

**THE UNIVERSITY OF TEXAS AT TYLER
College of Nursing and Health Sciences**

**NURS 4632: NURSING CARE OF THE ADULT II
Syllabus
Spring, 2008**

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The faculty members of the course welcome the addition of our adjunct faculty members

Lectures: Wednesday's, 9:00 –12:00
Tyler: BRB 1030

The content of this syllabus/WEB site is subject to change at the discretion of the faculty leaders according to current learning needs. Approved by FO: 10/02

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1.0 **II. CLASSROOM COMPONENT N4632**
 N 4632 Class Schedule: Spring 2008

<u>WK.</u>	<u>Date</u>	<u>Topic</u>
1	01/16	Coronary Artery Disease
2	01/23	Dysrhythmias
3	01/30	Inflammatory and Structural Heart Disorders
4	02/06	<i>Exam 1</i> Specific Lower Respiratory Problems
5	02/13	Respiratory Failure and Acute Respiratory Distress Syndrome
6	02/20	Shock, Systemic Inflammatory Response Syndrome, and Multiple Organ Dysfunction
7	02/27	<i>Exam 2</i> Integumentary Problems and Burns
8	03/05	Acute Renal Failure and Chronic Kidney Disease
Have a wonderful Spring Break!		
9	03/19	Endocrine Problems
10	03/26	<i>Exam 3</i> Acute Intracranial Problems
11	04/02	Stroke & Chronic Neurologic Problems
12	04/09	Peripheral Nerve and Spinal Cord Problems
13	04/16	<i>Exam 4</i> Human Immunodeficiency Virus Infection and Arthritis and Connective Tissue Diseases
April 14-April 28 ERI EXAM Available online		
14	04/23	Musculoskeletal Trauma and Orthopedic Surgery and Musculoskeletal Problems
15	04/30	Liver, Pancreas, and Biliary Tract Problems Obesity
16	05/05	<i>Comprehensive Final Exam (DATE MAY CHANGE according to room availability)</i>

2.0 OVERVIEW OF N4632

NURS 4632 – Adult Health II

Semester Credit Hours – 6 hours; 3 hours theory & 3 hours clinical

Prerequisites: Successful completion of all courses through Semester II for the generic and LVN student.

2.0 COURSE DESCRIPTION

Theoretical concepts related to common alterations in health in the adult are presented within the framework of critical thinking and caring. This course builds on knowledge and skills learned in NURS 3611 (Adult Health I). Emphasis is on the comprehensive use of assessment and communication skills when implementing nursing interventions and evaluating patient care outcomes. The focus is on high-level clinical judgment and decision-making abilities. Students provide comprehensive nursing to adult patients experiencing complex high acuity illness in selected structured settings.

3.0 COURSE OBJECTIVES

Upon successful completion of this course, the student will:

1. Utilize critical thinking to provide comprehensive care to adult patients and their families experiencing complex alterations in health.
2. Synthesize research findings and knowledge from nursing and other scientific and humanistic disciplines as they relate to adult health nursing.
3. Coordinate care of multiple adult patients by collaborating with members of the interdisciplinary health care team to promote health, reduce risk, and manage disease.
4. Performs the role of primary care giver in a variety of selected structured settings.
5. Display interpersonal caring by assuming responsibility and accountability for professional interactions.
6. Exemplify professional values that employ ethical, legal, and moral standards in caring for adult patients and their families.

APPROVED: Faculty Organization – 11/99

Texas Board of Nurse Examiners—04/2000

4.0 TEXTBOOKS:

Required:

ANA Foundation of Nursing Packet includes. (*Purchased in Level I*)

Nursing's Social Policy Statement (2nd Ed.) (2003). Washington, D.C.: American Nurses Association.

Nursing: Scope and Standards of Practice (2004). Silver Spring, MD: American Nurses Association.

Code of Ethics for Nurses with Interpretive Statements (2001). Silver Spring, MD: American Nurses Association.

College of Nursing. (2004). *BSN/MSN guide for nursing students*. Tyler: The University of Texas at Tyler. *Note: Must be current version of student guide.*

Lewis, S., Heikemper, M., Dirksen, S., O'Brien, P. & Bucher, L. (2007) *Medical-surgical nursing: Clinical management for positive outcomes* (7th ed.) St. Louis, Mosby.

NCLEX 3500 (2006) – Available in each campus computer lab or may be purchased.

Required Scantrons to be used for examinations: Look for the correct form which includes F-17255-PAR-L (there are 2 of the same color so make sure to look at the form)

A recent (within the past 2 years) lab book, IV drug book, and drug reference book are required. Any reference book purchased in the past semesters will suffice.

Elsevier website: You are encouraged to make use of this website to access the latest information on the subject matter that we will be covering in class.

<http://evolve.elsevier.com/Lewis/medsurg>

5.0 AMERICAN DISABILITIES STATEMENT

"If you have a disability, including a learning disability, for which you request disability support services/accommodation(s), please contact Ida MacDonald in the Disability Support Services office so that the appropriate arrangements may be made. In accordance with federal law, a student requesting disability support services/accommodation(s) must provide appropriate documentation of his/her disability to the Disability Support Services counselor. For more information, call or visit the Student Services Center located in the University Center, Room 282. The telephone number is 566-7079 (TDD 565-5579)." Additional information may also be obtained at the following UT Tyler Web address: <http://www.uttyler.edu/disabilityservices>.

6.0 EXAMINATIONS/ASSIGNMENTS AND GRADING POLICY

Completion of NURS 4632 is based on satisfactory attainment of didactic and clinical criteria. Any student who fails to meet the course objectives in either the classroom or clinical area must repeat the entire course and may not progress to the next level.

6.1 GRADING POLICY

The simple average of the exam grades, before weighted calculation is performed, must be 75 or above to pass the course. Grades will not be rounded when calculating the average (74.5-74.9 is not rounded to 75).

Students with an exam grade average of 75 or higher will have course grades calculated based on the weighted calculation of the exams and other required course work.

The Course Grade consists of the following components:

Four Unit Exams each (4 @ 16% each)	64%
Comprehensive Final	16%
A passing ERI result page will be used to gain admittance to the final exam. If not passed, a grade of "O" will be recorded.	
Medication Calculation Exam (Must obtain 90% on above exam to pass)	Pass/Fail
Comparative Analysis Worksheet Must obtain 75% to pass clinical	3%
Comorbidity Case Study Written work Must obtain 75% to pass clinical	12%
Evidence Based Case Study Presentation Must obtain 75% on presentation to pass clinical	5%
Clinical mastery	Pass/Fail
25 NCLEX 3500 questions each week Must obtain 75% on 350 questions to pass clinical	Pass/Fail
ERI Medical-Surgical test	<u>Above national score (Pass)</u> 100%

Letter grades will be assigned on the following scale:

A =	90 - 100
B =	80 - 89
C =	75 - 79
D =	60 - 74
F =	Below 60

Approved FO Fall 1999

B. Grade Replacement Policy

If you are repeating this course for a grade replacement, you must file an intent to receive grade forgiveness with the registrar by the 12th day of class. Failure to file an intent to use grade forgiveness will result in both the original and repeated grade being used to calculate your overall grade point average. A student will receive grade forgiveness (grade replacement) for only three (undergraduate student) or two (graduate student) course repeats during his/her career at UT Tyler. (2006-08 Catalog)

C. Paper/Assignment Re-grading Policy

Student assignments will not be re-graded. At the instructor's discretion, a draft may be written for review.

D. Examination and Examination Review Policy

1. Attendance for exams are mandatory
2. If absence for an exam is necessary, the student is responsible for notifying the faculty prior to the exam with an acceptable reason.
- 3.. Students will be allowed entry to the classroom after an exam has been started **ONLY** with faculty discretion.
4. Exams will be distributed at the time class is scheduled to begin.

5. All hats/caps must be removed during exam time. All personal items such as purses, books, backpacks, notebooks, and briefcases must be left in the front of the room during testing.
6. Silence will be enforced during the exam time. In order to avoid distraction during the exam, no one will be permitted to leave the room during the exam.
7. Make-up exams will only be given at the discretion of the faculty member and may be in a different format than the original exam.
8. Students will not share calculators during exams. Students will not bring their own calculators, cell phones, or any communicating devices into an examination
9. Exam reviews will be conducted at the discretion of the faculty. Test review may be scheduled with the faculty during office hours and within 10 school days from the return of the exam grades.
10. Any student achieving an examination grade less than 75%, must schedule an appointment with the faculty within 10 school days from the return of the exam grades.

7.0 Academic Integrity

1. Students are expected to assume full responsibility for the content and integrity of all academic work submitted as homework and examinations.
2. Students are advised to review the UTT Academic Dishonesty Policy and Academic Integrity Policy in the current College of Nursing Student Handbook. These policies are fully endorsed and enforced by all faculty in the College of Nursing.
3. Plagiarism, cheating, and collusion are unacceptable, and, if found violating any of these standards, the student will be disciplined accordingly.
4. The College of Nursing reserves the right to dismiss students from the program for any infraction of a legal, moral, social, or safety nature, pursuant to the procedures detailed in the Regent's Rules.

