MICHIGAN STATE UNIVERSITY
COLLEGE OF NURSING

NUR 822
PRACTICUM FOR THE
PRIMARY CARE FAMILY
APN I

COURSE SYLLABUS

CREDITS: 6

Course Chair:
Katherine Dontje, R.N., M.S.N., C.S., F.N.P.

Clinical Instructors
Patty Peek, R.N., C.S., M.S., P.N.P.
Brigid Warren, R.N., M.S.N.

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COURSE OVERVIEW

Course Description
This course is designed to provide opportunity to integrate assessment skills and apply theory to primary care management of clients across the life span. This will be done within a collaborative model of primary care practice. The emphasis is on developing skills in health promotion, health maintenance, risk reduction strategies and management of common single acute conditions. This will be done for individuals within the context of the family. Documentation will be done in the problem oriented format to facilitate organization of client data.

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

1. Provide health promotion, disease prevention and risk assessment services to clients based on age, gender, health risk, ethnicity and cultural background.

2. Apply appropriate diagnostic and therapeutic interventions (both medical and nursing) to manage client’s health/minor acute illness status in a primary care setting.

3. Integrate applicable conceptual and theoretical frameworks in the development of a comprehensive management plan.

4. Communicate data appropriately as evidenced by documentation including relevant individual and family assessment, and medical and nursing management plans.

5. Demonstrate progression in the level of decision making from preceptor made decisions to student mastered with preceptor validation.

6. Demonstrate professional development by initiating strategies for interdisciplinary team functioning with awareness of professional, ethical, legal and political issues.

7. Critically evaluate outcomes and effectiveness of care.
**Instructional Methods**

**Clinical Experience**

All students will participate in 16 hours of Clinical per week for 14 weeks at their selected agencies guided by a clinical faculty from that agency. The clinical faculty from the College of Nursing will be available for consultation, assistance, and evaluation.

The student will provide direct services to patients/families concerning well care, health maintenance and promotion, and management of single acute illness, while utilizing her/his knowledge from independent study, seminar/discussion and focal problems. The clinical experience should provide opportunity to see patients from birth to elderly, including pregnant patients.

The student will provide direct client services, students will be responsible for increasing independence in collecting and determining:

1. the client history and physical examination,
2. management plan including nursing and medical interventions,
3. nursing and medical diagnosis and interventions,
4. recording on the client record using the S.O.A.P. - P.O.R. method.

**Recording.** Recording will include the subjective and objective findings from the patient, the assessment including the medical and nursing diagnoses, and the management plan, which includes:

1. diagnostic studies, i.e., lab, developmental assessment, etc.;
2. therapeutic measures including medication, counseling, etc.;
3. patient education;
4. outcomes. The student will begin to generate outcome criteria for each management plan and form a master problem list and up to date medication list. Students will turn in written documentation on selected patients, as documented in patient record. Documentation will include NIC & NOC as appropriate.

**Caseload Data.** Students are required to collect and record data on all patients they see. The procedure and process for managing caseload data will be presented at the beginning of the semester. The data will be reviewed at midterm and finals weeks. In this manner, numbers and types of patients, and services provided can be tabulated for the educational experience.

**Web-Based Activities**

- We are utilizing BlackBoard (BB) as the basis for this course. BB is a web-based classroom experience that allows material to be up to date with easy access. It is the individual students responsibility to learn how to work through the system.

- Weekly readings, course information and forms, course documents, activities, grades and discussion board are all located in BB. It is strongly suggested that you check into BB on a frequent basis at it is the students responsibility to be present and active in the course.

- Access to BB is through the College of Nursing web page and then accessing NUR 832 course syllabus. Another route is <http://www.blackboard.msu.edu> Access requires use of your MSU pilot account.
COURSE EVALUATION & GRADING

A grade of 3.0 (80%) must be achieved in order to pass NUR 822 and progress in the nursing program. The MSU 4.0 grading system will be utilized to report final course grades.

Points will be rounded to whole numbers using the 0.5 rule. Points at \( \geq 0.5 \) will be rounded up while those \(< 0.5\) will be rounded down to the nearest whole number.

