-5 format errors.		paper.
Writing Skills	Spelling/grammar errors are frequent. Hard to follow ideas.	There are more than occasional spelling/grammar errors. Most ideas are presented clearly.	There are occasional spelling/grammar errors. Clear presentation of ideas.	Writing is totally free of grammar and spelling errors. Clear and concise presentation of ideas.

Shadow Health Digital Clinical Experience

The Shadow Health Digital Clinical Experience (DCE) provides a dynamic, immersive experience designed to improve your skills and clinical reasoning through the examination of digital standardized patients. Although these patients are digital, each one breathes, speaks, and has a complex medical and psychosocial history. One (1) Shadow Health DCE assignment is required in this course which is detailed below.

Focused Exam Assignment (10% of final grade):

The focused exam allows you to demonstrate mastery of skills relevant to multiple systems and professional communication in a graded activity. The focused exam will be graded using a point value rubric that considers the percentage of findings uncovered and time spent, among other criteria. ***You have the flexibility, after multiple attempts to select which assignment attempt to "Turn In" and you can reopen your assignment attempt to modify or add to a completed attempt.*** **This assignment is worth a total of 100 points.** The Shadow Health DCE Focused Exam assignment is worth 10% of your final grade.

Each student will be evaluated based on below Shadow Health DCE Focused Exam Grading Rubric.

Categories	Excellent	Satisfactory	Unsatisfactory
Data Collection	≥80% Subjective Data Collection; ≥80% Objective Data Collection **35 PTS**	60-80% Subjective Data Collection; 60-80% Objective Data Collection **18 PTS**	<60% Subjective Data Collection; <60% Objective Data Collection **0 PTS**

Communication (Transcript)	Comprehensive introduction with expectations of exam verbalized; questions worded in a non-judgmental way; assessments well-organized; empathy and education provided often and at appropriate times; appropriate closing with summary of findings verbalized to patient **15 PTS**	Incomplete introduction; some questions worded in a non-judgmental way; assessments somewhat organized; empathy and education provided occasionally; incomplete closing **8 PTS**	Introduction missing; questions worded in a judgmental way; assessments unorganized; no empathy and education provided; closing missing **0 PTS**
Documentation	Documentation detailed and organized with all abnormals and pertinent normals noted in professional language. **20 PTS**	Documentation with sufficient details and some organization; some abnormals and some normals noted in mostly professional language. **10 PTS**	Documentation with inadequate details and/or organization; inadequate identification of abnormals and pertinent normals noted; inadequate use of professional language. **0 PTS**
Time	≥45 minutes **10 PTS**	30-45 minutes **5 PTS**	<30 minutes **0 PTS**
End Exam (SBAR)	Student communicated the situation, background, differential diagnoses, and recommendation clearly, professionally, and efficiently and with sufficient and relevant details when giving report. **10 PTS**	Student communicated the situation, background, differential diagnoses, and recommendation somewhat clearly and with some relevant details when giving report. **5 PTS**	Student did not provide relevant and adequate details about situation, background, differential diagnoses, and recommendation when giving report. **0 PTS**
Self-Reflection	Reflections written clearly with relevant analysis related to the assignment and the student's experience; evaluation of personal biases **10 PTS**	Reflections somewhat unclear with some relevant analysis related to the assignment and the student's experience; little or no evaluation of personal biases **5 PTS**	Reflections unclear with irrelevant analysis related to the assignment and the student's experience; no evaluation of personal biases **0 PTS**

Clinical Requirements (PASS/FAIL):
Students are expected to complete a minimum of 180 clinical hours by the end of the semester. These hours should be distributed evenly throughout the 15 weeks unless otherwise approved by the clinical instructor. Arranging for clinical sites and times will be the responsibility of each student. Students are expected to complete the clinical hours by the last week of classes. By Thursday April 21, 2016 at 5:00pm PST all clinical hours, site evaluations, and paperwork must be completed. Students may complete their clinical hours and evaluations by the end of week 14 of the semester, which is Friday April 15, 2016. Students should calendar out their clinical hours from the first week of the semester until the end to make sure the 180 hours are completed in a timely manner. Students may have more than the recommended 12 hours per week on any given week. The requirement is that students have a minimum of 8 hours in the clinical setting per week during the weeks of the academic semester, excluding the finals week (week 15).

1. Call the clinical site to schedule dates and times for clinical. If the student is unable to attend clinical at the prearranged date/time it is his/her responsibility to contact the clinical site to make other arrangements.

2. Dress: Students must comply with the dress code regulations for the clinical site they are working in. Appearance and clothes should be neat and clean. Pants are fine except for blue jeans or sweat pants. Comfortable shoes are recommended except tennis shoes and sandals in some sites. Socks or nylons should be worn with shoes. The student must wear a lab coat and name tag (name tag must identify individual as a UNLV FNP student). Each student must also have his/her own stethoscope, watch and other tools needed for the individual site.

3. While in the clinical setting: the student will (1) complete comprehensive and/or interval health histories on selected patients, (2) perform head to toe physical exams, (3) be able to identify relevant lab/special tests, (4) formulate a list of differential diagnoses based on the health history and physical findings, (5) identify a plan of care, and (6) chart in patients' medical records utilizing the SOAP format (or a format the clinic/practice has adopted).

Students must have a passing grade to complete the clinical requirements for this course. The clinical faculty assigned to the clinical section determines the final clinical grade for the student based on clinical requirements 1-6 listed below. Below are detailed instructions for each clinical assignment. Completed assignments will be assigned a "1" and an uncompleted assignment will be assigned a "0". A student will fail if considered unsafe in the performance of clinical competencies (i.e. a failure in the standardized patient OSCE) or unethical professional conduct. The Preceptor Evaluation Tool: Student Performance form enclosed within this syllabus is to be completed by the preceptor. The preceptor may use the Guidelines for Student's Clinical Evaluation to help them in their evaluation process. The preceptor is expected to meet with the clinical instructor at mid-term and/or at the end of the clinical experience to discuss the student's clinic performance. The completed Preceptor Evaluation Tool: Student Performance form should be submitted to faculty via the student if not collected during the site visits. Although the clinical preceptor provides an overall evaluation of the student's clinical

performance, the clinical faculty assigned to the course makes the final determination as to whether the student passes or fails the clinical requirements for this course based upon expected competencies for safe practice as outlined by the National Task Force Criteria for Nurse Practitioner Education.

