SUPPLEMENTARY MATERIALS

INDEX

Pediatric Simulation

Simulation 1

1. Complete Respiratory case study as assigned.
2. Complete Pain Scales worksheet and quiz as assigned.
3. Review Infant and Pediatric CPR.
4. Review and practice using SBAR with practitioner in simulation.
5. Discuss various respiratory medications and selected pediatric respiratory conditions.
6. Discuss various airways used in pediatrics (nasal and oral).

Simulation 2

1. Complete GI case study as assigned.
2. Review and define hypovolemic shock (risk factors, identification, and treatment).
3. Review Infant and Pediatric choking.
4. Discuss various types of shock most commonly seen in pediatrics.
5. Practice SBAR with practitioner in simulation.
6. Calculate the minimum 24-hour fluid requirement for pediatric patients under 70 kg.

Simulation 3

1. Complete a Cardiac case study as assigned.
2. View video over congenital cardiac condition in pediatrics and mock code.
3. Practice CPR and introduce PALS in simulation setting with cardiac conditions.
4. Practice SBAR with practitioner in simulation.
5. Identify various cardiac rhythm strips.
6. Discuss various medications and administration methods used in the pediatric code setting.

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 3805 – Practicum in Nursing II
Pediatric Pre Clinical Worksheet

1. Read Chapters 34, 40 and 41.
2. Familiarize self with current immunization recommendations - Print and attach: http://www.cdc.gov/vaccines/recs/schedules/downloads/child/0-18yrs-pocket-pr.pdf
3. Create vital sign references for normal temperature (rectal vs axillary), heart rate, respiratory rate and blood pressure in children for the following age groups: Newborn, < 2years, 2-6 years, 6-10 years, and 10+ years.
4. Review how to take a temperature with oral, rectal, and axillary thermometers.
5. List and describe Erikson's psychosocial stages through adolescence.
6. Define the role of play therapy. Give appropriate examples of play for the hospitalized child for each of the age groups: (Infant, Toddler, Pre-school & School-age)
7. Develop communication skills with children of varying ages: You are administering a flu vaccination. How do you communicate this to an infant? A toddler? A preschooler? A school-age child? An adolescent?
8. Pain Scales: Print off a copy of following pain scales – FLACC, FACES, COMFORT and 0-10.

9. Explain why the following labs are done for patients in an icu setting. Include how they are drawn and a short definition.

Rsv, flu, MRSA, PCR, electrolytes, ABG, VBG, CBG, blood cultures, bronchial alveolar lavage and CBC.

MEDICATIONS FOR PEDIATRIC ROTATION

The following list includes some commonly prescribed pediatric medications. The student is required to prepare a completed medication sheet before their first day of pediatric practicum and maintain throughout the clinical rotation. Include the various routes to be given. Most common reason(s) medicine is given in pediatrics. Most common side effects. List any important implications for this medicine.

Acetaminophen
Albuterol
Ampicillin
Ancef
Ativan
Claforan
Ibuprofen

Gentamycin
Methadone
Morphine
Prelone Syrup/Prednisone Tabs
Pulmicort
Rocephin
Singulair
Solu-Medrol
Tobramycin
Vancomycin
Xopenex
Zantac
Zithromax

Important Pediatric Measurement Conversions:

5cc = 1 teaspoon
3 tsp = 1 tablespoon
15 cc = 1 tablespoon

30 cc = 1 ounce
1 kg = 2.2 pounds
2.5 cm = 1 inch
1 mcg = 0.001mg
1mL = 1cc
1 gram = 1cc

Pediatric Dosage Calculation EXAMPLE:

Amoxil 40mg/kg/day divided TID
The patient weighs 15 kg.
This drug comes in the concentration of 250mg/5cc.
How many mg per dose? How many cc's per dose?
40 mg x 15 kg = 600 mg per day
600 mg ÷ 3 = 200 mg per dose
200 mg ÷ 250 mg = 0.8 mg
0.8 mg x 5 cc = 4 cc per dose

Student Name:_____
Clinical Unit_____

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 3805 – Practicum in Nursing II
Pediatric Clinical Paperwork

Patient Initials: _____ Age: _____Male or Female

Allergy & Reactions: _____ □NKA

Medical Diagnose(s) for this hospitalization: _____

Chronic Illness: _____□ N/A

Event(s) that brought patient to the hospital:

Birth History IF <2 years of age:

What is the expected outcome for this patient long term?

