Course Description

NUR 834 focuses on the integration of assessment and applied theory in primary care management of older clients from a variety of ethnic and cultural groups. A collaborative model of primary care practice will be utilized. Topics will include the health care management of clients with complex health problems and functional losses. Practice issues will include development and evaluation of long term management plans and coordination of care with multiple agencies.

Course Objectives

At the completion of this course the student will be able to:

1) Demonstrate a synthesis of the nursing process through advanced utilization of assessment, diagnosis and clinical judgement with clients.
2) Apply the nursing process to all clients with emphasis on evaluating loss theories and their relevance to the management of clients with multiple and/or chronic health problems within the context of the client’s self-care abilities.
3) Provide nursing care within the context of interdisciplinary function with awareness of professional, legal, ethical and political issues.

Textbook

**Course Schedule**

Clinical conferences will be held on these dates (Thursdays) from 3:30pm - 5:20pm in Rm.1208 of the Engineering Building for East Lansing and in the designated site for Outreach MSN Programs.

<table>
<thead>
<tr>
<th>Date</th>
<th>Topics</th>
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<tbody>
<tr>
<td>1/11/01</td>
<td>Medicare Documentation Guidelines</td>
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<tr>
<td>1/18/01</td>
<td>End of Life Issues (guest: Linda Keilman)</td>
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<tr>
<td>1/25/01</td>
<td>Acute Abdominal Pain</td>
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<tr>
<td>2/1/01</td>
<td>Knee and Shoulder Problems</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>2/8/01</td>
<td>Anemia (Fe deficiency and ACD)</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>2/15/01</td>
<td>Arrhythmias/MIs in the Elderly</td>
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<td>Peer Review Activity</td>
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<tr>
<td>2/22/01</td>
<td>Ethical Issues in Managed Care (guest: Linda Keilman)</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>3/1/01</td>
<td>Syncope</td>
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<td></td>
<td><strong>Midterm Evaluations</strong></td>
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<tr>
<td>3/8/01</td>
<td><strong>Spring Break</strong></td>
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<tr>
<td>3/15/01</td>
<td>No class -- <strong>Study for Comps!</strong></td>
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<tr>
<td></td>
<td>(Need 2 extra clinical hours this week)</td>
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<tr>
<td>3/22/01</td>
<td>Pain Management</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>3/29/01</td>
<td>Multiple Sclerosis/ALS</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>4/5/01</td>
<td>Unintended Weight Loss and Pressure Ulcers</td>
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<td></td>
<td>Peer Review Activity</td>
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<td>4/12/01</td>
<td>LTC Issues: MDS and CQI</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>4/19/01</td>
<td>Case Management and Electronic Medical Record</td>
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<td></td>
<td>Peer Review Activity</td>
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<tr>
<td>4/26/01</td>
<td><strong>Final Evaluations</strong></td>
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COURSE REQUIREMENTS / STUDENT RESPONSIBILITIES

1) Attendance at clinical conferences is mandatory. Options for missed conference time will be arranged with the course chair.

2) Students are required to keep a log of each patient seen in the clinics which includes their diagnoses and interventions for the encounter. Logs shall also include referrals, case management activities, and interdisciplinary activities.

3) Students will select and present cases for two formal peer review activities.

4) Students are to be active participants in discussions and case presentations. This includes peer review activities during clinical conferences. Be prepared to share cases related to weekly topic areas.

5) Materials for midterm and final evaluations are to be forwarded to the clinical instructor one week in advance of scheduled evaluation appointment. This will include the documentation of encounters, log sheets and skills checklist. A midterm and final self-evaluation (included in syllabus) will also be submitted with these.

6) Copies of chart documentation, as requested by course chair, shall be submitted weekly along with the patient encounter log and hours logged at clinical sites.

7) **19 hours/wk.** of clinical time for 14 weeks is required in NUR 834. The clinical conference time is not included in this.

8) Notification of course chair and clinical preceptor ASAP for emergencies and absences.