The following is the breakdown of the clinical requirements for this course:

1. **Weekly Clinical Log (PASS/FAIL):** Students will be required to log their individual patient encounters. Weekly clinical logs are to be submitted through E-Value first. Students will also submit to WebCampus a verification of clinical hours that match the E-Value system; this serves as an attestation of the hours and patient encounters have been logged in E-Value prior to submitting to WebCampus. For example, week 1 clinical log will be due Sunday January 10, 2016 at 11:59pm PST. If clinical hours are not done the first week of the semester, students must notify their clinical instructor prior and then submit a note in the clinical log assignment indicating that hours were not completed that week. Each clinical log is pass/fail. Students who fail to turn in a clinical log will receive a fail for the week. Any student who receives two (2) 'fails' will automatically fail the clinical requirements for this course. If you have a prearranged absence for one week (i.e. week 1 or week 15), you are still required to submit in the clinical log assignment noting that you did not do clinical hours for reasons noted (i.e. week 1 – have not started clinical rotations yet; week 15 – not doing hours this week since done with required clinical hours).

2. **Student Accountability Log (PASS/FAIL):** There are a total of 3 student accountability log submissions (NOTE: #3 log due date not a Sunday). These logs are required to be completed entirely including signatures prior to submission into WebCampus. Each student accountability log is pass/fail and follows the same grading system noted above. Students who fail to submit or submit late will receive a zero (0). Any student who receives two (2) zeros (0) will automatically fail the clinical requirements for this course.
    - #1 Student Accountability Log **(due Sunday 2/7/16 11:59pm PST)**
    - #2 Student Accountability Log **(due Sunday 3/6/16 11:59pm PST)**
    - #3 Student Accountability Log **(due Thursday 4/21/16 5:00pm PST)**

3. **SOAP Notes (PASS/FAIL):** Students will need to submit one SOAP note weekly based on a patient seen during clinical rotations. Follow the SOAP format (S = Subjective, O = Objective, A=Assessment, P=Plan) and include pertinent history, physical findings, assessment, and interventions. Feedback will be provided for each submission. A formal written SOAP note is required along with a scanned copy of the actual patient note from the clinical setting. Make sure patient identification is blackened out. Students must submit the original note from the clinical setting along with the SOAP note or a zero (0) for the assignment with be received. Students who receive a failing grade on a SOAP note will be required to remediate the SOAP note until the clinical instructor issues a passing grade. Each SOAP note is pass/fail and will be evaluated using the grading rubric enclosed at the end of this syllabus. Students who fail to submit

or submit late will receive a zero (0). Any student who receives two (2) zero (0) will automatically fail the clinical requirements for this course. It is up to the discretion of the clinical instructor to determine if there is a need to continue additional SOAP note submissions based on need of further evaluation.

4. **Reflective Journals (PASS/FAIL):** Each student will complete two 1-2 page (use references as appropriate) reflective journals. Journal #1 should address the following: 1.) Objectives for semester (i.e. what are your goals for the semester and how do you plan to achieve them), 2.) Personal strengths, 3.) Areas for improvement, 4.) Personal competency to include the APRN role and cultural competency, 5.) Nursing theory, 6.) Communication, 7.) Professionalism and 8.) Leadership. Journal #2 should evaluate the goals set at the beginning of the semester, and evaluate what goals remain for the rest of the semester. Also, look ahead as to what your goals are for next semester and the remainder of the program.

   Each reflective journal is pass/fail and follows the same grading system noted above. Students who fail to submit or submit late will receive a zero (0). Any student who receives two (2) zeros (0) will automatically fail the clinical requirements for this course. Each journal is to be submitted in the assignment section in Web Campus.
   - #1 Reflective Journal **(due Sunday 1/17/16 11:59pm PST)**
   - #2 Reflective Journal **(due Sunday 2/28/16 11:59pm PST)**

5. **Clinical Evaluations (PASS/FAIL):** Students are responsible for giving a copy of the guidelines for clinical evaluation and the Preceptor Evaluation Tool: Student Performance form to their respective preceptor(s). This is a clinical requirement for this course. You should do this at the beginning of the semester and review these with your preceptor(s) in order to establish goals for the clinical experience for both student and preceptor(s). The Preceptor Evaluation Tool: Student Performance form (completed by ***each*** of your preceptor's) needs to be submitted through WebCampus at both the midterm and final portions of the semester. A course grade will not be issued until evaluation forms have been received by the assigned clinical instructor; students are responsible for providing the clinical instructor with the original Preceptor Evaluation Tool: Student Performance form(s).

   The assigned clinical instructor will also conduct a clinical site evaluation of each student at a minimum during midterm of the semester. Please refer to the Family Nurse Practitioner Student Competency-Based Clinical Evaluation Tool enclosed at the end of this syllabus. This tool is to be used by the clinical instructor to evaluate the student's performance at midterm and final. *A minimum rating score of 2 in all applicable criteria's is required by the final clinical evaluation in order for the student to receive a pass rating for the clinical practicum*. ***Any score of 1 by the final clinical evaluation is considered a failing grade.***

The mid-term clinical evaluation will consist of a site visit from the clinical instructor to speak briefly with the preceptor and evaluate the student in their clinical setting. Two weeks prior to the mid-term clinical evaluation, the student should review these expectations with their preceptor by selection of one-three patient encounters in order to have a productive site visit. The following are expectations for the clinical site visit:

1. A site visit is where a student is observed and graded at the clinical site with the clinical preceptor. This site visit will include a comprehensive evaluation of the student progress in the clinical site.
2. The site visit will include observation of the student as they perform duties to meet specific course objectives to include assessment, diagnosis, evaluation of appropriate interventions, prescribing, interpretation of testing, and follow up care. Observation of professional behavior, communication, critical thinking, and management of patient acute/chronic health concerns are part of the site clinical assessment.
3. Students have one site visit per semester at a minimum and additional site visits as determined by individual clinical faculty.
4. Clinical site visits are conducted at the site where the student is practicing. If there is more than one clinical site, the clinical faculty may choose to visit each site but one site is the required minimum. It is up to the discretion of the clinical faculty to make this determination.
5. Evaluation by the clinical faculty will utilize the Family Nurse Practitioner Student Competency-Based Clinical Evaluation Tool for all clinical courses.
6. The site visit will include, but not limited to the following:
    a. Observation of the student and patient interaction: history taking, physical examination, diagnosis, interpretation of laboratory and other testing, prescribing and education, plan of care, and follow-up.
    b. Observation of the student 'presenting' a case to the preceptor and interaction between student and preceptor in relation to patient care.
    c. Clinical instructor discusses patient(s) with student to ask pertinent questions regarding different diagnosis, final diagnosis, physical findings, plan of care, health promotion, follow up and other areas of discussion relevant to the patient observed.
    d. The clinical instructor will discuss the student's progress with the preceptor to identify areas of strength, weaknesses, and areas to improve for the remainder of the semester.
    e. Site visits are documented on the Family Nurse Practitioner Student Competency-Based Clinical Evaluation Tool in E-Value. See the Family Nurse Practitioner Student Competency-Based Clinical Evaluation Tool for specific areas of evaluation and grading (located at the end of the syllabus).

The final clinical evaluation will be completed at the Clinical Simulation Center of Las Vegas (CSCLV) Friday April 15, 2016. The final clinical evaluation will involve one-two OSCE cases with use of standardized patients and is required of all students; **failure to show will result in a failure of the course, in addition a failure of the OSCE evaluation will result in a failure of the course.** The following are expectations for the final clinical evaluation:

1. All students are required to participate in the end of semester OSCE clinical evaluation at the CSCLV.
2. Students will report to the CSCLV on the date and time provided by the course instructor.
3. On the day of the clinical evaluation, students will have an orientation for the OSCE testing. Each student will have the standardized patient encounter at the CSCLV. Directly after the clinical encounter, students will complete a self-evaluation while viewing their standardized patient encounter. After the self-evaluation is completed, students will have a debriefing session with the clinical faculty at the CSCLV.
4. Students will be evaluated by their clinical faculty, who will view and grade the OSCE encounters using the Family Nurse Practitioner Student Competency-Based Clinical Evaluation Tool.
5. Clinical faculty will discuss and review final OSCE evaluation with student of the OSCE encounter.
6. If there are any concerns by clinical faculty regarding grading, the faculty may request an objective review by a second faculty member.

6. **Clinical Preceptor Worksheet to Generate Clinical Contract (PASS/FAIL):** Each student should identify a clinical preceptor and complete the FNP preceptor worksheet located in WebCampus in preparation for course NURS 750R (Pediatric and OB clinical rotations). **This assignment is due Sunday 2/21/16 11:59pm PST.** The student needs to complete this form and send electronically in the designated assignment box in WebCampus. The student will still need to submit a clinical preceptor worksheet even if there is no preceptor identified (indicate this information on the worksheet). The student will not be able to participate in clinical rotations unless a clinical contract is completed.

****NOTE:** The student must complete a worksheet for <u>each</u> preceptor they plan to rotate with if there is more than one preceptor. If the Projects Coordinator requires additional information, the student may need to provide a copy of the following for a clinical contract to be generated:

1. License to practice as either an MD, DO, or APRN
2. Updated resume
3. Degree earned
4. Insurance certificate (i.e. malpractice, liability)

Grading Scale: Grades are determined in accordance with the policy of the School of Nursing. Grades are calculated to the tenth and are not rounded up. For example, 82.99% will not be rounded up to 83%.

A = 93--100	B- = 80--82	D+ = 68--69
A- = 90--92	C+ = 78--79	D = 63--67
B+ = 88--89	C = 75--77	D- = 60--62
B = 83--87	C- = 70--74	F = < 59

****83% "B" OR GREATER IS REQUIRED FOR A PASSING GRADE.**

****Failure to either the theory or clinical component of this course results in a failure for the entire course.**

Tentative Weekly Schedule

Unit 1: APRN Role and Responsibility in Acute and Chronic Conditions: Meaning and Implementation

MODULE/DATE	TOPIC(s)	READINGS/EXAMS	ASSIGNMENTS
Module 1 Jan 4-11	Health Promotion The Art of Diagnosis and Treatment Evidence-Based Practice	Dunphy: Chapters 3, 4, & 5	**NURS 740R Syllabus Contract due Monday 1/11/16 11:59pm PST**

Unit 2: APRN Role and Responsibility in Acute and Chronic Conditions: Assessment and Management

MODULE/DATE	TOPIC(s)	READINGS/EXAMS	ASSIGNMENTS
Module 2 Jan 11-18	Assessment and Management of Cardiovascular Disorders	Dunphy: Chapter 10	
Module 3 Jan 18-25	Assessment and Management of Cardiovascular Disorders	Dunphy: Chapter 10	
Module 4 Jan 25-Feb 1	Assessment and Management of Endocrine and Metabolic Disorders	Dunphy: Chapter 16	**Online Discussion #1 ends Monday 2/1/16 11:59pm PST**
Module 5 Feb 1-8	Assessment and Management of EENT Disorders	Dunphy: Chapter 8	