8.0 GENERAL EXPECTATIONS OF STUDENTS IN ADULT HEALTH II

8.1 Attendance

- a. Attendance during lecture, clinical experiences and clinical conferences is a professional expectation and will be monitored by course faculty. Attendance for clinical assignments is addressed at length in the syllabus. Refer to the university catalog for the policy regarding student attendance and possible student consequences.
- b. Students should read and understand the attendance statement in the current UT Tyler General Catalogue.
- c. Students are responsible for all material discussed and all announcements made if they are absent.
- d. Students must notify the instructor prior to any scheduled clinical or post clinical conference if an absence is necessary. When scheduled in the clinical agency, the students must contact the agency personnel at least one hour prior to the scheduled

clinical time. If the student is going to be late, the student must notify the agency and indicate the approximate time of arrival.

- e. Make up time for missed clinical time will be arranged at the discretion of the instructor. A student missing one or more days in one rotation will present a written plan as to how he/she will meet the clinical objectives. Make up time and location for missed post clinical conferences learning experiences will be arranged at the discretion of the instructor.
- f. The use of pagers and cellular phones during class or in the clinical setting is prohibited. ***Due to interference with the interactive video equipment, all cell phones are to be turned completely off during lecture.***

8.2 Dress Code Requirements

A. General: It is the philosophy of the College of Nursing that the student has a responsibility to be neatly groomed and modestly dressed. Appearances should promote good health, safety and general well-being of the student. Clothing should avoid brevity and/or design that are offensive to the dignity and rights of others. School officials have the right and responsibility to counsel with the student or take any other corrective action. Types of clothing (other than those specified in this document) may be worn at the direction of the nursing instructor for special events.

B. Classroom: Casual or every day business wear is recommended. This includes but is not limited to the following: Slacks or skirt; sweater, blouse, and shirt. Jeans as well as conservative shorts (mid-thigh or longer) may be worn, but avoid overly frayed or soiled. Shoes must be worn. See items to be avoided below.

C. Professional Presentations, Ceremonies/ Graduation: Business or dressy day social: suit, dress, dressy separates, jacket, ties, nice fabrics. Dress shoes. Avoid denim, jeans, t-shirt or other casual clothes. For workshops/seminars attended by students, business attire will be worn.

D. Items to be avoided in all School-related Functions (including but not limited to): Overly frayed, worn or soiled garments. Costume look, transparent blouses, bare midriff shirts, tank tops, spaghetti straps, muscle shirts, overtly sexual, gang colors or logos, facial or body piercing, obscene slogans or pictures, bedroom wear, short-shorts, short skirts, or clothing that may be offensive to others.

E. Laboratory: The school clinical laboratory setting is designed to simulate the health care clinical area. Students will wear clean white lab coats with name tag and UT Tyler school patch on the front left uniform jacket. Classroom attire will be worn under the lab coat.

F. Pre or Post-clinical Experiences in the Health Care Setting: Students may be required to attend conferences or visit the clinical areas as part of their course requirements. Students should wear lab coat with name tag and UTT school patch. The following items will be avoided in the clinical areas: jeans, shorts, sandals, jogging/athletic suits, t-shirts, ball-caps, etc.

G. Clinical Experience:

1. When attending any clinical experience students are required to wear the standardized student uniform and white uniform jacket with name badge and school patch. Street clothes will be worn in appropriate clinical settings as directed by the clinical faculty with the white uniform jacket, name tag and school patch (see items above to be avoided in clinical areas). Students are to remember that whenever they are visiting a clinical agency or any clinical site, they represent UT Tyler and the College of Nursing and are expected to be professional in appearance and behavior at all times.

2. When student uniforms are required for clinical experiences, as specified by the course, the following guidelines must be adhered to:

- a) School patch on the front left of the uniform jacket and the top of the standardized uniform.
- b) The UTT name badge will be worn in all clinical setting. Name tag must be worn above the waist, so name and title are clearly visible.
- c) White or neutral nylon hose are worn with dress/skirt; nylon hose, knee-highs or white socks with pants. Socks must cover ankle.
- d) Clean, white clinical shoes or white leather athletic shoes should be worn (shoes may be mostly white and if stripes or logos are on shoes, these must be minimal and light colored). No canvas shoes or athletic shoes with colored stripes or large logos.
- e) Jewelry: wedding or engagement rings only; single stud earrings and only 1 in each lobe (no dangling or hoops); no rings or studs in the nose, tongue, lip or any other facial or body piercing (other body piercing must be covered or removed); and, no necklaces or bracelets (only Medic Alert). Must have a watch with a second hand.
- f) Make-up, hair, and grooming should be conservative. Hair shoulder length or longer must be pulled neatly back in a ponytail or bun. Hair clips, bands, etc. shall be functional, not decorative (no bows). Mustaches and beards will be neatly groomed, clean and trimmed.
- g) Tattoos must be covered and not visible.
- h) Nails are to be clean and neatly trimmed to no more than fingertip length, with clear or no polish. No artificial nails in OR or L & D.
- i) No perfume, after-shave or other strong scents since this causes nausea and /or difficulty in breathing for many patients.
- j) Gum chewing is not allowed
- k) Any question concerning adherence to the dress code should be directed toward the clinical instructor.

3. Failure to comply with the above requirements may result in an unexcused clinical absence and/or negative clinical evaluation

4. If the dress code rules are broken and a change of clothes is not available, the student may be removed from the school-related function for the remainder of the day. **Appropriate disciplinary action will be taken for repeated violations of this code.**

8.3 Professional Liability Insurance/CPR/Required Immunizations

Students are responsible for providing proof of professional liability, CPR Certification and immunizations prior to hospital experience. Failure to comply with the College of Nursing requirements will result in unexcused clinical absence.

8.4 Clinical Injuries

Hospital and other health facilities DO NOT cover any medical expense as a result of accident or injury; thus, each student is responsible for any medical expenses as a result of accident or injury; thus, each student is responsible for any medical or hospitalization charges that occur.

8.5 Working Prior To Clinical

Students working the shift prior to the assigned clinical experiences are at high risk for unsafe clinical practice. It is advised that the student not work prior to the assigned clinical day.

8.6 Lecture

- a) If lecture outlines are used, they will be posted on Blackboard a minimum of two (2) working days prior to class and will be removed at midnight prior class,
- b) The clinical portion of the course syllabus, handouts, and any other required course materials will to be placed on blackboard.
- c) All submitted written material (papers, assignments, examinations, etc.) are the property of the College of Nursing. They will be maintained in an archived file in the College of Nursing.
- d) A two-week window prior to the final exam is being provided to take the ERI from any internet computer. You may retake the exam up to 5 times to achieve a score above the national average. If the student has not fulfilled this requirement, he/she will not be allowed to take the final exam. A grade of 0* will be recorded for the final exam for this student
- e) All nursing students are required to use their student email accounts for all correspondence (Approved FO: 2/03)

8.7. Student Affirmation Form

1. Each line must be initialed, signed, and dated for each course every semester.
2. The form will be placed in the student's file

8.8 Audio/Video-Recording Agreement

1. Any student wishing to record a class must sign this agreement no later than the second week of classes each semester. An agreement must be signed for each course every semester.
2. Due to the confidential nature of some course content, the student will provide written documentation of the erasure of any recordings made during the current semester. Failure to return this written documentation to the faculty by the date of the final examination will result in a grade of "I" (Incomplete).

WEEK 1

Nursing Management: Coronary Artery Disease and Acute Coronary Syndrome

OBJECTIVES:

Following completion of this unit, the student will be able to:

1. Describe the etiology and pathophysiology of coronary artery disease.
2. Identify risk factors for coronary artery disease and the nursing role in the promotion of therapeutic lifestyle changes in patients at risk.
3. Compare and contrast the precipitating factors, clinical manifestations, and collaborative care and nursing management of the patient with coronary artery disease and chronic stable angina.
4. Describe the clinical manifestations, complications, diagnostic study results, and collaborative care of the patient with acute coronary syndrome.
5. Describe the pathophysiology of myocardial infarction from the onset of injury through the healing process.
6. Identify commonly used drug therapy in treating patients with coronary artery disease and acute coronary syndrome.
7. Identify key issues to include in the rehabilitation of patients recovering from acute coronary syndrome and coronary revascularization procedures.
8. Describe the precipitating factors, types, clinical presentation, and collaborative care of patients who are at risk for or have experienced sudden cardiac death.

Learning Activities

1. Pre-Class Assignment: Read Lewis, Chapter 34 (784 – 820).
2. Review readings from pharmacological text.
3. Evaluation: Exam

WEEK 2
Nursing Management: Dysrhythmias

OBJECTIVES:

Following completion of this unit, the student will be able to:

1. Describe the nursing management of patients requiring continuous electrocardiographic (ECG) monitoring
2. Identify the clinical characteristics and ECG patterns of normal sinus rhythm, common dysrhythmias, and acute coronary syndrome (ACS)
3. Describe the nursing and collaborative management of patients with common dysrhythmias and ECG changes associated with ACS.
4. Differentiate between defibrillation and cardioversion, identifying indications for their use and physiologic effects of each.
5. Describe the management of a patient with temporary and permanent pacemakers.
6. Describe the management of patients with implantable cardioverter-defibrillators.
7. Explore through evidence-based research the quality of life patients experience s/p ICD's.
8. Explain the management of a patient undergoing electrophysiologic testing and radiofrequency catheter ablation therapy.

