California State University, Bakersfield
Department of Nursing

N6321 Advanced Practice Nursing
Care for Individuals and Families Across the Lifespan I (Clinical)
Syllabus
Spring 2017

Course Placement in Curriculum: 2nd semester of a 5 semester FNP program

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Office hours: As posted

Website for course: https://bb.csub.edu/webapps/login/

Days and Time and Location:
To be arranged with the preceptor

Credit:
Lecture: 3 unit laboratory practice (9 hours per week x 15 weeks = 135 hours)

Course Description:
Application of beginning nurse practitioner skills in individual and family assessment, intervention, and management in primary care and community-based settings. Clinical focus is on data gathering, conducting routine health histories physicals, and health promotion/ risk reduction activities in rural, urban, and multi-ethnic and culturally diverse populations. Models of individual, family, aggregate, and community systems are used to analyze health promotion, risk reduction, and health restoration. Students will develop and use disease protocols for intervention and management.
Pre-requisites:
Classified in the MS degree program in Nursing and the nurse practitioner option, or permission of the instructor. N5200, N5201, N6300 and N6310 are prerequisites. N6320 is co-requisite.

Course Objectives:
Upon completion of Nursing 6321, the student will be able to competently:

<table>
<thead>
<tr>
<th>Course Objective Description</th>
<th>Student Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform routine health assessments (including analysis of laboratory data) that are developmentally and age appropriate to the target population.</td>
<td>PO: VIII, IX</td>
</tr>
<tr>
<td>2. Identify health risk factors and health maintenance deficits relevant to the individual, family unit, and aggregate.</td>
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<tr>
<td>3. Assess the health needs, barriers, and modifying factors of the culturally and ethnically diverse individual, family unit, and aggregate.</td>
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<td>5. Develop and use disease protocols as a basis for intervention and management of common health problems.</td>
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<tr>
<td>6. Design a plan of care that is specific to the individual, family or aggregate unit that addresses the specific needs of the client to include the three levels of prevention (primary, secondary, and tertiary).</td>
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<tr>
<td>7. Implement a plan of care that addresses the identified needs of the client (individual, family, aggregate). The plan of care will be the result of collaboration and negotiation based on the client’s understanding.</td>
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<tr>
<td>8. Evaluate the outcomes of the plan of care as they relate to the effectiveness of health promotion and risk reduction strategies.</td>
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<td>9. Accurately and systematically document client/family encounters in the electronic health record to ensure continuity of care, monitor health status, and outcomes</td>
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<td>10. Utilize available technology for knowledge management to improve health care</td>
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<tr>
<td>11. Maintain professional standards of the advanced practice nursing role while preserving confidentiality and demonstrating respect for client autonomy.</td>
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</table>

PO: MSN Program Objectives
E: The Essentials of Master’s Education in Nursing
NONPF: The National Organization of Nurse Practitioner Faculties NP Competencies
**Teaching Methods:**
Teaching methods include: directed reading; student case presentations through journals; case studies; and clinical laboratory practice with supervised care of clients. Documentation of care is done using SOAP format.

**Required and Recommended Textbooks:**
All books used in N6320
Any current laboratory interpretation book
Useful apps: Epocrates, Medscape

**Student Evaluation:**

1. **Grading Scale:**

<table>
<thead>
<tr>
<th>Grade</th>
<th>Range</th>
<th>Grade</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>100-93</td>
<td>C</td>
<td>76-73</td>
</tr>
<tr>
<td>A-</td>
<td>92-90</td>
<td>C-</td>
<td>72-70</td>
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<tr>
<td>B+</td>
<td>89-87</td>
<td>D+</td>
<td>69-67</td>
</tr>
<tr>
<td>B</td>
<td>86-83</td>
<td>D</td>
<td>66-63</td>
</tr>
<tr>
<td>B-</td>
<td>82-80</td>
<td>D-</td>
<td>62-60</td>
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<tr>
<td>C+</td>
<td>79-77</td>
<td>F</td>
<td>59 or below</td>
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**Progression Policy:**
A grade of “B-” or better must be obtained in all FNP specialty courses. A student may not advance to candidacy status without an overall GPA of 3.0 (on a scale of 4.0=A). Please see the Graduate Nursing Student Policy Handbook for further information.