Module 6 Feb 8-15	Assessment and Management of Pulmonary Disorders	Dunphy: Chapter 9	**Shadow Health DCE Focused Exam Assignment due Monday 2/15/16 11:59pm PST**
Module 7 Feb 15-22		Dunphy: Chapter 11 **Thursday 2/18/16 9:00am-5:00pm Mock OSCE & TBA CSCLV** **Friday 2/19/16 9:00am-11:00am Midterm Exam (Modules 1-6) CSCLV Classroom 4 & 1:00pm-5:00pm CSCLV Classroom 4**	
Module 8 Feb 22-29	Assessment and Management of Renal Disorders	Dunphy: Chapter 12	**Online Discussion #2 ends Monday 2/29/16 11:59pm PST**
Module 9 Feb 29-March 7	Assessment and Management of Neurologic and Mental Health Disorders	Dunphy: Chapters 6 & 18	
Module 10 March 7-14	Assessment and Management of Hematologic and Immune Disorders	Dunphy: Chapter 17	**Case Study due Monday 3/14/16 11:59pm PST**
Module 11 March 14-21	Assessment and Management of Musculoskeletal and Arthritic Disorders	Dunphy: Chapter 15	
Module 12 March 21-April 4 **SPRING BREAK 3/21/16-3/27/16**	Assessment and Management of Men & Women Health Problems	Dunphy: Chapters 13 & 14	
Module 13 April 4-11	Assessment and Management of Skin Disorders	**Exam #2 (Modules 1-13) Thursday 4/14/16 9:00am-11:00am Main Campus BHS** **NURS 740R Standardized Patient Final Clinical Evaluation Friday 4/15/16 9:00am-5:00pm CSCLV**	

UNIVERSITY POLICIES

ACADEMIC MISCONDUCT

Academic integrity is a legitimate concern for every member of the campus community; all share in upholding the fundamental values of honesty, trust, respect, fairness, responsibility and professionalism. By choosing to join the UNLV community, students accept the expectations of the Student Academic Misconduct Policy and are encouraged when faced with choices to always take the ethical path. Students enrolling in UNLV assume the obligation to conduct themselves in a manner compatible with UNLV's function as an educational institution.

An example of academic misconduct is plagiarism. Plagiarism is "using the words or ideas of another, from the Internet or any source, without proper citation of the sources." See the *Student Academic Misconduct Policy* (approved December 9, 2005) located at: http://studentconduct.unlv.edu/misconduct/policy.html.

COPYRIGHT

The University requires all members of the University Community to familiarize themselves **with** and to follow copyright and fair use requirements. **You are individually and solely responsible for violations of copyright and fair use laws. The university will neither protect nor defend you nor assume any responsibility for employee or student violations of fair use laws.** Violations of copyright laws could subject you to federal and state civil penalties and criminal liability, as well as disciplinary action under University policies. Additional information can be found at http://www.unlv.edu/provost/copyright

Please be advised that the instructor of any nursing course may use the computer software entitled: "Turn it In" if he/she has reason to believe that the student has violated copyright laws.

DISABILITY RESOURCE CENTER (DRC) ACCOMODATIONS

The UNLV Disability Resource Center (SSC-A 143, http://drc.unlv.edu/ 702-895-0866) provides resources for students with disabilities. If you feel that you have a disability, please make an appointment with a Disabilities Specialist at the DRC to discuss what options may be available to you.

If you are registered with the UNLV Disability Resource Center, bring your Academic Accommodation Plan from the DRC to the instructor during office hours so that you may work together to develop strategies for implementing the accommodations to meet both your needs and the requirements of the course. Any information you provide is private and will be treated as such. To maintain the confidentiality of your request, please do not approach the instructor before or after class to discuss your accommodation needs.

POLICY ON RELIGIOUS HOLIDAYS

Any student missing class quizzes, examinations, or any other class or lab work because of observance of religious holidays shall be given an opportunity during that semester to

make up missed work. The make-up will apply to the religious holiday absence only. It shall be the responsibility of the student to notify the instructor no later than the end of the first two weeks of classes, January 29, 2016, of his or her intention to participate in religious holidays which do not fall on state holidays or periods of class recess. For additional information, please visit:
http://catalog.unlv.edu/content.php?catoid=6&navoid=531

CONSENSUAL RELATIONSHIPS
UNLV prohibits romantic or sexual relationships between members of the university community when one of the individuals involved has direct professional influence or direct authority over the other. For further information, see
http://www.unlv.edu/hr/policies/consensual

FERPA
The Family Education Rights and Privacy Act of 1974, commonly known as FERPA, is a federal law that protects the privacy of student education records. Students have specific, protected rights regarding the release of such records, and FERPA requires that institutions adhere strictly to these guidelines. Only UNLV school officials with a legitimate educational interest can access student records. This is not a right of every UNLV employee. Those who have the right to access student records are held responsible for the information.

REBELMAIL
By policy, faculty and staff should e-mail students' Rebelmail accounts only. Rebelmail is UNLV's official e-mail system for students. It is one of the primary ways students receive official university communication such as information about deadlines, major campus events, and announcements. All UNLV students receive a Rebelmail account after they have been admitted to the university. Students' email prefixes are listed on class rosters. The suffix is always @unlv.nevada.edu. **Emailing within WebCampus is acceptable.**

TUTORING
The Academic Success Center (ASC) provides tutoring and academic assistance for all UNLV students taking UNLV courses. Students are encouraged to stop by the ASC to learn more about subjects offered, tutoring times, and other academic resources. The ASC is located across from the Student Services Complex (SSC). Students may learn more about tutoring services by calling (702) 895-3177 or
visiting the tutoring web site at http://academicsuccess.unlv.edu/tutoring/.

UNLV WRITING CENTER
One-on-one or small group assistance with writing is available free of charge to UNLV students at the Writing Center, located in CDC-3-301. Although walk-in consultations are sometimes available, students with appointments will receive priority assistance. Appointments may be made in person or by calling 702-895-3908. The student's Rebel ID Card, a copy of the assignment (if possible), and two copies of any writing to be

reviewed are requested for the consultation. More information can be found at: http://writingcenter.unlv.edu/

STUDENT OF CONCERN

Faculty may come in contact with students whose behavior may cause concern. A process has been developed to deal with such situations and training is also available by contacting the Office of Student Conduct at 702-895-2308. To report an issue, go to http://studentconduct.unlv.edu/concern/. For immediate emergency assistance from UNLV Police Services, dial 911 on a UNLV land-line phone or 702-895-3668 option 2 from a cell phone.