Learning Activities

1. Pre-Class Assignment: Read Lewis, chapter 36, (pg. 842--864).
2. Review readings from pharmacological text.
3. Review the EBP scholarly work of Samuel Sears, PhD regarding quality of life and ICD patients.
4. Participate in the mandatory Sim-Man arrhythmia training; date and time depends on campus. (Tyler campus –Feb 1 or Feb 4, Skills lab 2, sign up for date in class)
5. Evaluation: Exams

WEEK 3
NURSING MANAGEMENT: INFLAMMATORY AND STRUCTURAL HEART DISEASE

OBJECTIVES

1. Describe the etiology, pathophysiology, and clinical manifestations of infective endocarditis and pericarditis.
2. Discuss the collaborative care and nursing management of infective endocarditis and pericarditis.
3. Explain the importance of prophylactic antibiotic therapy in infective endocarditis.
4. Explain the etiology, clinical manifestations, collaborative care, and nursing management of myocarditis.
5. Describe the etiology, pathophysiology, and clinical manifestations of rheumatic fever and rheumatic heart disease.
6. Discuss the collaborative care and nursing management of the patient with rheumatic fever and rheumatic heart disease.
7. Identify the etiologies of acquired valvular heart diseases.
8. Discuss the pathophysiology, clinical manifestations, and diagnostic studies for the various types of valvular heart problem.
9. Describe the collaborative care and nursing management of the patient with valvular heart disease.
10. Describe interventions used in management of the patient with valvular heart problems.
11. Describe the pathophysiology and clinical manifestations of the different types of cardiomyopathies.
12. Discuss the nursing and collaborative management of patients with different types of cardiomyopathies.

Learning Activities

1. Pre-Class Assignment: Read Lewis, chapter 37, (pg, 865 – 891)
2. Review readings from pharmacological text.
3. Evaluation: Exams

WEEK 4
NURSING MANAGEMENT: SPECIFIC LOWER RESPIRATORY PROBLEMS

OBJECTIVES

1. Identify the mechanisms involved and the clinical manifestations of pneumothorax, fractured ribs, and flail chest.
2. Describe the purpose, methods, and nursing responsibilities related to chest tubes.
3. Explain the types of chest surgery and appropriate preoperative and postoperative care.
4. Describe the pathophysiology, clinical manifestations and collaborative and nursing management of pulmonary emboli.

LEARNING ACTIVITIES

1. Pre-Class Assignment: Read Lewis, pgs. 585-592 & 598-600.
2. Review readings from pharmacological text.
3. Evaluation: Exams

WEEK 5
NURSING MANAGEMENT: RESPIRATORY FAILURE AND ACUTE RESPIRATORY DISTRESS SYNDROME

OBJECTIVES

1. Compare the pathophysiologic mechanisms that result in hypoxemic and hypercapnic respiratory failure.
2. Differentiate between early and late clinical manifestations of acute respiratory failure.
3. Describe the nursing and collaborative management of the patient with hypoxemic or hypercapnic respiratory failure.
4. Select appropriate nursing interventions to manage the care of an intubated patient.
5. Differentiate the indications for and modes of mechanical ventilation.
6. Describe the principles of mechanical ventilation and related collaborative care of critically ill patients.
7. Relate the pathophysiologic mechanisms that result in acute respiratory distress syndrome (ARDS) to the clinical manifestation.
8. Describe the nursing and collaborative management of the patient with ARDS.
9. Identify complications that may result from acute respiratory failure or ARDS and measures to prevent or reverse these complications.

Learning Activities

1. Lewis, pgs. 1799 – 1820 & Chapter 66 (pgs 1751 –1768).
2. Review pharmacological textbook readings.
3. Evaluation: Exams

WEEK 6

NURSING MANAGEMENT: SHOCK AND MULTIPLE ORGAN DYSFUNCTION SYNDROME

OBJECTIVES

1. Define shock
2. Differentiate the two major classifications of shock: low blood flow and maldistribution of blood flow.
3. Describe the pathophysiology and clinical manifestations of the different types of shock.
4. Compare and contrast the effects of shock, systemic inflammatory response syndrome, and multiple organ dysfunction syndrome on the major body systems.
5. Compare the collaborative care, drug therapy, and nursing management of patients with different types of shock.
6. Describe the nursing management of a patient experiencing multiple organ dysfunction syndrome.
7. Discuss the principles of hemodynamic monitoring and collaborative care and nursing management of the patient receiving hemodynamic monitoring.

Learning Activities

1. Pre-Class Assignment: Read Lewis, Chapter 66 (pgs. 1738 – 1751 & Chapter 67 (pgs 1772- 1798).
2. Review readings from pharmacology textbook.
3. Evaluation: Exams

WEEK 7
NURSING MANAGEMENT: BURNS

OBJECTIVES

1. Describe the causes and prevention of burn injuries.
2. Describe the burn injury classification system.
3. Describe the relationship between the involved structures and the clinical appearance of partial- and full-thickness burns.
4. Identify the parameters used to determine the severity of burns.
5. Describe the pathophysiology, clinical manifestations, complications, and nursing and collaborative management of the three burn phases.
6. Explain fluid and electrolyte shifts during the emergent and acute burn phases.
7. Describe the nutritional therapy of the burn patient during the three burn phases.
8. Describe the interventions that the nurse may use in the management of pain in the burn patient.
9. Explain the physiologic and psychosocial aspects of burn rehabilitation.
10. Describe the nursing management of the emotional needs of the burn patient and family.
11. Discuss the issues involved and rationale for preparing the burn patient to return home.

Learning Activity:

- 1). Pre-Class Assignment: Read Lewis, chapters 25, (pgs. 483-507)
- 2). Review readings from pharmacology textbook.
- 3). Evaluation: Exams

WEEK 8**NURSING MANAGEMENT: ACUTE RENAL FAILURE AND CHRONIC KIDNEY DISEASE**OBJECTIVES

1. Differentiate between acute renal failure and chronic kidney disease.
2. Differentiate among the causes of prerenal, intrarenal, and postrenal acute renal failure.
3. Describe the clinical course of reversible acute renal failure.
4. Explain the collaborative care and nursing management of a patient with acute renal failure.
5. Describe the systemic manifestations of chronic kidney disease.
6. Explain the conservative collaborative care and the related nursing management of the patient with chronic kidney disease.
7. Differentiate between peritoneal dialysis and hemodialysis in terms of purpose, indications, advantages and disadvantages and nursing responsibilities.
8. Describe common vascular access sites used for hemodialysis.
9. Compare dialysis and renal transplantation as methods of treatment for end-stage renal disease.
10. Describe the nursing management of patients in the preoperative, intraoperative, and postoperative stages of kidney transplantation.
11. Discuss the potential long-term problems of the patient with a kidney transplant.

Learning Activities

1. Pre-Class Assignment: Read Lewis, Chapter 47 (pg. 1197 – 1232).
2. Review readings from pharmacology textbook.
- 3). Evaluation: Exams

WEEK 9
NURSING MANAGEMENT: ENDOCRINE PROBLEMS

OBJECTIVES

1. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of the patient with an imbalance of hormones produced by the anterior pituitary gland.
2. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of the patient with thyroid dysfunction.
3. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of the patient with an imbalance of the hormone produced by the parathyroid glands.
4. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of the patient with an imbalance of hormones produced by the adrenal cortex.
5. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of the patient with an imbalance of hormones produced by the adrenal medulla.
6. Describe the side effects of corticosteroid therapy.
7. List common nursing assessments, interventions, rationales, and expected outcomes related to patient teaching for management of chronic endocrine problems.

Learning Activities

1. Pre-Class Assignment: Read Lewis, Chapter 48 (pgs, 1234-1252) & Chapter 50 (pgs. 1290-1321).
2. Review readings from pharmacology textbook.
3. Evaluation: Exams

WEEK 10
NURSING MANAGEMENT: ACUTE INTRACRANIAL PROBLEMS

OBJECTIVES

1. Identify the physiologic mechanisms that maintain normal intracranial pressure.
2. Identify the common etiologies, clinical manifestations, and collaborative care of the patient with increased intracranial pressure.
3. Describe the collaborative and nursing management of the patient with increased intracranial pressure.
4. Differentiate types of head injury by mechanism of injury and clinical manifestations
5. Describe the collaborative care and nursing management of the patient with a head injury.
6. Compare the types, clinical manifestations, and collaborative care of brain tumors.
7. Discuss the nursing management of the patient with a brain tumor.
8. Describe the nursing management of the patient undergoing cranial surgery.
9. Compare the primary causes, collaborative care, and nursing management of meningitis, encephalitis, and brain abscess.
10. Describe the etiology, clinical manifestations, and nursing management of the patient with rabies.