The following point scale will be used for final grade determination:

<table>
<thead>
<tr>
<th>RANGE</th>
<th>GRADE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low High</td>
<td></td>
</tr>
<tr>
<td>188 to 200</td>
<td>4.0</td>
</tr>
<tr>
<td>174 to 187</td>
<td>3.5</td>
</tr>
<tr>
<td>160 to 173</td>
<td>3.0</td>
</tr>
<tr>
<td>148 to 159</td>
<td>2.5</td>
</tr>
<tr>
<td>140 to 147</td>
<td>2.0</td>
</tr>
</tbody>
</table>

Point Determination Will Be As Follows:

- Clinical Evaluation: 120
- Professional Participation: 50
- Course Activities: 20
- Encounter & Activity Logs: P/F

Total = 200

A clinical evaluation form will be completed by the student and the course coordinator at midterm and at the conclusion of clinical. The rating at midterm is expected to be at a low level since it is highly unlikely that a student will be meeting end course objectives at this time. The midterm point totals are utilized to help identify areas that need work. The midterm evaluation is NOT used to calculate the final grade. Only the rating on the final evaluation will be used to determine the course grade.

The final evaluation will count for a possible 120 points toward the final grade. The student is expected to provide rationale/evidence for their self rating if it exceeds a #2. The course coordinators evaluation will be used to calculate the final grade. If there is a discrepancy, the student must provide documentation. The final grade decision is determined by the clinical instructor.
NURSING INTERVENTIONS:

The following is a list of nursing interventions, found in your Nursing Diagnosis text by Ackley and Ludwig. These are only a few of many interventions that you will be utilizing in practice, thus you need to become familiar with the interventions and integrate them into your practices. You need to be able to define the interventions and include them in your case discussions and later in your plan of care in the clinical courses (NUR822/824).

- Anxiety reduction
- Assertiveness training
- Behavior management: overactivity/inattention
- Behavior modification
- Caregiver support
- Cognitive restructuring
- Counseling
- Family support
- Hope installation
- Humor
- Patient contracting
- Progressive relaxation
- Reminiscence therapy
- Simple relaxation therapy
- Smoking cessation assistance
- Spiritual Support
- Values clarification

REQUIRED TEXT:


RECOMMENDED (Optional) TEXT:


Long Term Client Experience

Each student is responsible for selecting a patient to follow over time. This should be a client who has health care issues, which require behavior modification (smoker, over-weight or need to start exercise program). The purpose of the assignment is to provide opportunity to work with a client on behavior change. Many of the health care concerns we are dealing with are related to health behaviors, changing behavior is a long-term process and learning to assist in behavior change is a major role of the NP in primary care settings.

The student will determine, with the client, a health risk that would benefit from behavior management strategies. The student is responsible to discuss these issues with the client and get agreement to work with the individual over time. This experience should continue over both semesters, as behavior change takes at least six months. Not all of the interactions need to be face to face, you can utilize phone and mail as well as home visits as needed. The patient needs to be identified by mid-term of fall semester. The experience will be evaluated by your clinical instructor the grading is determined as follows:

1. Presentation of case in class including NANDA, NIC, NOC and theory basis for interventions. This will occur during clinical conference. (10 points)
2. Identify family and nursing diagnosis and develop a management plan that incorporates these issues and addresses the outcomes. (10 points)
3. Discuss your philosophy of nursing and how that impacts the case you are presenting (10 points).

The long-term client needs to be presented two times in class with reference to the information indicated above. Client documentation should be turned into clinical instructor each time you have interaction with the long-term patient.
Student Responsibilities

1. Transportation to and from clinical agencies is the responsibility of the student.

2. Clothing: Students are to wear white lab coats or jackets while working at all clinical agencies.

3. Picture ID tags, name tags should be worn on your lab coat or jacket.

4. Personal equipment needed at your clinical site:
   a. Stethoscope
   b. Pen light
   c. Tape measure

5. Absences: If the student becomes ill during the term, it is her/his responsibility to notify her/his clinical faculty, the clinical agency and the supervising faculty. All missed clinical days must be made up prior to the final exam. Arrangements for make-up days are to be made with the supervising faculty. Attendance at weekly clinical conferences is required.