TITLE IX OF THE EDUCATION AMENDMENTS OF 1972

Title IX of the Education Amendments of 1972 (20 U.S.C. 1681) is an all-encompassing federal mandate prohibiting discrimination based on the gender of students and employees of educational institutions receiving federal financial assistance. Sex discrimination includes sexual harassment, sexual violence, and/or discrimination related to pregnancy. In compliance with Title IX, the University of Nevada, Las Vegas prohibits discrimination in all programs and activities, including employment on the basis of sex and gender. If you or someone you know has been harassed or assaulted, you can find the appropriate resources here: http://www.unlv.edu/compliance/TitleIX-resources

CLASSROOM POLICIES/RULES:

CONFIDENTIALITY

An important part of nursing ethics is maintaining the client's confidentiality. Therefore, written work submitted to the instructor must NEVER contain his/her full name. Client's problems must not be discussed with family or friends. If the School of Nursing ascertains that
a client's confidentiality has been violated, the student violating the confidence will be subjected to disciplinary action.

ATTENDENCE POLICY

The class will be conducted on WebCampus; however, we will meet as a group during the semester. The learning modules will be posted weekly as stated in the enclosed tentative weekly class schedule. It is up to the student to log onto WebCampus as much as daily to assess for any further information or changes that may occur during the semester other than what is documented in the tentative weekly class schedule. The student is expected to take responsibility for their own learning.

It is a faculty member's discretion and prerogative to determine what is and is not acceptable behavior in his or her classroom (i.e., late arrival, wearing hats). Also, classroom occupants are at the discretion of the instructor (per UNLV General Counsel). Although there is no policy prohibiting bringing children to class, it falls within the Student Conduct Code, Section Two, III. K. and L. relating to "disrupting" the classroom and/or university operations. See http://studentlife.unlv.edu/judicial/student.html.

LATENESS OF ASSIGNMENT
Written work is expected on the date indicated in the enclosed tentative weekly class schedule. Assignments may be submitted no later than 11:59pm on the due date without reduction in the grade. The student will receive a score of zero (0) if the assignment is not submitted on time. It is the student's responsibility to notify the instructor that an emergency has occurred.

MAKE-UP EXAMS & QUIZZES
Make-up exams and quizzes are provided only under exceptional circumstances. An alternative date must be scheduled prior to the scheduled day of the exam or quiz. Any student missing an exam or quiz will earn a grade of zero (0). The instructor is under no obligation to provide remediation for material missed due to an unexpected absence.

NOTE: An absence **MAY** be considered under the following circumstances:

- A student missed class in observance of a religious holiday.
- A student representing UNLV at an official extracurricular event. The student must provide written verification no less than one week prior to the class that he or she will miss.
- Illness of the student or a first degree family relative requiring a physician office visit or hospitalization. Students will be asked to provide written verification from the health care provider.

**When a total of three absences occurs (also defined as when you have not logged into WebCampus), whether excused, unexcused, or any combination of the two, the student will schedule a meeting with the instructor to determine ability to complete the course requirements successfully.

DROP/WITHDRAWAL FROM CLASS
A student may drop or withdrawal from full semester courses during the free drop period without a grade. No drops or withdrawals will be permitted after the end of the free drop period. A student who stops attending class and fails to drop/withdrawal from the course electronically will receive a grade of "F". **If the student is failing at the time of withdrawal, the School of Nursing will consider the class as an unsuccessful completion in consideration of progression in the program. Please note when dropping a course electronically it is the student's responsibility to print a copy of the drop verification that the drop was successfully executed. A student who officially drops a class and are no longer registered for credit or audit are ineligible for further attendance in that class.**

INCOMPLETE
An incomplete "I" grade can be granted when a student has satisfactorily completed at least three-fourths of the semester but for reason(s) beyond the student's control, and acceptable to the instructor, cannot complete the last part of the course and the instructor believes that the student can finish the course without repeating it. A student who receives an incomplete "I" is responsible for making up whatever work was lacking at the end of the semester. The incomplete must be made up before the end of the following

regular semester. If course requirements are not completed within the time indicated, a grade of "F" will be recorded and the GPA will be adjusted accordingly. Students who are fulfilling an Incomplete "I" do not register for the course but make individual arrangements with the instructor who assigned the "I" grade.

COMPUTER PROGRAMS

♦Word Processing Program: Microsoft Word preferred. If using WordPerfect or Works, submit text files in .rtf format. Otherwise, I will not be able to open the file. (Select "Save as" from the drop down File menu, then ".rtf" or "Rich Text Format.")

♦Presentation Program: such as PowerPoint

GETTING HELP in WEB-CAMPUS

http://ccs.unlv.edu/scr/support/webcampus/using.asp

You can call the Help Desk: 702-895-0761 if you have questions or need support

TEACHING EVALUATIONS

In order to evaluate the effectiveness of teaching at UNLV, course evaluations are required to be administered at the end of each course. Teaching evaluations are a very important piece of assessment data and it is important that the reliability, validity, and legitimacy of these instruments be maintained. The minimum standards for administering these evaluations (Anonymity, Objectivity and Post-Evaluation Procedures) are outlined in the document "Minimum Standards for Teaching Evaluation by Students." This document has been approved unanimously by the Academic Council of Deans and the Executive Vice President and Provost as reflecting the minimum standards that apply to all departments/schools/units when administering student evaluations of teaching. To review the policy, please see "Evaluations by Students - Minimum Standards for" in the alphabetical listing at: http://provost.unlv.edu/policies.html#list_e.

STUDENT RESPONSIBILITIES

Students are expected to take responsibility for their own learning. Successful completion of this course requires participation with WebCampus based learning, reading of required/recommended materials, and meeting on campus for scheduled clinical workshops. Each student should monitor his/her progress throughout the semester, and ask for help when necessary. Numerical averages as calculated above convert to letter grades consistent with those published in the School of Nursing Student Handbook.

INSTRUCTOR RESPONSIBILTIES

Students may need additional help throughout the semester. The instructor is expected to maintain weekly office hours. Office hours will be posted on the bulletin board of the faculty member's office and they are also listed in the syllabus. Special arrangements could be made for meeting outside the documented office hours at the discretion of the instructor. Keep in mind with an online course faculty members are available to answer questions in a different manner. For emails sent Monday through Friday (during normal business hours), faculty should attempt to respond within 24-48 hours. It may take up to 72 hours for faculty to respond to your questions—especially after 5:00pm (1700) PST excluding weekends and holidays. Faculties are not online 24 hours a day, 7 days a

week. Expect a reasonable response time for your questions. Generally, faculty will not respond to discussion forums after 5:00pm (1700) PST on Friday.