Learning Activity

1. Pre-Class Assignment: Read Lewis, Chapter 55 (pgs 1467 – 1501)
2. Review readings from pharmacology textbooks.
3. Evaluation: Exams

WEEK 11
NURSING MANAGEMENT: STROKE

OBJECTIVES

1. Describe the incidence of and risk factors for stroke.
2. Explain mechanisms that affect cerebral blood flow.
3. Compare and contrast the etiology and pathophysiology of ischemic and hemorrhagic strokes.
4. Correlate the clinical manifestations of stroke with the underlying pathophysiology.
5. Identify diagnostic studies performed for patients with strokes.
6. Describe the collaborative care, drug therapy, and nutritional therapy for a patient with a stroke.
7. Describe the acute nursing management of the patient with a stroke.
8. Describe the rehabilitative nursing management of the patient with a stroke.
9. Explain the psychosocial impact of a stroke on the patient and the family.

NURSING MANAGEMENT: CHRONIC NEUROLOGIC PROBLEMS

OBJECTIVES

1. Compare and contrast tension-type, migraine, and cluster headaches in terms of etiology, clinical manifestations, collaborative care, and nursing management.
2. Describe the etiology, clinical manifestations, diagnostic studies, collaborative care, and nursing management of seizure disorder, multiple sclerosis, Parkinson's disease and myasthenia gravis.
3. Describe the clinical manifestations and nursing and collaborative management of restless legs syndrome, amyotrophic lateral sclerosis and Huntington's disease.
4. Explain the potential impact of chronic neurologic disease on physical and psychologic well-being.
5. Outline the major goals of treatment for the patient with a chronic, progressive neurologic disease.

Learning Activities

1. Pre-Class Assignment: Read Lewis-
Chapter 58 (pgs. 1502 – 1526) & Chapter 59 (pgs. 1527 – 1560)
2. Review readings from pharmacology textbook
3. Evaluation: Exams

Week 12**NURSING MANAGEMENT: PERIPHERAL NERVE AND SPINAL CORD PROBLEMS**OBJECTIVES

1. Explain the etiology, clinical manifestations, collaborative care, and nursing management of trigeminal neuralgia and Bell's palsy.
2. Explain the etiology, clinical manifestations, collaborative care, and nursing management of Guillain-Barre syndrome, botulism, tetanus, and neurosyphilis
3. Describe the classification of spinal cord injuries and associated clinical manifestations.
4. Describe the clinical manifestations, collaborative care, and nursing management of spinal cord shock.
5. Correlate the clinical manifestations of spinal cord injury with the level of disruption and rehabilitation potential.
6. Describe the nursing management of the major physical and psychologic problems of the patient with a spinal cord injury.
7. Describe the effects of spinal cord injury on the older adult population.
8. Explain the types, clinical manifestations, collaborative care, and nursing management of spinal cord tumors.
9. Describe the pathophysiology, clinical manifestations, and nursing and collaborative management of postpolio syndrome.

Learning Activities

1. Pre-Class Assignment: Read Lewis-Chapter 61 (pgs 1580 – 1613).
2. Review readings from pharmacology textbook.
3. Evaluation: Exams

WEEK 13

NURSING MANAGEMENT: INFECTION AND HUMAN IMMUNODEFICIENCY VIRUS (HIV)

OBJECTIVES

1. Discuss the impact of emerging and reemerging infections on health care.
2. List ways that nurses can decrease the development of resistance to antibiotics.
3. List the ways HIV is transmitted and the factors that affect transmission.
4. Describe the pathophysiology of HIV infection.
5. Outline HIV disease progression in the spectrum of untreated infection.
4. Identify the diagnostic criteria for acquired immunodeficiency syndrome (AIDS).
5. Explain methods of testing for HIV infection.
6. Discuss the collaborative management of HIV infection.
7. Summarize the characteristics of opportunistic diseases associated with AIDS.
8. Describe the long-term consequences of HIV infection and or treatment of HIV infection.
9. Compare and contrast the methods of HIV prevention that eliminate risk and those that decrease risk.
10. Describe the nursing management of HIV-infected patients and HIV-at-risk patients.

NURSING MANAGEMENT: ARTHRITIS AND CONNECTIVE TISSUE DISEASES

OBJECTIVES

1. Compare and contrast the sequence of events leading to joint destruction in osteoarthritis and rheumatoid arthritis.
2. Describe the clinical manifestations, collaborative care, and nursing management of osteoarthritis and rheumatoid arthritis.
3. Compare and contrast the pathophysiology, clinical manifestations, collaborative care, and nursing management of ankylosing spondylitis, psoriatic arthritis, and reactive arthritis.
4. Describe the pathophysiology, clinical manifestations, and collaborative care of septic arthritis, Lyme disease, and gout.
5. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of systemic lupus erythematosus, polymyositis, dermatomyositis, and Sjorgen syndrome.
6. Describe the drug therapy and related nursing management associated with arthritis and connective tissue diseases.
7. Compare and contrast the possible etiologies, clinical manifestations, and collaborative and nursing management of myofacial pain syndrome, fibromyalgia syndrome, and chronic fatigue syndrome.

Learning Activities.

1. Pre-Class Assignment: Read Lewis, Chapter 15 (pgs. 243 – 270) & Chapter 65 (pgs 1693 – 1730)
2. Review readings from pharmacological text
3. Evaluation: Exams

WEEK 14

NURSING MANAGEMENT: MUSCULOSKELETAL TRAUMA AND ORTHOPEDIC SURGERY OBJECTIVES

1. Explain the etiology, pathophysiology, clinical manifestations, and collaborative care of soft tissue injuries, including strains, sprains, dislocations, subluxations, bursitis, repetitive strain injury, carpal tunnel syndrome, rotator cuff injury, meniscus injury, and muscle spasms.
2. Describe the sequential events involved in fracture healing.
3. Differentiate among closed reduction, cast immobilization, open reduction, and traction regarding purpose, complications, and nursing management.
4. Describe the neurovascular assessment of an injured extremity.
5. Explain common complications associated with fracture injury and fracture healing.
6. Describe the collaborative care and nursing management of patients with specific fractures.
7. Describe the indications for and the collaborative care and nursing management of the patient with an amputation.
8. Describe the types of joint replacement surgery associated with arthritis and connective tissue diseases.
9. Identify the preoperative and postoperative management of the patient having joint replacement surgery.

NURSING MANAGEMENT: MUSCULOSKELETAL PROBLEMS

OBJECTIVES

1. Describe the pathophysiology, clinical manifestations, collaborative care, and nursing management of osteomyelitis.
2. Describe the types, pathophysiology, clinical manifestations, and collaborative care of bone cancer.
3. Differentiate between the causes and characteristics of acute and chronic low back pain.
4. Describe the conservative and surgical therapy of intervertebral disk damage.
5. Describe the postoperative nursing management of a patient who has undergone spinal surgery.
6. Explain the etiology and nursing management of common foot disorders.
7. Describe the etiology, pathophysiology, clinical manifestations, and collaborative and nursing management of osteomalacia, osteoporosis, and Paget's disease.

Learning Activities

1. Pre-Class Assignment: Read Lewis, Chapter 63 (pg 1629 – 1667) and Chapter 64 (pgs 1669- 1691).
2. Evaluation: Exams

Week 15
NURSING MANAGEMENT: LIVER, PANCREAS, AND BILIARY TRACT PROBLEMS

OBJECTIVES

Upon successful completion of the unit, the student will be able to:

1. Define jaundice and describe signs and symptoms that may occur with the different types of jaundice.
2. Differentiate among the types of viral hepatitis, including etiology, pathophysiology, clinical manifestations, complications, and collaborative care.
3. Describe the nursing management of the patient with viral hepatitis.
4. Explain the pathophysiology, clinical manifestations, complications, and collaborative care of the patient with nonalcoholic fatty liver disease.
5. Explain the etiology, pathophysiology, clinical manifestations, complications, and collaborative care of the patient with nonalcoholic fatty liver disease.
6. Describe the clinical manifestations and management of liver cancer.
7. Describe the pathophysiology, clinical manifestations, complications, and collaborative care of acute and chronic pancreatitis.
8. Describe the nursing management of the patient with pancreatitis.
9. Explain the clinical manifestation and collaborative care of the patient with pancreatic cancer.
10. Explain the pathophysiology, clinical manifestations, complications, and collaborative care, including surgical therapy of gallbladder disorders.
11. Describe the nursing management of the patient undergoing conservative or surgical treatment of cholecystitis and cholelithiasis.

NURSING MANAGEMENT: OBESITY

OBJECTIVES

1. Discuss the etiologies and collaborative care of obesity.
2. Describe the classification systems for determining a person's body size.
3. Explain the health risks associated with obesity.
4. Discuss the nutritional therapy and exercise plans for the obese patient.
5. Describe the different bariatric surgical procedures used to treat obesity.
6. Describe the nursing management related to conservative and surgical therapies for obesity.
7. Describe the etiology, clinical manifestations, and nursing and collaborative management of metabolic syndrome.