2. **Evaluation Methods/Assignments**
Letter grade is based upon class participation and assignments.

<table>
<thead>
<tr>
<th>Assignments</th>
<th>% of Final Grade</th>
<th>Due Date</th>
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</thead>
<tbody>
<tr>
<td>A. Individual Learning Objectives</td>
<td>10</td>
<td>2/1/17</td>
</tr>
<tr>
<td>B. Episodic Soap Notes (2 total)</td>
<td>35</td>
<td>Soap #1: 3/1/17</td>
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<td></td>
<td></td>
<td>Soap #2: 4/5/17</td>
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<tr>
<td>C. Clinical Journals (2 total)</td>
<td>35</td>
<td>CL #1: 3/15/17</td>
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<td></td>
<td></td>
<td>CL #2: 4/19/17</td>
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<tr>
<td>D. Student Self-Evaluation</td>
<td>10</td>
<td>5/10/17</td>
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<tr>
<td>E. Professional Conference</td>
<td>10</td>
<td>5/10/17</td>
</tr>
<tr>
<td>F. Clinical Practice 1.</td>
<td>Pass/Fail</td>
<td>5/10/17</td>
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<tr>
<td>1. preceptor evaluation of student</td>
<td></td>
<td></td>
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<tr>
<td>2. preceptor evaluation of preceptor experience</td>
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<td></td>
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<td>3. student evaluation of preceptor</td>
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<tr>
<td>4. student evaluation of agency/site</td>
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<td>5. patient encounter log (Typhon NPST)</td>
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<tr>
<td>6. faculty site evaluation of student</td>
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<tr>
<td>G. Clinical Attendance (135 hours or more)</td>
<td>Pass/Fail</td>
<td>5/10/17</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
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</tbody>
</table>
Loss of 10% of grade for every day paper is late unless previous arrangement has been made with faculty.

A. Student Individual Learning Objectives
Develop at least two measurable objectives for this clinical course, including how the objectives will be obtained and how the progress will be measured. The objectives may include areas for growth in: history taking, physical assessment skills, presentation of findings to preceptors, assessment skills and management practice, documentation skills, an application of growth in the Advanced Nursing Practice role. Students are encouraged to review the “Minimal Clinical Requirements” and “Clinical Guidelines for Student Progress” in the Graduate Student Handbook when developing their individual learning objectives.

B. Episodic SOAP Note (relates to all course objectives)
An episodic SOAP note is the format used for documentation of a client’s episodic problem.

Compliance with the Privacy Rule that underlies the Health Insurance Portability and Accountability Act (HIPAA) is required when submitting patient information such as SOAP notes or case presentations in class. This rule includes the concept of protected health information (PHI) which is information that refers to the past, present, or future physical/mental health of an individual that contains data specifically identifying that individual or patient (name, address, social security number and other elements). The PHI applies to verbal conversations, computer and telephone conversations and financial records. Make sure patient privacy is protected at all times.

SOAP Note Outline

Student Identifying Data
Name, Date, Agency or Clinic

Client Identifying and General Data
Client initials, age, address (city only), marital status, gender, occupation, health insurance company

Source and Reliability of Data
Historian's identity (relationship to client or self-report), judgment about the reliability of the historian's information

Subjective
Chief complaint or reason for seeking care
History of Present Illness (current)
(OLDCART)
Onset:
Location:
Duration:
Character:
Aggravating factor:
Relieving factor:
Treatment:
Past Medical History
Relevant illnesses and prior health, hospitalizations, surgeries, medications (prescribed, over-the-counter or herbal), immunizations, allergies, female menstrual history if applicable

Family Medical History
Major health or genetic disorders (first degree relatives), contagious diseases (TB)

Personal/Social History
Occupation, education, economic condition, number in household, cultural background, environment (home, school, work), current health habits or risk factors (exercise, nutrition, smoking or tobacco use, alcohol or drug use)

Review of Systems
Particularly systems pertaining to current complaints, including at least one system up and one system down
See N5201 BB handout

Objective
Vital signs including height, weight and BMI
General appearance
Mental Status
Physical Findings: particularly systems pertaining to current complaints, including at least one system up and one system down
Laboratory Diagnostic Tests- results (from prior visits)

Assessment
Diagnosis with rationale derived from the subjective and objective data is stated (include relevant medical and nursing diagnosis).