NOTE: The instructor reserves the right to make changes as necessary to this syllabus. If changes are necessitated during the term of the course, the instructor will immediately notify students of such changes both by individual email communication and posting both notification and nature of change(s) on the course announcement board.

SOAP Note Grading Rubric

Objective/Criteria	Performance Indicators		
	Unacceptable	Average	Exceptional
Style	(0 points) Documentation is unclear and/or unorganized and/or inappropriate as evidenced by any of the following: Absence of appropriate medical terminology Frequent use of lay terminology or slang Misspelled words and/or poor grammar are common (>2). Contains repetitious information that creates distractions. Format does not follow a standard format for SOAP documentation. Narratives such as the HPI and Exam are haphazardly written.	(0.5 points) Documentation meets criteria for "exceptional" but there is occasional redundant information. Documentation meets criteria for clarity but needs to be better organized. Documentation occasionally strays from standard format for SOAP documentation. Narratives such as the HPI and Exam occasionally stray from logical sequence but the reader is able to determine findings with minimal difficulty.	(1 point) Documentation is clear and well organized. Appropriate medical terminology is used. Redundant (repetitious) words, phrases, and other distracting information are omitted. Format follows a standard. Narratives such as the HPI and Exam have a logical flow.
Content	(0 points) Either the subjective or objective assessment is not developed and/or the assessment is inappropriate for the patient's age, gender, and/or inappropriate for the presenting problem.	(0.5 points) Either the subjective or objective assessment is missing an element needed for adequate evaluation of the patient's problem. Includes irrelevant information Selection of diagnostic tests is too broad or expensive for evaluating the presenting problem OR Selection of diagnostic tests is inadequate to address the presenting problem.	(1 point) Subjective and objective assessments of health status are fully explicated CC and HPI are targeted toward the reason for presentation without the inclusion of extraneous information. CC is succinct. HPI is fully developed and includes location, duration, timing, character, severity provocative/palliative factors and/or other features appropriate for the reason for presentation. Physical exam includes vital signs, height and weight for all children and for others as appropriate, and any relevant developmental data related to assessment of CC. Elements of the PMH, FH, and ROS that expand on the CC and HPI are included yet irrelevant information is excluded. Appropriate diagnostic tests are performed/ordered.
Management	(0 points) Diagnosis and/or management plan is inappropriate.	(0.5 points) Diagnosis has coherence, adequacy, and parsimony.*	(1 point) Diagnosis has coherence, adequacy, and parsimony.*

Objective/Criteria	Performance Indicators		
	Unacceptable	Average	Exceptional
		Management plan is appropriate for diagnosis and addresses the problem identified but has one of the following problems: Is too expansive (thus expensive) or overwhelming for the client or healthcare system OR Needs to consider alternative features for optimal outcomes.	Management plan is appropriate for the diagnosis and accurately addresses the problem identified. Management plan is economically sound. Management plan includes plans for evaluation/follow-up care (as appropriate). Management plan is individualized to the patient's age and development, culture, religion, family, environment, education, and/or any other unique concerns uncovered in assessment.
			out of 3

UNIVERSITY OF NEVADA, LAS VEGAS
SCHOOL OF NURSING

Family Nurse Practitioner Student Competency-Based Clinical Evaluation Tool

This tool is to be used by the clinical instructor to evaluate the student's performance at midterm and final. *A minimum rating score of 2 in all applicable criteria's is required by the final clinical evaluation in order for the student to receive a pass rating for the clinical practicum.* ***Any score of 1 by the final clinical evaluation is considered a failing grade.***

NURS 740R **NURS 750R** **NURS 760R** **NURS 773**

1 = Below expectations for this level of student.
2 = Appropriate for this level of student.
3 = Exceeds expectations for this level of student.
N.A./O = Not applicable/Not observed.

Criteria of Evaluation	**1**	**2**	**3**	**N.A./O**	**Comments**
NONPF Domain 1: Management of Patient Health/Illness Status					
Obtains a comprehensive and/or problem-focused health history from the patient/family using appropriate interviewing skills.					
Performs a comprehensive and/or problem-focused physical examination.					
Differentiates between normal, variations of normal and abnormal findings.					
Demonstrates critical thinking and diagnostic reasoning skills in clinical decision-making.					
Employs appropriate diagnostic, procedural, and other interventions with attention to safety, cost, invasiveness, simplicity, acceptability, adherence, and efficacy.					
Analyzes and interprets history, physical findings, and diagnostic information to develop appropriate differential diagnoses, concluding with the appropriate final diagnosis.					
Prioritizes health problems including initiation of effective emergent care.					
Demonstrates knowledge of the pathophysiology and genetic basis of illness.					

Criteria of Evaluation	1	2	3	N.A./O	Comments
Formulates and documents a plan of care based on scientific rationale, evidence-based standards of care and practice guidelines.					
Prescribes appropriate pharmacological and non-pharmacological treatment modalities based on relevant individual client characteristics.					
Integrates and counsels the patient on the use of complementary/alternative therapies.					
Develops and implements health promotion/disease prevention plans based on relevant individual patient characteristics (includes environmental health problems affecting patients).					
Provides anticipatory guidance and counseling for patients and/or families.					
Communicates the patient's health status with the patient and/or other health care providers using appropriate terminology, format, and technology.					
Prioritizes health needs/problems.					
Provides for continuity of care and evaluates outcomes of care when applicable to case.					
NONPF Domain 2: The Nurse Practitioner-Patient Relationship					
Demonstrates effective communication skills in patient interactions that support the patient and/or families:					
a) Sharing information, including health beliefs and behaviors,					
b) Discussing family and cultural preferences,					
c) Conveying feelings,					
d) Making decisions about health care and,					
e) Engaging in self-care.					
Demonstrates an ability to establish partnerships with the patient and/or family through:					
a) Mutually agreed upon plans of care and,					
b) Appropriate documentation regarding the patient's and/or family understanding of health care plans.					