Learning Activities

1. Pre-Class Assignment: Read Lewis, Chapter 41 (pgs 971 – 989) & 44 (pgs 1087 – 1134)
2. Review readings from pharmacology textbook.
3. Review PICO case study of patient with cirrhosis with use of Alternative Medicine.
4. Evaluation: Exams

10.0 CLINICAL COMPONENT

10.1 OVERVIEW OF CLINICAL EXPECTATIONS

The clinical component of this course consists of 112.5 hours of clinical time within an acute care facility. To receive a satisfactory score within the clinical component of the course, the student must achieve a score of 2 or 3 in all areas of the clinical evaluation tool. Please refer to the clinical objectives and the clinical evaluation tool and Guidelines for clinical evaluation sections of the clinical syllabus.

Clinical experiences may vary between groups, but each student's total hours must equal 112.5. These hours may be divided (according to clinical instructors' discretion) as follows:

Orientation to clinical area,	4 hours
Observational experiences (cath lab, emergency room, etc.)	up to 16 hours
Direct patient care unit with preceptor	84 hours (or more)
Post Clinical Conferences (sim lab & PICO presentations)	8.5 hours

Clinical experiences are precepted at each facility.

Clinical Conferences: Students will meet to discuss clinical experiences as announced by their clinical instructor(s). This time will be used to encourage critical thinking through use of case studies and current patient assignments, to provide time for student presentations and other learning opportunities. **Attendance at clinical conferences is mandatory, and plans should be made to be on time for conferences.** Planned times for these conferences are individualized between groups.

10.1 CLINICAL OBJECTIVES:

Upon completion of the course, the student will:

A. PROVIDER OF CARE

1. Assess the adult patient with medical-surgical conditions for health status and health needs.
2. Identify actual and potential problems for the adult patient based on assessment data.
3. Formulate an individualized plan of care with appropriate interventions and patient outcomes for the adult patient.
4. Implement nursing actions that are based on current theory and research.
5. Evaluate the effectiveness of nursing interventions in meeting the expected outcomes.
6. Revise the plan of care when the expected outcomes are resolved or not met.

B. COORDINATOR OF CARE

7. Coordinate comprehensive care for a minimum of four patients with medical-surgical conditions through collaboration with the individual, family, and other health care providers, utilizing critical decision-making and time management skills.

C. MEMBER OF THE PROFESSION

8. Demonstrate responsibility and accountability for own actions.
9. Abide by the laws and standards designated by the University of Texas at Tyler College of Nursing, Texas State Board of Nurse Examiners, and the ANA Code of Ethics.
10. Project a professional image by adhering to the dress code and meeting the attendance requirements.

D. COMMUNICATION

11. Document in a comprehensive, organized, and clearly stated manner the nursing care delivered.
12. Communicate with the clinical faculty and other health care providers regarding patient status.
13. Establish effective working relationships with clinical faculty, facility personnel, peers, patients, and patient's families.

E. SAFETY

14. Provide safe care by accurately administering medications in real and simulated situations.
15. Accurately identify safety risks and appropriately intervene to provide a safe patient and family environment.

Approved: Faculty Organization—11/99; Board of Nurse Examiners—04/2000

Clinical student evaluations will be placed in the student's file at the end of the semester for each clinical course.

10.2 Clinical Visit Expectations

During your clinical rotation, the instructor will make clinical visits to each student. For this course, it is expected for the student to be prepared to discuss the following information with the instructor regarding their patient/patients:

Name of their patient and physician.

Diagnosis with any co-morbidities, pathophysiology of primary diagnosis

History of Present illness.

Medications and treatments the patient is receiving (ventilator, IV's, monitor, etc.)

Diagnostic tests, including laboratory and x-rays. (Including those due today)

Nursing process – including assessment, diagnosis, planned outcome, appropriate.

Individualized interventions, and evaluation of their patient.

10.3 Clinical assignments:

For this course, the following assignments will be required:

a. Successful completion of *medication calculation exam*

Medication Calculation Policy

1. Students are required to achieve a 90 or higher on the medication calculation exam prior to the first clinical day. Students are permitted two (2) attempts for success on the exam.
2. Students who are unsuccessful on the first attempt of the medication calculation exam must provide written evidence that remediation has taken place before being permitted a second attempt.
3. If a student fails to achieve the required 90% or higher on the second attempt, the student will be required to withdraw from the course for the semester. A grade of W will be posted on the student's transcript, but will be regarded as a nursing course failure in the College of Nursing.
4. Medication calculation is a component of medication administration. Mastery of medication administration must be demonstrated in the clinical and classroom settings for successful completion of all clinical courses. In addition to the initial medication calculation exam (above), medication questions on unit exams and observation in the clinical setting will be used to assess and evaluate the clinical safety of students on an individual basis. Serious or repetitive medication and/or calculation errors may indicate unsafe clinical practice.

b. Successful completion of one *Comparative Analysis Worksheet (CAW)*. A minimum of 75 points must be achieved on the CAW. The paper will be graded according to the Grading Criteria. No "redos" or revisions will be allowed. If a grade of 75 is not achieved, the students will be required to choose another patient and submit an entirely new patient study.

c. One (1) *Co-morbidity Patient Case Study*, detailing the care of a patient with two or more disease processes. A minimum of 75 points must be achieved on this *Co -morbidity Case Study*. The paper will be graded according to the Grading Criteria. No "redos" or revisions will be allowed. If a grade of 75 is not achieved, the student will be required to choose another patient and submit an entirely new patient *Case Study*.

d. One (1) *Evidence Based Case Study Presentation* - Each student is to take an active leadership role in coordinating and directing the learning of others in his or her clinical group. Their clinical instructor will provide the student with a case study. Students will need to develop the case study into a presentation format. In addition, the student must expand the case study by developing one EBP question and will need to include at least two nursing research based or EBP articles to support/refute their EBP question. If a group is assigned to one case study, each student is responsible for developing a separate PICO question and providing two EBP articles.

e. Submit 25 NCLEX 3500 questions each for a total of 350 questions for the semester.

f. Successful completion of the Adult 1 and Adult 2 ERI. Student must achieve above national average on each exam to successfully pass course.

10.4 Student accountability in special situations

1. Students are not allowed to:
 - a. take verbal or telephone orders from physicians
 - b. transcribe or note physician's orders
 - c. witness operative permits
 - d. administer blood transfusions*** Students are expected to seek experiences where they may observe blood administration and assist with assessment of the patient and procedure.
2. Students must be supervised by a staff nurse or by the clinical instructor to:
 - a. perform IV-related procedures, including IV hepllock flushes, IV starts, IVPB, and IV pushes.
 - b. sign out narcotics (requires co-signature)
3. In Code 44 situations students may perform CPR only.
4. Students must wear full UTT Students Uniforms to all clinical experiences. (See Dress Code Requirements)
5. Students **are expected to appropriately** identify situations in which the presence of the preceptor/clinical instructor is necessary for student learning and/or patient safety, and to call their preceptor/instructor as necessary.
6. It is recommended that the primary nurse review all medications before a student administers them.
7. No medication will be given unless the student has established the 5 rights of medication administration: Right Patient, Right Time, Right Route, Right Dose, Right Medication. The student must use 2 patient identifiers (Joint Commission requirement) when administering medications, and visibly check armband accuracy
8. Students should refer to facility clinical policy and procedure manuals as part of your practice development and learning.

Unsafe Clinical Performance:

Any act of omission or commission which may result in harm to the patient is considered unsafe clinical practice, and may result in removal from the clinical setting, disciplinary action according to the discretion of the course faculty, a negative clinical evaluation, a course failure, and/or dismissal from the program. During the clinical practicum, unsafe clinical practice is defined as any one of the following:

When the student:

1. Commits repetitive and/or a single, serious medication error.
2. Violates or threatens the physical, psychological, microbiological, chemical, or thermal safety of the patient.
3. Violates previously mastered principles/learning objectives in carrying out nursing care skills and/or delegated medical functions.
4. Assumes inappropriate independence in action or decisions.

5. Does not adhere to current CDC guidelines for infection control.
6. Fails to recognize own limitations, incompetence, and/or legal responsibilities.
7. Fails to accept moral and legal responsibility for his/her own actions thereby violating professional integrity as expressed in the Code for Nurses.
8. Arrives at clinical settings in an impaired condition as determined by the clinical instructor.

Failure to comply with any of the above requirements may result in an unexcused clinical and/or negative clinical evaluation.

10.5

University of Texas at Tyler
Nursing 4632 – Adult Health II
Scoring Criteria for Co-morbidity Case Study

Student Name _____

Due Date _____ Date Submitted _____

Category	Possible Points	Earned Points
Patient Information	10	
Diagnostic Studies	20	
Medications	15	
Assessment	20	
Nursing Care Concept Map	10	
Nursing Plan of Care	25	
Total Points	100	
Overall Comments		

**University of Texas at Tyler
Nursing 4632 – Adult Health II
Scoring Criteria for Co-morbidity Case Study**

Student Name _____

Date _____

Area of Concern	Criteria	Points possible	Points Earned
Clinical Worksheet is to be submitted on time, legible and complete. 2% of total score is deducted for each calendar day that the worksheets are late. If a score of 75% is not achieved, the student will be required to select a new patient and develop a new worksheet.			