Types of Assessment/Diagnostic Statements:
1) working diagnoses: hypothetical
   a. in the process of being tested
   b. probabilities being evaluated
2) differential diagnosis: concurrent, competing hypotheses
   a. often stated in format of “rule out”
   b. example: left lower abdominal cramping
      R/O Colitis
      R/O Ectopic Pregnancy
      R/O Endometriosis
      R/O Ovarian Cyst
3) final diagnosis: approached as more and more confirmatory data obtained for one diagnosis and other diagnoses are eliminated
   a. nursing or / and medical diagnoses
   b. health problems
4) relevant client strengths and weaknesses
5) Client and provider goals (if indicated)

Plan
Diagnostic: test (s) performed or ordered
• Necessary diagnostic tests, lab and additional exploration of history required for subsequent visit
  • (be sure to include rational why a particular test is ordered/performed)

Therapeutic treatment plan
• non-pharmacological interventions such as dietary changes,
• pharmocotherapeutic treatment,
• and other treatments such as physical therapy, wound irrigation and dressings

Client education
Referrals or consultations
Target date for reevaluation (follow up/return to office)

Review Problem List
All active and inactive problems with date of diagnosis, health maintenance deficits and health risk factors

C. Clinical Journal (Refers to all course objectives)
The purpose of the journal is to provide the student with an opportunity to:
➢ describe the attainment of course objectives and individual objectives,
➢ describe the clinical experience in a SOAP format,
➢ reflect on the experience, including skill development, empathy and ethical dilemmas,
➢ demonstrate links between theory, research and practice (theoretical and evidence based note)
➢ demonstrate clinical decision making and
➢ consider the varied aspects of the nurse practitioner role.

The journal should start with the student name, date and clinical setting. The entry should refer to specific course objectives. You do not need to repeat information you will be providing in other SOAP notes. The journal entry should include both your subjective evaluation of and feelings about clinical practice as well as theoretical, research and clinical journal sources to support your assessments, diagnoses, plan, intervention and evaluation (professional sources). Be selective in what you report. The intent is quality not quantity. For example, if your encounter log indicates you saw four clients on a specific day and you are already doing a SOAP note on Mr. A, then your journal entry should report on specific objectives attained when seeing child B and a women's health client C. Of course, it is always interesting to report on unusual opportunities to observe either clients seen by your preceptor or other clinical personnel or a specific procedure. Remember the HIPAA guidelines for maintaining patient privacy.

D. Student Self-Evaluation
Compile and submit an evaluation summary of this semester’s clinical experience. This self-evaluation will help you gain an honest perspective on your developing practice. Include the following in the self-evaluation:
• Describe the depth and breadth of experiences
• Reflect on the role of the NP and health care today
- Recognize individual qualities, deficiencies in or strengths gained in knowledge base, technical skills interpersonal skills and in all areas of the developing NP roles.
- Indicate whether the learning objectives are achieved
- Identify measures to correct identified deficiencies in areas of knowledge and technical skills.

E. Professional Meetings

Students are required to attend at least one Advanced Practiced Nurse (APN) professional meeting locally or nationally during the semester. Local APN professional organizations include California Association Nurse Practitioner (CANP) and Kern Nurse Practitioner and Physician Assistant Association (KNPPAA). To receive the credit for this assignment, students are required to submit a 1-2page reflection paper after attending the professional meeting. See BB for detailed instructions.

F. Clinical Practice (Refers to all course objectives)

Clinical Requirements:
Students must complete all the clinical requirements prior to starting the clinical rotation. See BB for detailed instructions. A nursing student must follow the Nurse Practice Act and policies of the agency. The student should follow the agency policy regarding clinical attire. A name badge and student ID must be worn at all times when in the clinical setting. See Graduate Nursing Student Policy Handbook details.

A major portion of your clinical practice in N6321 should involve health assessment and risk assessment of individual clients in an ambulatory setting. The performance of health assessments is evaluated by self-assessment in the student journal, faculty assessment during site visits, and ongoing preceptor assessment. Students are encouraged to select clients that have common health problems or have been or are being addressed in the conference case studies.