Criteria of Evaluation	1	2	3	N.A./O	Comments
Collects, maintains, and documents the patient's health care information in a confidential and private manner that complies with current rules and regulations.					
NONPF Domain 3: The Teaching-Coaching Function					
Assess the patient's and/or family's need for learning based on developmental level, understanding of health concerns, motivation for change, and limitations.					
Provides developmentally appropriate teaching, guidance, and counseling regarding management of health/illness conditions.					
Coaches the patient and/or family in an empathetic manner by reminding, supporting, and encouraging healthy behavior changes over time.					
NONPF Domain 4: Professional Role					
Applies current, relevant evidence into plans of patient care.					
Uses available resources from the community in designing patient treatment plans.					
Communicates personal strengths and professional limits.					
Participates as a member of the health care team.					
Advocates for the patient.					
Accepts personal responsibility for professional development.					
Assumes accountability for ethical behavior in the nurse-patient relationship.					
Delivers safe care.					
NONPF Domain 5: Managing and Negotiating Health Care Delivery Systems					
Considers access, cost, efficacy, and quality when making health care decisions.					
Practices within an authorized scope of practice.					

Criteria of Evaluation	1	2	3	N.A./O	Comments
NONPF Domain 6: Monitoring and Ensuring the Quality of Health Care Practice					
Engages in self-evaluation concerning practice.					
Monitors quality of care.					
Assumes accountability for practice.					
NONPF Domain 7: Culturally-Sensitive Care					
Prevents personal biases from interfering with the delivery of quality care.					
Provides culturally sensitive care.					
Shows respect for the inherent dignity and worth of every human being.					
Incorporates patient and family cultural preferences, health beliefs, traditional practices, and health beliefs into the health care plan.					

Please indicate below:

1. Strengths of student

2. Weakness of student

3. General comments about student's performance

4. Learning plan to address identified weaknesses

Adapted from:

National Organization of Nurse Practitioner Faculties (2007). *NP competency based education evaluation: Using a portfolio approach.* Washington, DC.: Author.

GUIDELINES FOR STUDENT'S CLINICAL EVALUATION

A. **Verbal Communication:**

1. Identifies self appropriately as a student.
2. Utilizes open-ended and closed questions, listening skills appropriately with patients and families.
3. Provides clear verbal instructions and explanations to patients and families.
4. Communicates openly, clearly, and concisely with preceptor.
5. Asks questions or requests clinical assistance from preceptor when necessary.
6. Responds appropriately to constructive criticism from preceptor.
7. Demonstrates open communications with staff and office personnel.

B. **Cognitive Skills:**

1. Reviews chart, identifying current/chief complaint as well as PMH prior to entering exam room.
2. Elicits appropriate history re: chief complaint.
3. Elicits additional history re: PHM, problem list, family history, ROS, medications, allergies, health maintenance/promotion.
4. Screens appropriately for risk factors.
5. Determines whether a complete or partial physical assessment is appropriate for the visit.
6. Demonstrates ability to synthesize subjective and objective data and begins to conceptualize a differential diagnosis with assistance of preceptor.
7. Begins to provide a health counseling and education and prescribes a variety of modalities to meet wellness and illness needs, e.g., nutrition, exercise, etc.
8. Present case findings to preceptor in a concise, organized, methodical manner.
9. Integrates research findings into clinical practice (e.g., demonstrates evidence of based practice).
10. Utilizes reference material when problem solving.

C. **Technical/Manual Skills:**

1. Performs physical exam techniques safely and correctly.
2. Performs appropriate emotional and social assessments based on patient/family needs.

D. **Written Communications:**

1. Charts all pertinent data in a legible, organized, accurate, concise format.
2. Charts all data in a SOAP format or a modified format consistent with a particular clinical site.
3. Provides patient/family with written instructions.

E. **Efficiency:**

1. Completes the health care visit in an appropriate amount of time.
2. Exhibits familiarity/orientation to site, office procedures.

F. **Professional and Role Development:**

1. Maintains confidentiality.
2. Able to articulate the role of the nurse practitioner.
3. Dresses appropriately and professionally.
4. Maintains professional demeanor by presenting self to patient and preceptors in a confident, assertive manner.
5. Exhibits sensitivity toward patient/family's needs for modesty.
6. Maintains professional and ethical integrity, trustworthiness and honesty.

G. **Evaluation Process:**

1. Participates actively in clinical evaluation.
2. Identifies own strengths.
3. Identifies own limitations.
4. Modifies behavior in response to documented clinical evaluation.

THE ONE-MINUTE PATIENT PRESENTATION

Guidelines for presentation:

The 60-second presentation is a quick synopsis of your patient and covered in NURS 701. This is presented to your preceptor or evaluator after the initial assessment of the patient. This is a brief, concise and organized way to present a patient's presenting problem, diagnosis and treatment plan to another professional. It should include some key components:

1. Age, gender and chief complaint.
2. History of present illness, pertinent medical history - example: polyuria, dysuria and flank pain x 2 days).
3. Medications – both chronic and meds taken for presenting illness.
4. Physical exam – what you found, usually this is only the abnormalities noted with some synopsis of normal variants you would want the provider to know.
5. Vital signs – note numbers if significant.
6. State positive/pertinent findings - example: CVA tenderness, temp of 100.5 F, HR 101.
7. Pertinent laboratory findings -example: + nitrites, + leukocytes in urine dip.
8. Differential Diagnosis list - example: UTI, pyelonephritis.
9. Treatment plan to include medications, lab studies, radiology studies and follow-up.