Patient Information

Demographic Data			
	Age, gender, and race are indicated		
	Code status: full resuscitation or no resuscitation is indicated		
	Height and weight indicated		
Chief Complaint SWIPE	Chief complaint per patient (essential characteristics) s-start, w-worsens, l-improve, p-pattern, e-evaluate		
Admission diagnosis	List all admitting diagnosis, identify primary diagnosis		
Date of admission	First day of admission to setting indicated by a date		
Surgery	Type and #days post-op		
Allergies	Allergies to medications, foods and another allergens noted in red		
Pain	Scaled pain, designated location, quality, effectiveness of intervention (Report Richmond or BIS scale if sedated)		
Vital Signs	Compared to baseline		
Health History			
Chronic or previous health conditions	List is comprehensive and identified through medical record or interview		
Previous surgeries	Previous surgeries listed, note if any in the past year		
Care prescriptions			
Diet	Diet type/tolerance, supplements, restrictions including tube feedings (include formula, rate, residual, method of adm.)		
Activity	Level of activity, degree of required assistance, restrictions noted		
IV access	Type(s) location(s), rate(s) indicated, placement/rotation due date		
Wound care	Type and frequency indicated, drains indicated		
Pulmonary care	O ₂ , included liter flow, method of administration, pulmonary treatments and medication types. Ventilator settings included		
	Points for Patient Information	10	
Diagnostic Studies			
	If designated study was not performed for this patient during this hospitalization, indicated NP (not performed)		

Lab studies 13 points	Included latest 2 (serial) pertinent laboratory studies, included date patient value, normal values, and a statement regarding why that variance is found, with a reference citation. For all critically ill patients, this includes hematological studies, electrolytes, BUN, creatinine, liver studies, and cardiac enzymes (if appropriate)		
X-ray studies 1 point	Identified x-ray studies performed the date, and the interpretation. Included result of the latest chest x-ray		
Scans / ultrasounds	Identified test performed, date, and results.		
Cardiovascular studies 1 point	Identified test performed, date and interpretation of EKG tracing. Include echocardiograms, Transesophageal electrocardiograms, etc. If patient is continuously monitored, included an interpretation of current rhythm.		
Arterial Blood Gases	Included most recent ABG's, including interpretation		
Cultures/Sensitivity 1 point	Included results of all cultures, compares current medications to those to which the organism is sensitive		
Neurological Studies 2 point	Identified test performed, date, and interpretation. If ICP is monitored, included an interpretation.		
Cardiac rhythm (2 p)	Results and interpretation of 12 lead/continuous monitoring		
	Points for Diagnostic Studies	20	
Medications			
Generic name (1 p)	Generic name of medication identified and spelled correctly		
Brand name (1 p)	The brand name of the medication will be identified		
Classification (1 p)	The specific classification of the medication will be identified		
Expected effects (1p)	The expected effect of the medication is described.		
Source (1 p)	Source of information designated, including page #s.		
Dose (1 p)	Dose prescribed is indicated correctly		
Route (1 p)	Route designated		
Frequency (1 p)	How often, and at what intervals the medication is to be given		
Side effects (1p)	Common side effects & significant adverse effects are listed		
Nursing implications (6 points)	Nursing implications related to the administration of or monitoring of the effects of the medication.		
	Points for Medications	15	

Assessment / Documentation			
Physical Assessment (12 points)	Student assessment of the patient on the day of care, written in a narrative format.		
(2 points)	Braden Pressure Sore Risk Assessment		
(1 points)	Developmental Assessment		
(1 points)	Cultural Assessment		
(1 points)	Spiritual Assessment		
(1 points)	Nutritional Assessment		
(2 points)	Fall assessment		
	Points for Assessment	20	

Comorbidity Interactions			
Comorbidities (2.5 p)	List all patient disease processes present at time of admission and identify primary and secondary medical diagnosis		
Medical diagnosis(2.5)	Primary and secondary medical diagnoses are defined and the pathophysiology is also included.		
Interactions (2.5)	How do these diagnoses interact with each other and complicate the patient's well being (outcome)		
Nursing Care (2.5)	How do these complications affect your care		
	Points for Comorbidity Interactions	10	

Nursing Plan of Care			
Nursing diagnosis (5 points)	Nursing diagnosis, etiology, and symptomatology (a minimum of five) are identified and prioritized using NANDA terminology.		
Expected outcome (5 points)	Outcomes are written for each nursing diagnosis in patient centered, measurable terms. Identified as short term or long-term outcomes. Outcomes meet "SMART" criteria. [S-short; M-measurable; A-attainable, R – realistic, T – timely]		
Nursing Interventions (10 points)	Nursing interventions relate specifically and directly to the outcome and nursing diagnosis. A minimum of five interventions is identified for each nursing diagnosis. Nursing interventions are specific to the particular patient.		
Evaluation (5 points)	Evaluation completed for each outcome, against criteria stated in the expected outcome.		
	Points for Nursing Plan of Care	25	
TOTAL SCORE	Total Score Was paper submitted on time __Yes __No Deduction of 2% per day late	100	

10.6

University of Texas at Tyler
Nursing 4632 – Adult Health II
Evidence Based Practice (EBP) Clinical Presentation

The primary purpose of the EBP clinical presentation is to assist your developing ability to utilize evidence-based research in providing the most appropriate patient care. Each student is to take an active leadership role in coordinating and directing the learning of others in his or her clinical group during the presentation. The clinical instructor will provide each student with a case study. Students will need to develop the case study into a presentation format. In addition, the student must expand the case study by developing one EBP question and will need to include at least two nursing research based or EBP articles to support/refute their EBP question. If a group is assigned to one case study, each student is responsible for developing a separate PICO question and providing two EBP articles.

Grading Criteria for Clinical Presentation

- | | |
|---|-----------------|
| 1. Select 2 EBP (Nursing) articles related to the case study to develop your PICO questions | 10 points _____ |
| 2. Develop PICO question related to the case study | 5 points _____ |

Presentation

- | | |
|---|-----------------|
| 3. Integrate your PICO question into the case study during the presentation | 10 points _____ |
| 4. Creatively engage the audience into answering the case study | 10 points _____ |
| 5. The two research or EBP articles are integrated into the presentation and are used to support/refute your PICO question. | 10 points _____ |
| 6. Based on your research, what are the implications for nursing practice and what would you change? | 10 points _____ |
| 5. Presentation completed within time frame (50 minutes) | 10 points _____ |
| 6. Answers case study questions knowledgeably | 20 points _____ |
| 7. Professional presentation using audiovisual | 10 points _____ |
| 8. Professional dress | 5 points _____ |

Total Points _____

10.7

University of Texas at Tyler
Nursing 4632 – Adult Health II
Scoring criteria for Comparative Analysis Worksheet

Student Name _____ Date _____

The student is to complete the above information and submit this form with the comparative analysis worksheet to the clinical faculty on or before the due date. Student must complete one (1) Comparative worksheet with a minimum grade of 75 on each Worksheet. Highlight correlations between your textbook and patient.

Category	Possible Points	Earned Points
Diagnosis (5 points) and Pathology (5 points)	10	
Signs and symptoms (3 p) Complete Head to toe Patient Assessment; including assistant devices (7 points)	10	
Diagnostic Studies usually Performed (3 p) Patient's studies; including patient results and significance to patient (7 p)	10	
Possible Complications (3) Actual Complications (7)	10	
Textbook Medical Treatment (3 points) Patient Medical Treatment (7 points)	10	
Text Surgical Treatment (2) Patient Surgical Procedures (3 points)	5	
3 part Nursing Diagnosis 1 3 part Nursing Diagnosis 2	10	
Care plan for priority Nursing Diagnosis Smart Goal – 5 points 5+ Interventions – 25 p Evaluation – 5 points	35	
Points Deducted for Late Paper	(10)	
Total		

Appendix A

**THE UNIVERSITY OF TEXAS AT TYLER
 COLLEGE OF NURSING**

CLINICAL EVALUATION TOOL

NURS 4632: Adult Health II Fall _____ Spring _____

Student Name: _____

Clinical behaviors are evaluated throughout the required clinical experience.

1. A score of 2 or 3 must be obtained for successful completion of the clinical objective of the course.
2. A score below 2 will result in a written contract with expected measures to demonstrate improvement. Failure to demonstrate improvement will result in clinical failure and failure of the clinical course.
3. A score of 0 in any behavior at any time may result in failure in the clinical component of the course and failure of the clinical course.

Mastery Level Clinical Skills are skills deemed necessary to accomplish in order to satisfactorily complete the clinical component of the course.