**Course Chair**

Lynn Swick  RN, CS, MSN  
A205 Life Sciences Bldg.  
College of Nursing  
Michigan State University  
East Lansing, MI 48824  
office 517-353-3098; pager 517-229-1108; home 517-336-6864
Office hours by appointment

EVALUATION

The clinical evaluation is based on the gerontological nursing standards of care and the course objectives. These categories include Assessment, Diagnosis, Outcome Identification, Planning, Implementation, Evaluation, Professionalism and Documentation. Students will receive a rating for each of these categories. The rating scale is based on a scale from 0-4.

4.0 = outstanding performance/ exceeds expectations at high level
3.5 = very consistently meets objective/exceeds expectations
3.0 = meets objective at least 80% of time
2.5 = meets objective majority of the time
2.0 = inconsistently meets objective (50%)
1.5 = occasionally meets objective (25%)
1.0 = rarely meets objective
0 = objective never met

An evaluation form will be completed by the student and also by the clinical instructor both at midterm and at the conclusion of the 14 weeks of clinical. The Assessment area of the evaluation will carry more points since this should be perfected throughout this semester. The midterm evaluation is NOT used to calculate the final grade. Only the rating on the final evaluation will be used to determine the clinical grade.

The final evaluation will count for 70% of the final grade in the course. The student is expected to provide rationale (with examples) for his/her rating. The instructor’s evaluation will be used to determine the grade. If there is a discrepancy between the student and faculty member’s point allocation, the student may give rationale for his/her rating. The final decision about point allocation is determined by the faculty member.

The clinical preceptor’s evaluation will count as 15% of the grade and must be completed and submitted to the course clinical faculty member PRIOR to final evaluations and receiving a grade. Peer review case presentations will count as 15% of the grade.

STUDENTS MUST PASS COMPONENTS AT 80% FOR PASSING GRADE IN COURSE.
NUR 832/834 Midterm and Final Evaluation

Student evaluations are based on the standards of gerontological nursing care and course objectives. The measurement criteria for each category will be evaluated based on faculty-student conferences and group clinical conference participation, as well as your documentation of encounters in your clinical settings. Refer to grading scale in syllabus (under evaluation).

CATEGORY I: ASSESSMENT

___ Priority of data collection is determined by the patient’s immediate condition or needs.

Data includes:

___ ADLs and IADLs
___ Physical, psychological, socioeconomic, cognitive, cultural and spiritual status.
___ Environmental and safety issues.
___ Support systems and resources.
___ Patient’s response to the aging process.
___ History of health patterns and illness(es).
___ Medication and self-medication practices.
___ Lifestyle and interpersonal relationships.
___ Communication skills.
___ Coping patterns.
___ Perception of and satisfaction with health status.
___ Health beliefs and practices.
___ Knowledge of and receptivity to health care.
___ Advance directives.
___ Strengths and competencies for health promotion.

___ Data are collected using various assessment techniques and multiple sources.
___ Patient confidentiality is maintained.
___ Assessments are systematic and ongoing.
___ Documentation is legible with correct abbreviations and spelling.
CATEGORY II : DIAGNOSIS

___ Diagnoses and potential problems are derived from, and supported by, documented assessment data.
___ Diagnoses are based on accepted classification systems such as NANDA, ICD and/or agency requirements.
___ Diagnoses and risk factors validated with patient, significant others and other health care providers as appropriate and possible.

Diagnoses identify actual or potential illness and health problems pertaining to:
   ___ Maintaining optimal health and well-being, preventing illness, restoring health, and/or allowing a peaceful death.
   ___ Determining self-care limitations or impaired functioning.
   ___ Physical, emotional, social, economic, environmental and spiritual problems.
   ___ Patient and caregiver’s education and health care knowledge.
   ___ Managing symptoms, side effects of pharmacological intervention or other treatment regimens.
   ___ Noting alterations in thinking, perceiving, communicating and decision-making.
___ Diagnoses are documented in a manner that facilitates expected outcomes.