UNIVERSITY OF NEVADA, LAS VEGAS
SCHOOL OF NURSING

Graduate Program: Family Nurse Practitioner Sequence

PRECEPTOR EVALUATION TOOL: Student Performance

Student: _____ Preceptor: _____

Clinical Site: _____ Date: _____

FNP Clinical Course: 740R 750R 760R

Directions: Please check the frequency of the listed behaviors that you have observed using the following scale:

0 = Failed to attempt objective
1 = Inadequate: did not achieve objective safely
2 = Adequate: achieved objective safely, but required significant guidance
3 = Very Good: achieved objective with skill; required moderate guidance
4 = Excellent: achieved objective with skill and efficiency; required little or no guidance
N/A= Not applicable to particular patient or setting or unable to evaluate

S: History Taking, Interviewing Skills	**RATING**					
a. At ease with interpersonal skills	0	1	2	3	4	N/A
b. Identifies needed data	0	1	2	3	4	N/A
c. Utilizes systematic approach to data gathering	0	1	2	3	4	N/A
d. Obtains data which are pertinent and comprehensive	0	1	2	3	4	N/A
Comments:						

O: Physical Examination Skills	**RATING**					
a. Uses orderly systematic approach	0	1	2	3	4	N/A
b. At ease with techniques and process of physical examination	0	1	2	3	4	N/A
c. Conducts a physical examination appropriate for client's age and/or problem	0	1	2	3	4	N/A
Comments:						

A: Decision-Making Skills	**RATING**					
a. Utilizes subjective and objective data systematically	0	1	2	3	4	N/A
b. Cites necessary but unattained/unavailable data	0	1	2	3	4	N/A
c. Considers appropriate differential diagnoses	0	1	2	3	4	N/A
d. Distinguishes client's/student's/preceptor's responsibilities for decision-making	0	1	2	3	4	N/A
Comments:						
P: Implementation Skills	**RATING**					
a. Demonstrates knowledge of and implements the following in collaboration with preceptor:						
• Necessary and appropriate diagnostic measures	0	1	2	3	4	N/A
• Appropriate treatment plans/rationale	0	1	2	3	4	N/A
• Follow-up and evaluation of care	0	1	2	3	4	N/A
b. Collaborates appropriately with other health care professionals to manage client's needs	0	1	2	3	4	N/A
Comments:						
Caring	**RATING**					
a. Carries out data collection and treatment plan in a caring manner ("caring" includes having compassion, confidence, competence, conscience, and commitment)	0	1	2	3	4	N/A
Communication Skills	**RATING**					
a. Interacts appropriately with client	0	1	2	3	4	N/A
b. Interacts appropriately with client's family	0	1	2	3	4	N/A
c. Verbally presents client information to preceptor in an organized, complete, and succinct manner	0	1	2	3	4	N/A
d. Records all relevant data using SOAP format	0	1	2	3	4	N/A

Responsibility for Own Learning Needs	**RATING**					
a. Identifies own competencies and deficits	0	1	2	3	4	N/A
b. Communicates learning needs to preceptor/faculty	0	1	2	3	4	N/A
c. Assertively seeks appropriate client care situations	0	1	2	3	4	N/A
d. Initiates discussions concerning perceptions/development of nurse practitioner role in primary care	0	1	2	3	4	N/A
Comments:						

Preceptor: _____ Date: _____

Student: _____ Date: _____

Revised 12/22/15

UNIVERSITY OF NEVADA, LAS VEGAS
SCHOOL OF NURSING

Graduate Program: Family Nurse Practitioner Sequence

Student Evaluation of Preceptor and Clinical Site

Student: _____ Preceptor: _____

Clinical Site: _____ HRS/WEEK: _____

FNP Clinical Course: 740R 750R 760R

Please respond to the following by checking the appropriate box

PRECEPTOR:	**RATING**				
	EXCELLENT	GOOD	FAIR	POOR	N/A
e. Knowledge of field/specialty					
f. Overall teaching effectiveness					
g. Allowed student to see and assess/mange patients to student's level of ability					
h. Encouraged student to ask questions					
i. Challenged student to explain findings and treatment plan					
j. Supported student's learning with helpful feedback and critique					
k. Sensitive to student's learning needs					
l. Availability for consultation					
CLINICAL SITE:	**RATING**				
	EXCELLENT	GOOD	FAIR	POOR	N/A
1. Balance of learning experiences					
2. Opportunity to learn and practice					
3. Accomplishment of clinical learning objectives					
4. Overall organization of clinical site					

UNIVERSITY OF NEVADA, LAS VEGAS
SCHOOL OF NURSING
FAMILY NURSE PRACTITIONER PROGRAM

Student Accountability Log

DATE	START & STOP TIME	FACILITY NAME AND LOCATION	PRECEPTOR NAME	PRECEPTOR'S SIGNATURE

PRECEPTOR'S SIGNATURE **DATE**

STUDENT'S SIGNATURE **DATE**

UNIVERSITY OF NEVADA, LAS VEGAS
SCHOOL OF NURSING
NURS 740R
CLINICAL SUMMARY SHEET

Semester: _____ Course #: _____Year: _____

Student Name: _____

Preceptor Name	Preceptor Site	Address	Phone #	# of Hours Spent with Preceptor

Total Clinical Hours Completed this semester: _____ Program total: _____
Semester Hours: Pediatrics_____ OB/GYN____ Adult____
Program Total: Pediatrics_____ OB/GYN____ Adult____

Clinical Experience Summary: Number of Patients Seen for Categories Listed:
Pediatric Patients: (0-15)

- Well assessments _____
- Sick visits (acute illnesses) _____
- Sick visits (chronic illnesses) _____

Adult Patients:

- Well assessments _____
- Sick visits (acute illnesses) _____
- Sick visits (chronic illnesses) _____
- Geriatric Patients (over 65 years of age)
- Well assessments _____
- Sick visits (acute illnesses) _____
- Sick visits (chronic illnesses) _____

Procedures:

- PAP/cultures _____
- Prostate/testicular _____
- Suturing _____
- Biopsies _____

_____ _____
Student Signature Date

_____ _____
Faculty Signature Date

UNIVERSITY OF NEVADA, LAS VEGAS
SCHOOL OF NURSING

NURS 740R
Syllabus Contract

I_____ have read the entire syllabus for NURS 740R Spring 2016. I understand that I am accountable for the information in this syllabus and will adhere to due dates and requirements in this syllabus.

_____
Student Signature

_____
Date

***Print this page, fill in your name and sign/date. Return in the assignment tab under "syllabus contract" before the due date.