Expected Behavior	Mid-Clinical Evaluation				Final Evaluation				Comments
	3	2	1	0	3	2	1	0	
A. PROVIDER OF CARE									
Assesses adult patients with medical-surgical conditions health status & health needs. Identify actual & potential problems for the adult patient based on assessment data. Formulate an individualized plan of care with appropriate interventions and patient outcomes for the adult patient. Implement nursing actions that are based on current theory & research. Evaluate the effectiveness of nursing interventions in meeting the expected outcomes. Revise the plan of care when the expected outcomes are not met									
1. Assessment Data									
2. Diagnostic Statement									
3. Patient Outcomes									
4. Delivery of Care									
5. Evaluation of Patient Outcomes									
B. COORDINATOR OF CARE									
Coordinate comprehensive care for a minimum of four patients with medical-surgical conditions through collaboration with the individual, family, and other health care providers, utilizing critical decision making & time management skills.									
1. Time Management									
2. Critical Thinking: Clinical decision-making & Clinical Judgment									
C. MEMBER OF THE PROFESSION									

Expected Behavior	3	2	1	0	3	2	1	0	Comments
Demonstrates responsibility and accountability for own actions. Abide by the laws and standards designated by the University of Texas at Tyler College of Nursing, Texas State Board of Nurse Examiners, and the ANA Code of Ethics. Project professional image by adhering to the dress code and meeting the attendance requirements.									
a. Professional character									
1. Accountability/Responsibility									
2. Professional Awareness									
3. Integrity									
4. Advocacy									
5. Moral Conduct									
b. Ethical/Legal Conduct									
1. Confidentiality									
2. Professional Standards									
c. Professional Image									
1. Dress Code									
2. Attendance									
D. COMMUNICATION									
Document in a comprehensive, organized, and clearly stated manner the nursing care delivered. Communicate with the clinical faculty and other health care providers regarding patient status. Establish effective working relationships with clinical faculty, facility personnel, peers, patients, and patient's families									
1. Written Documentation									
2. Verbal Communication									
3. Interpersonal Relationships									
E. SAFETY									
Provide safe care by accurately administering medications in real & simulated situations. Accurately identify safety risks and appropriately intervene to provide a safe patient and family environment. Safety is graded as "2" or "0" only.									
1. Medication administration/simulations									
2. Environmental									
F. MASTERY SKILLS: Skills performed in the clinical area or learning lab are completed following accepted standards of nursing practice.									
Mastery skills will be evaluated on a pass/fail basis					Either preceptor or instructor may evaluate student. Preceptor or instructor is to write date skill performed, and initial, under either "pass" or "fail" below.				
					2	0	Comments		
1. Head-To-Toe Assessment									
2. Focus assessment of the CV system									
3. Focus assessment of neurological system									
4. Score neurologically impaired patient according to Glasgow coma scale									
5. Perform patient teaching									
6. Apply ECG electrodes									
7. Identify life-threatening dysrhythmias									
8. Coordinate care for multiple patients									

MID-CLINICAL

Contract Initiated: Yes No

Demonstrated clinical strengths:

Demonstrated clinical weaknesses

Measures to strengthen clinical performance

Clinical Faculty

Student

Date: _____

FINAL EVALUATION

Demonstrated clinical strengths:

Demonstrated clinical weaknesses:

Measures to strengthen clinical performance:

Clinical Faculty

Student

Date: _____

THE UNIVERSITY OF TEXAS AT TYLER
SCHOOL OF NURSING
CLINICAL EVALUATION CRITERIA
NURS 4632

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
A. PROVIDER OF CARE NURSING PROCESS				
1. Assessment				
Assesses multiple adult patients with complex medical-surgical conditions for health status and health needs	Completes data base with all objective and subjective data of the individual, family, aggregate, and/or community, identifying strengths and weaknesses.	Usually completes data base with all objective and subjective data of individual, family, aggregate, and/or community identifying strengths and weaknesses.	Frequently requires assistance in completing data base with all subjective and objective data of the individual, family, aggregate, and/or community and identifying strengths and weaknesses.	Consistently requires assistance in completing data base with all subjective and objective data of the individual, family, aggregate, and/or community and does not identify strengths and weaknesses.
2. Nursing Diagnosis & Expected Outcomes				
Identify and prioritize actual and potential problems for the adult patient based on assessment data	Formulates and prioritizes appropriate, individualized nursing diagnosis and expected outcomes from assessment data.	Usually formulates and prioritizes appropriate, individualized nursing diagnosis and expected outcomes from assessment data. May require assistance.	Frequently requires assistance in formulating and prioritizing appropriate, individualized nursing diagnosis and expected outcomes from assessment data.	Consistently requires assistance with formulating and prioritizing appropriate, individualized nursing diagnosis and expected outcomes.
3. Planning				
Formulate an individualized plan of care with appropriate interventions and patient outcomes for multiple adult patients	Formulates a plan of care that <u>consistently</u> meets the needs of the individual, family, aggregate, and/or community. Interventions are individualized. Is able to correlate and apply theory to practice.	Formulates a plan of care that <u>adequately</u> meets the needs of the individual, family, aggregate, and/or community. Interventions are usually individualized. Requires guidance in correlating and applying theory to practice.	Frequently requires assistance with formulating a plan of care that meets the needs of the individual, family, aggregate, and/or community. <u>Frequently</u> needs assistance in individualizing interventions. Has difficulty correlating and applying theory to practice.	<u>Consistently</u> requires assistance in formulating a plan of care that meets the needs of the individual, family, aggregate, and/or community. Does not individualize interventions. Cannot correlate or apply theory to practice.

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
<p>4. Implementation Implement nursing actions that are based on current theory and research</p>	<p>Implements planned nursing actions in a safe manner according to nursing principles/theoretical rationales. Previously learned skills performed in organized manner without supervision. Is prepared for new skills utilizing appropriate scientific principles and seeks appropriate supervision.</p>	<p>Implements planned nursing actions in safe manner according to nursing principles/theoretical rationales. Performs previously learned skills in organized manner with <u>minimum</u> supervision and support. Generally is prepared for new skills and seeks appropriate supervision.</p>	<p>Requires <u>direct</u> support and supervision to perform previously learned and new skills in an organized manner. Requires assistance in seeking appropriate supervision and implementing planned nursing actions in a safe manner according to nursing principles/rationales.</p>	<p><u>Consistently</u> requires direct support and supervision to perform previously learned and new skills in an organized manner. <u>Consistently</u> requires assistance in seeking appropriate supervision and implementing planned nursing actions in a safe manner according to nursing principles/rationales.</p>
<p>5. Evaluation Evaluate the effectiveness of nursing interventions in meeting the expected outcomes Revise the plan of care when the expected outcomes are resolved or not met</p>	<p>Evaluates process and outcomes of nursing interventions based upon desired outcomes and patient response. Alters and/or revises plan of care according to outcomes.</p>	<p>Evaluates process and outcomes of nursing interventions based upon desired outcomes and patient response. <u>Needs assistance</u> with altering and/or revising plan of care according to outcomes.</p>	<p><u>Frequently</u> requires assistance evaluating process and outcomes of nursing interventions based upon desired outcomes and patient response. <u>Frequently</u> needs assistance with altering and/or revising plan of care according to outcomes.</p>	<p><u>Consistently</u> requires assistance evaluating process and outcomes of nursing interventions based upon desired outcomes and patient response. Cannot alter and/or revise plan of care according to outcomes.</p>
<p><u>B. COORDINATOR OF CARE</u></p>				
<p>A. Time Management Coordinate comprehensive care for a minimum of four patients with complex alterations in health through</p>	<p>Nursing care is organized and timely to meet the prioritized needs of the IFA and/or C.</p>	<p>Nursing care is organized and timely to meet the prioritized needs of the IFA and/or C. Requires <u>minimal</u> supervision.</p>	<p><u>Frequently</u> requires supervision with time utilization to organize and prioritize needs of the IFA and/or C.</p>	<p>Poor judgment is consistently used in work organization, priority setting, and/or time utilization.</p>

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
collaboration with the individual, family, and other health care providers, utilizing critical decision making and time management skills	Utilizes multidisciplinary resources and individuals, families, aggregates, and/or communities and participates in planning delivery and evaluation of care in a variety of settings.	Utilizes multidisciplinary resources and individuals, families, aggregates, and/or communities and requires <u>minimal</u> supervision when planning delivery and evaluation of care.	Has <u>difficulty</u> identifying multidisciplinary resources and working with individuals, families, aggregates, and/or communities to plan health care delivery.	Cannot identify multidisciplinary resources to plan and coordinate care and has difficulty working with individuals, families, aggregates, and/or communities to plan health care delivery.
B. Critical Thinking	Makes autonomous decisions in providing care, with referral to appropriate resources.	With <u>supervision</u> , is able to make appropriate decisions to provide care and referrals.	<u>Frequently</u> requires supervision to make appropriate decisions to provide care and referrals.	Unable to make decision regarding appropriate care and referrals.
C. MEMBER OF THE PROFESSION a. Professional Character 1. Accountability/ responsibility Demonstrate responsibility and accountability for own actions	Identifies physiological, psychological, socio-cultural strengths and weaknesses when evaluating individual, family, aggregate, and/or community health care needs in a variety of settings.	With <u>minimal</u> supervision identifies physiological, psychological, socio-cultural strengths and weaknesses when evaluating individual, family, aggregate, and/or community health care needs in a variety of settings.	<u>Frequently</u> requires supervision to identify physiological, psychological, socio-cultural strengths and weaknesses when evaluating the individual, family, aggregate, and/or community health care needs in a various settings.	Cannot identify physiological, psychological, socio-cultural strengths and weaknesses when evaluating individual, family, aggregate, and/or community health care needs in a variety of settings.
Assumes accountability and responsibility for quality of nursing care for individuals, families, aggregates, and/or	Assumes accountability and responsibility for quality of nursing care for individuals, families, aggregates, and/or	Assumes accountability and responsibility for quality of nursing care for individuals, families, aggregates, and/or	Fails to assume responsibility for own actions and fails to utilize constructive criticism to enhance clinical	