CATEGORY III : OUTCOMES

Expected outcomes are:
___ Derived from the diagnoses.
___ Documented as measurable goals.
___ Mutually formulated with the patient, their significant other and interdisciplinary team members when appropriate and possible.
___ Realistic in relation to the patient’s present and potential capabilities.
___ Attainable in relation to resources available to patient and their care setting.
___ Identified with consideration of associated benefits and costs.
___ Expected outcomes include a time estimate for attainment.
___ Expected outcomes provide direction for continuity of long term care.
CATEGORY IV : PLANNING

The plan is individualized to a patient’s health status or needs and meets the following objectives:

___ Identifies priorities of care in relation to expected outcomes (EOs).
___ Identifies effective interventions to achieve EOs.
___ Specifies interventions that reflect current gerontological nursing practice and research.
___ Includes educational components for health maintenance, self-care, medications and treatments.
___ Includes environmental modifications when appropriate.
___ Indicates responsibilities of specific health team members, patient or caregivers, when appropriate.
___ Identifies sequence of actions to achieve EOs.
___ Verbal and/or written instructions given to patients and/or caregivers when appropriate.
___ Provides for appropriate referral and case management to ensure continuity of care.
___ Provides for quality of life as perceived by the patient and, when appropriate, a peaceful death.
___ Addresses the cultural, therapeutic, preventive, restorative and rehabilitative needs of the patient.
___ Settings for services appropriate to patient’s condition.
___ Proposes alternatives for continuity of care for long term needs.
___ Identifies resources required to accomplish care plan and EOs.
___ Includes a discharge plan when appropriate.
___ Plan is developed in collaboration with the patient, significant others and interdisciplinary team members, when appropriate.
___ Plan is documented so that other team members can access, review and modify.

CATEGORY V : IMPLEMENTATION

___ Interventions selected on basis of needs, desires, and resources of patient and accepted nursing practice.
___ Interventions appropriate to APN level of education, certification and practice.
___ Interventions implemented within the established care plan and facilitate optimal
functioning, self-care, health promotion, disease prevention, health teaching and counseling.

___ Interventions include specific treatments, medications (with specific instructions) and education regarding side effects, adverse reactions or monitoring of effects.
___ Interventions include palliative care, when appropriate.
___ Interventions include caregiver training.
___ Interventions include case management.
___ Interventions are implemented in a safe, ethical, culturally competent, and appropriate manner.

CATEGORY VI : EVALUATION

___ Evaluation is systematic and ongoing.
___ The patient, significant others and health team members are involved in evaluation process, as possible and appropriate.
___ Patient’s response at follow-up is documented.
___ Effectiveness of interventions is evaluated in relation to Eos.
___ Diagnoses, EOs and plan of care is revised through ongoing assessment and follow-up.
___ Revisions to plan of care are discussed with patient and caregiver and documented.

CATEGORY VII : PROFESSIONAL

___ Develops good working relationship with preceptor/staff/faculty.
___ Develops therapeutic relationships with patients and families.
___ Able to accept constructive comments from faculty/peers/preceptors.
___ Appropriately seeks consultation and collaboration.
___ Communicates effectively with patients and families.
___ Presents and articulates patient information in an organized, concise manner.
___ Evaluates own progress in developing advanced practice role.
___ Actively participates in clinical conferences.
___ Reviews and evaluates peers constructively.

CATEGORY VIII : DOCUMENTATION

___ Uses appropriate terminology/ abbreviations/ spelling.
___ Uses SOAP format.
___ HPI’s are organized and complete.
___ H&P’s are organized and complete.
___ Coding of visit and charting content are consistent.
___ Records collaborative and consultative activities.
___ Provides encounter data and logs to faculty in timely manner.

SUMMARY STATEMENT:

PRECEPTOR COMMENTS:

PEER REVIEW ACTIVITIES:

RECOMMENDATIONS:

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<tr>
<th>GRADE</th>
<th>0</th>
<th>1</th>
<th>1.5</th>
<th>2.0</th>
<th>2.5</th>
<th>3.0</th>
<th>3.5</th>
<th>4.0</th>
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