During clinical practice the student is expected to regularly present cases (orally) to the preceptor for suggestions regarding assessment, diagnosis, plan, and evaluation for the client. This process is intended to facilitate the student's skill in organizing the subjective and objective data, arriving at preliminary diagnoses and differential diagnosis and supervised development of a plan, including diagnostic tests, therapeutic interventions and education. Students should develop skill in presenting a case in a short period of time (less than 5 minutes) and demonstrate increased organizational and clinical decision making skills. Since this is the first clinical course in the Family Nurse Practitioner option, except for the Advanced Health Assessment course, it is anticipated that the student will require more assistance with the diagnosis, plan and evaluation aspects of the case than in the collection and presentation of the subjective and objective data related to the case. The case presentations are evaluated by the preceptor and faculty.
There are several forms that need to be completed at the end of the term. The student should arrange to meet with the preceptor to discuss the performance evaluation for N6321. The student should complete the sections for student name, faculty name, date, dates seeing patients, and the agency and agency address information and give the form to the preceptor prior to your meeting so the preceptor has time to consider the evaluation form. The Performance Evaluation form must be signed by your preceptor and submitted during the last week of the term. This is required in order to receive a passing grade for this course.

The student should complete the Student Evaluation of Preceptor form and the Student Clinical Site Evaluation form and submit to the faculty by the end of the term. These forms are available on the BB.

**Clinical Log (Typhon)**
See BB for the detailed instructions.
Submission of a clinical log for each patient encounter into the Typhon system is a mandatory expectation of the clinical experience. Each student is responsible for maintaining his or her own clinical experience logs. All patient encounters, whether seen independently, in collaboration with preceptor, or as observation, require an entry into Typhon.
Each student will maintain a clinical hour log. The log should be an ongoing record of the student's clinical hours and will be verified by the preceptor at the end of the quarter. See BB for the Clinical Attendance Record form. This form is submitted with the Preceptor evaluation at the end of the term. The hours must total 135 hours to pass the course.

**Clinical Site Visit**
The clinical faculty member for the clinical group will arrange to attend the clinical site to complete the evaluation of student at the clinical site. See BB for this form. The student and preceptor should ensure that several client encounters are expected during the time the faculty member is present. The student will be evaluated for skill in performance of client assessment and accuracy and completeness of records. The faculty member will meet with the preceptor and discuss the student's progress. At the end of the site visit the faculty will review with students the faculty member's perception of their current level of functioning and progress and suggest areas for improvement. A written report of the evaluation is provided to the student and is placed in the student's file.

**G. Attendance**
Each student will submit a calendar with his or her clinical schedule to the Typhon system. It is expected that the student be at the clinical site with the preceptor on the days indicated on the calendar. Students are also expected to notify the faculty member of any missed clinical days. Students are expected to develop a schedule with the preceptor during the first week of the term. The student or preceptor can adjust the schedule as needed. Timely notification is a professional responsibility and expectation. The course does not include any time for illness. All days missed due to illness must be made up to total the minimum 135 hours of clinical practice for the term.
Policies for Withdrawals and Incompletes:
According to Department of Nursing policy, withdrawal from a nursing course will be considered a nursing course failure if the student was not passing the course with a “B” or better at the time of withdrawal. Although the University transcript may reflect a “W,” the course will be viewed as a nursing course failure by the Department of Nursing. Please review the Progression Policy (above) very carefully.

Important Dates:
January 23 - first day of classes at CSUB
January 26 - first day of class for this course (N6320/6321)
February 17 - Last day to withdraw from class without a W being recorded
April 7 - Last day to withdraw from class for a serious and compelling reason

Services for Students with Disabilities:
To request academic accommodations due to a disability, please contact the Office of Services for Students with Disabilities (SSD) as soon as possible. Their office is located in Bldg. 200, and they may be reached at 661-952-5061 (voice) or 661-952-5120 (tdd). If you have an accommodation letter from the SSD Office documenting that you have a disability, please present the letter to me during my office hours, or email me as soon as possible, so we can discuss the specific accommodations that you might need in this class.

Academic Honesty:
All students are expected to read and adhere to the Academic Honesty Policy detailed in the CSUB Catalogue and Ethical and Academic Standards found in the Graduate Nursing Student Policy Handbook. All work must be original work written for this course by the individual submitting it. See the definition for plagiarism according to the University Catalogue and Graduate Nursing Student Policy Handbook. If you have any question about the academic honesty policy, ask your instructor.

HH 1/2017