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
2. Professional awareness	<p>communities according to level of competence and course objectives. Utilizes constructive criticism consistently.</p> <p>Realistically identifies own strengths and weaknesses and independently seeks measures to increase professional growth.</p>	<p>communities according to level of competence and course objectives. <u>Usually</u> utilizes constructive criticism.</p> <p>Requires <u>minimal</u> supervision to realistically identify own strengths and weaknesses and seeks measures to increase professional growth.</p>	<p>performance.</p> <p><u>Frequently</u> requires assistance to identify strengths and weaknesses, or initiate measures for professional growth.</p>	<p><u>Fails to</u> identify own strengths and weaknesses, or initiate measures for professional growth.</p>
3. Integrity	<p>Always reports errors/incidents to clinical faculty and appropriate facility personnel in a timely manner and seeks resolution to the issue/s.</p>		<p><u>Does not</u> report errors/incidents to clinical faculty and appropriate facility personnel in a timely manner or seek resolution to the issue/s.</p>	
4. Advocacy	<p>Consistently functions as an advocate for IFA and/or C within the health care delivery system.</p>	<p><u>Usually</u> functions as an advocate for the IFA and/or C within the health care delivery system.</p>	<p><u>Frequently</u> requires supervision to function as an advocate for the IFA and/or C within the health care delivery system.</p>	<p><u>Does not</u> function as patient advocate.</p>
b. Ethical/legal/moral Conduct		<p>Protects faculty, peers, patient/s, and patient/s family confidentiality in all settings.</p>		<p>Breaches confidentiality</p>
1. Confidentiality		<p>Abides by the laws and</p>		<p>Violates any law or standard</p>
2. Professional Standards				

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
<p>Abides by the laws and standards designated by the University of Texas at Tyler College of Nursing, Texas State Board of Nurse Examiners, and the ANA Code of Ethics</p> <p>c. Professional Image</p> <p>1. Dress code - Project a professional image by adhering to dress code</p> <p>2. Attendance</p>		<p>standards designated by the University of Texas at Tyler, Division of Nursing, Board of Nurse Examiners, and Nursing Code of Ethics.</p> <p>Adheres to the standards of the clinical agency</p> <p>Complies with required clinical dress code in all settings.</p> <p>Always arrives to clinical assignment on time with timely notification of clinical faculty and/or facility if going to be late. Excused absence with prior notification to clinical faculty and clinical facility</p>		<p>designated by the University of Texas at Tyler, Division of Nursing, Board of Nurse Examiners, Nursing Code of Ethics, and/or standards of the clinical agency.</p> <p>Does not comply with required clinical dress code.</p> <p>Unable to meet clinical objectives due to repeated absences and/or tardiness.</p>
<p>D. COMMUNICATION</p> <p>1. Written - Documents in a comprehensive, organized and clearly stated manner the nursing care delivered</p> <p>2. Verbal - Communicate with the</p>	<p>Documentation of care is comprehensive, organized, and clearly stated without errors.</p> <p>Penmanship is legible. Spelling, punctuation, and grammar correct.</p> <p>Updates clinical faculty and/or facility personnel</p>	<p>Documentation of care is <u>generally</u> comprehensive, organized, and clearly stated.</p> <p>Penmanship is legible. <u>Occasional</u> spelling, punctuation, and grammar correct.</p> <p><u>Occasional</u> reminder required to update clinical</p>	<p><u>Frequent</u> assistance required to organize comprehensive, clear documentation.</p> <p>Penmanship is often <u>not</u> legible.</p> <p><u>Frequent</u> spelling, punctuation, and grammar errors made.</p> <p>Consistent reminders to update clinical faculty</p>	<p>Documentation of care is incomplete and not legible. Poor grammar, spelling and punctuation.</p> <p><u>Does not</u> update clinical faculty or facility personnel</p>

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
clinical faculty and other health care providers regarding patient status	regarding patient/s status as required. Gives concise end of shift report to appropriate clinical facility personnel and/or clinical faculty.	faculty and/or facility personnel regarding patient/s status. Gives concise end of shift report to appropriate clinical facility personnel and/or clinical faculty.	and/or facility personnel regarding patient/s status. End of shift report is incomplete and requires cueing from clinical faculty and/or facility personnel.	regarding patient status. End of shift report not done.
3. Interpersonal/ Psychological relationships Establish effective working relationships with clinical faculty, facility personnel, peers, patients and patient's families	Establishes effective working relationships with clinical faculty, facility personnel, peers, patient/s, and patient/s family. Demonstrates insight and understanding of therapeutic behavior/s.	Generally establishes effective working relationships with clinical faculty, facility personnel, peers, patient/s, and patient/s family. Demonstrates insight and understanding of therapeutic behavior/s.	Frequently has problems establishing effective working relationships with clinical faculty, facility personnel, peers, patient/s, and patient/s family. May not recognize therapeutic behavior/s.	Consistently has problems establishing effective working relationships with clinical faculty, facility personnel, peers, patient/s, and patient/s family. Does not recognize therapeutic behavior/s
E. SAFETY 1. Medication Administration/Simulation/Therapeutic Interventions Provide safe care by accurately administering medications in real and simulated situations.		Administers medications utilizing the 5 rights with occasional supporting cues from clinical faculty or designate. Does not put the patient in jeopardy. Knowledgeable of major drug classification, actions, side effects, why patient receiving, and nursing implications of all patient medications.		Continuous support required to administer medications and/or places patient in jeopardy.
2. Environmental Accurately identify safety risks and appropriately intervene to provide a safe		Complies with OSHA guidelines and Universal Precautions. Provides safe patient environment.		Does not comply with OSHA guidelines or Universal Precautions. Does not provide safe patient

EXPECTED BEHAVIOR	3 EXCEEDS EXPECTATION	2 MEETS EXPECTATIONS	1 UNSATISFACTORY	0 UNSAFE
patient and family environment		Anticipates unsafe situations and provides preventive interventions. Seeks guidance from appropriate facility personnel / clinical faculty.		environment or anticipate unsafe situations. Performs interventions without seeking guidance from appropriate facility personnel or clinical faculty.

STUDENT AFFIRMATION FORM

_____ I agree to protect the privacy of faculty, peers, patients, and family members of patients by not inappropriately disclosing confidential information about faculty, peers, patients or their family members that is disclosed to me in my capacity as a University of Texas at Tyler nursing student. In addition, I agree not to inappropriately disclose confidential information about any agency or institution that is disclosed to me in my capacity as a University of Texas at Tyler nursing student. I will adhere to HIPAA guidelines.

_____ I have/will read the syllabus of this nursing course I am taking this semester, and I understand the criteria established for grading my course work. I understand that my average on exams must be 75 or higher in order to attain a passing grade for the course.

_____ I agree that I will conduct myself in a manner that exhibits professional values and in accordance with the American Nurses Association (ANA) Code of Ethics for Nurses, the Texas Nurse Practice Act and UTT's Student Academic Dishonesty Policy.

_____ I will maintain and uphold the academic integrity policy of the College of Nursing and will not condone or participate in any activities of academic dishonesty including, but not limited to, plagiarism, cheating, stealing, or copying another's assigned work.

_____ I will not recreate any items or portions of any exam for my own use, or for use by others during my enrollment in the College of Nursing

_____ I will not accept or access any unauthorized information related to any exam administered during my enrollment in the College of Nursing.

_____ I will sign only my own papers and other documents and will not sign any other student's name to anything, including class rolls.

_____ I will not allow any other student access to any of my paperwork for the purpose of copying.

Student's Signature

Date

Student's Printed Name

____ NURSE 4632 ____
Course

Revised: Fall 2000; May 2004, Summer 2005

AUDIO/VIDEO-RECORDING AGREEMENT

I have been given permission to record the following class, NURS _____.

I understand that, the recordings are for my personal studies only. I realize that lectures recorded may not be shared with other people without the written consent of the faculty member. I also understand that recorded lectures may not be used in any way against the faculty member, other lecturer, or students whose classroom comments are recorded as part of the class activity.

I am aware that the information contained in the recorded lectures is protected under federal copyright laws and may not be published or quoted without the expressed consent of the lecturer and without giving proper identity and credit to the lecturer. I agree to abide by these guidelines with regard to any lectures I record while enrolled as a student at The University of Texas at Tyler.

Due to the confidential nature of some course content, I agree to provide written documentation of the erasure of any recordings made during the current semester. Failure to return this written documentation to the faculty by the date of the final examination will result in a grade of "I" (Incomplete).

Print Name

Date

Signature of Student

NURS _____
Course Number

I have erased all recordings made during this current semester in NURS _____.

Signature of Student

Date

(Revised with permission from TCU
Approved FO: 10/06)