List all procedures this patient has had since admission (List most current for long term patients)

WEIGHT	KG	% Growth Chart
HEAD CIRCUMFERENCE <2yo		% Growth Chart
HEIGHT/LENGTH		% Growth Chart

NUTRITION

WHAT TYPE OF NUTRITION OR DIET IS THE PATIENT RECEIVING? BE SPECIFIC – FEEDING SCHEDULE, TYPE OF FORMULA, ROUTE, RATE… IF NOT RECEIVING FEEDS WHAT OTHER NUTRITION IS THE PATIENT RECEIVING?

INTAKE & OUTPUT

24 Hour Fluid Requirement: SHOW YOUR MATH: 100cc FIRST 10kg 50cc NEXT 10kg 20cc REMAINDER OF WT kg □ N/A if >70kg	What is the hourly and shift fluid requirement?
What was your patient's total shift intake? _____cc	Was the intake adequate? □ YES □ NO Rationale: If inadequate
Type of IV Fluid: _____@ _____ hour □ N/A if not IV fluids.	Why is the patient receiving IV fluids? □No IV □Saline Lock
24 Hour Output Requirement & Shift Total (1cc/kg/hour) □ N/A if > 30cc/hour	Was the output adequate? □ YES □ NO Rationale: If inadequate

VITAL SIGNS

VITAL SIGNS	MORNING	AFTERNOON	INTERPRET	NURSING INTERVENTIONS
Temperature			**NORMAL HIGH LOW**	
Pulse			**NORMAL HIGH LOW**	
Respiration			**NORMAL HIGH LOW**	
Blood Pressure			**NORMAL HIGH LOW**	
Oxygen Saturation			**NORMAL HIGH LOW**	

PAIN

CIRCLE Pain Scale Utilized: 0-10 FLACC FACES COMFORT OTHER: _____

Pain Score: _____

Interventions (What would be used if no pain?)_____

Effectiveness: _____ □N/A

FAMILY

Who cares for the child? And who is at the bedside? Who else lives with this family?

_____

Do you observe any abnormal family interaction? □YES □NO

EXPLAIN: _____

INTERVENTIONS NECESSARY: _____

TEACHING

What did you teach the child or family today? What teaching could be done if not?

PLAY THERAPY

What type of play did you initiate or observe? What toys were used?

What play would be appropriate for age/medical condition?

LAB & DIAGNOSTIC TESTING

IDENTIFY THE LAB OR DIAGNOSTIC TEST	WHY WAS IT ORDERED?	IDENTIFY ABNORMAL RESULTS & CAUSE	NURSING INTERVENTIONS

MEDICATIONS

BRAND & GENERIC NAME & DRUG DOSE	DOSAGE + ROUTE	WHY IS DRUG PRESCRIBED	RECOMMENDED DOSAGE	WEIGHT BASED (MG/KG) DOSAGE CALCULATION (SHOW YOUR MATH)	SAFE Y OR N	MAJOR SIDE EFFECTS
BRAND GENERIC CLASS						
BRAND GENERIC CLASS						
BRAND GENERIC CLASS						

Weight: _____kg

MEDICATIONS

BRAND & GENERIC NAME & DRUG DOSE	DOSAGE + ROUTE	WHY IS DRUG PRESCRIBED	RECOMMENDED DOSAGE	WEIGHT BASED (MG/KG) DOSAGE CALCULATION (SHOW YOUR MATH)	SAFE Y OR N	MAJOR SIDE EFFECTS
BRAND GENERIC CLASS						
BRAND GENERIC CLASS						
BRAND						

Wt _____Kg

CRITICAL THINKING

1. During your first interaction with the child/family, what did you notice (odors/smell, general appearance, location and position of child, family & visitor interaction, equipment in room)? What were your initial thoughts about the child and family? What emotions did you feel? What came to mind?
2. What things are connected to or inserted in your patient? Make a list of all dressings, tubes, lines, monitors, and equipment that are being utilized for patient care. For each item, list separately and explain: (If in ICU setting, address central lines, chest tubes and feeding tubes only)
    a. Purpose of item?
    b. How you know the item is accomplishing its intended result?
    c. What about the item or patient should be reported to the instructor and staff, why, & how soon?
3. What interventions did you implement for your patient/family? Include a rationale for each intervention.
4. Were your interventions effective? Explain. What other interventions could have been implemented?
5. In your opinion, what did you do well today? What do you need to improve upon? How could your clinical day be improved?