6. Clinical agency: In most cases each student should have a primary care clinical site for two semesters (NUR 822, 824), thus providing continuity of care to the patients. Additionally, by remaining at the same agency for two semesters, the student and agency staff have time to develop their relationships while the student develops her/his APN role.

7. If there are problem(s) with site arrangement, it is the student’s responsibility to first discuss the problems with her/his supervising faculty. If the student feels that the problem is not resolved, students should discuss this with the course coordinator.
SCHEDULE OF CLINICAL CONFERENCES

<table>
<thead>
<tr>
<th>DATE</th>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 29</td>
<td>Orientation introduction to ethics discussions</td>
</tr>
<tr>
<td>September 5</td>
<td>Hyperlipidemia management</td>
</tr>
<tr>
<td>September 12</td>
<td>Abnormal Pap/ Criteria for treatment of abnormal pap</td>
</tr>
<tr>
<td>September 19</td>
<td>Mammography reports/ common breast conditions</td>
</tr>
<tr>
<td>September 26</td>
<td>Review of common labs and meaning in practice</td>
</tr>
<tr>
<td>October 3</td>
<td>Complementary therapies ways to incorporate in practice</td>
</tr>
<tr>
<td>October 10</td>
<td>Midterm Conferences/Evaluation</td>
</tr>
<tr>
<td>October 17</td>
<td>Weight management/ eating disorders</td>
</tr>
<tr>
<td>October 24</td>
<td>Topic of choice</td>
</tr>
<tr>
<td>October 31</td>
<td>Developmental Issues with adolescents</td>
</tr>
<tr>
<td>November 7</td>
<td>Behavioral Peds/ Parenting issues</td>
</tr>
<tr>
<td>November 14</td>
<td>Topic of choice</td>
</tr>
<tr>
<td>November 21</td>
<td>Dizziness/ Neuro Assessment</td>
</tr>
<tr>
<td>November 28</td>
<td>Thanksgiving</td>
</tr>
<tr>
<td>December 5</td>
<td>Final Conferences/Eval</td>
</tr>
</tbody>
</table>

Each student will be required to present cases at Clinical Conferences and be prepared to discuss relevant issues. Any missed clinical conferences will need to be made up with the clinical instructor. Topic areas are meant to guide discussion of relevant health care issues that need to be addressed to meet the objectives of this course.
APPENDIX A

CHARTING REQUIREMENTS
HANDOUT #4
The Problem Oriented Record (POR)
SOAP Charting

CC: (chief complaint) Reason for visit, in the patient's own words.

S: (subjective data) - Gathered from the patient.
1. Opening statement about the patient-age, reason for visit, when was last visit.
2. HPI (history of present illness) includes - usual state of health, chronology of symptoms - when did they start, how long have they lasted, any pattern, any change location, quality, quantity, setting, aggravating/alleviating factors associated manifestations - review of systems that are pertinent, also pertinent negatives.
3. Relevant past history, family history and personal social history.
4. Major medical problems or surgeries.
5. Current medications or any medication allergies.
6. Assessment of disability-has this affected ability to function on a daily basis.

O: Objective Data - Gathered from observation and physical exam
1. Includes pertinent general survey.
2. Physical exam appropriate to chief complaint.
3. Any lab results.

A: Assessment/Diagnosis - Must match data you have. Both nursing and medical diagnosis are expected.
1. Rationale must be present.
2. If multiple problems can say, "This person presents with multiple problems/concerns based on..." the priority for this visit will be." Or list problems as 1,2,3
3. If don't know the cause for sure can state need to use symptom with indication of what you are looking for such as cough need to evaluate for pneumonia vs. asthma.
**P: Plan - Has four components. Interventions should incorporate NIC when appropriate**

1. **Dx:** anything that will give data, i.e. lab tests awaiting results, x-ray, diet diary, home visit, group meeting.

2. **Tx:** i.e. medications written as if a prescription, special diets (1500 cal ADA), increase fluids to 64 oz per day, etc, specific nursing interventions

3. **Ed:** use words "counseling/education", i.e. counseled on the risks of smoking and the use of oral contraceptives.

4. **Expected outcomes these should be measurable and utilize NOC when appropriate**