ARKANSAS TECH UNIVERSITY
Department of Nursing
NUR 3805 – Practicum in Nursing II
Obstetrical Clinical Worksheet

1. You will be assigned to all three areas usually on different clinical days (L &D, Nursery, & postpartum) during your rotation.

2. Please complete the following prep work before your OB rotation starts

- **a. Prep for Newborn Nursery**
- **b. Prep for Labor/Postpartum Patient**
- **c. Normal/Abnormal Column of Newborn Assessment**
- **d. EFM Worksheet *areas**

Bring ALL of your prep work with you to EVERY clinical day.

3. You will complete

- **a. One Nursing Care Plan during your rotation (NO PAIN or INFECTION).**
- **b. Newborn Assessment Findings Column**
- **c. Postpartum Assessment (preferably for postpartum patient, but may be on labor/delivery patient)**
- **d. Complete EFM worksheet**

4. Please also bring your gestational age assessment sheet provided in class to clinical.

5. Be prepared to answer questions related to your prep work as well as your suggested medication list.

6. You will have 2 quizzes and 2 articles due during this rotation.

7. Please turn in your completed prep and post clinical paperwork online.

POSTPARTUM ASSESSMENT

Student Name:_____

IDENTIFYING DATA Date:_____ Pt initials: _____

Age: _____ Race: _____

Allergies:_____

Occupation: _____ Medical Diagnosis:_____

Delivery Type:_____

Gravida: _____Para: _____ Abortions: _____

Term: _____ Preterm: _____Living: _____

Complications (maternal/fetal): _____

Prepregnancy wt: _____ Pregnancy wt: _____

Height: _____

ASSESSMENT

General Appearance: _____

Skin/Hair: _____

Respirations: Rate_____

Breath Sounds and effort: _____

Smoker: Y/N Pk/day: _____ No. of years _____

Hx of Drug Use: Y/N Current Drug Use: Y/N Positive drug screen for:_____

Temperature _____

B/P: _____ Pulse: _____ Regular/Irregular

Heart Sounds: _____

Peripheral Pulses (1-4+): Radial:_____ Dorsalis pedis: _____

Edema(grade/location):_____

Skin turgor: _____ Mucous membranes: _____

Nausea/Vomiting: _____

Prescribed diet: _____ Food restrictions: _____

Current IV solution and rate: _____

24 hour I and O (if ordered/has IV/ or PIH): Input_____ Output_____

Meal %: _____ Last bowel movement: _____

Bowel sounds: _____ Hemorrhoids: Y/N

Difficulty voiding: Y/N Bladder palpable: Y/N Foley catheter: Y/N

Estimated Blood Loss: _____

PAIN/COMFORT

Location: _____Quality: _____Duration: _____

Precipitating factors: _____ Guarding: _____ Facial Grimace: _____

Pain Scale: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

NEUROSENSORY

Hearing Aid: _____ Glasses: _____Contacts: _____

Headaches: Location: _____ Frequency: _____

Seizures: _____ Reflexes: _____

Epigastric pain:_____

Lab:

Hgb&Hct: Pre Delivery_____ Post Delivery: _____

WBC_____ Platelets_____ Blood Type: _____

If mother Blood type O or Rh-: Baby's Blood Type _____Coombs: _____

HIV: _____ Hep. B: _____ Group B Strep: _____

Rubella Titer: _____ VDRL/Syphillis: _____

Urinalysis if ordered:_____

Feeding: Breast or Bottle Feeding

If breastfeeding, complete the following – poor, fair, well

Bra: _____Nipples (shape, condition): _____

Latching on: _____Any referral to Lactation specialist_____

UTERUS

Fundus: Consistency:_____ Height:_____Position:_____

Lochia: Color:_____ Amount:_____ Clots:_____

Episiotomy/Lacerations: Type_____ Swelling_____ Redness/or drainage: _____

Surgical incision: Appearance:_____

Type: _____ Dressing: _____

MENSTRUAL HISTORY

Frequency: _____ Duration: _____

Amount: _____LMP: _____

Pap smear: _____Contraceptive Plan: _____

Pregnancy planned (Y/N) Marital Status: _____

Living With: _____ Financial Concerns: _____

Extended family/other support: _____

Religion: _____ Cultural Factors: _____

Report stress factors: _____

Verbal/nonverbal communication with family/significant other:

_____

Hx of Postpartum Depression: Y/N Patient Demeanor:_____

Bonding behavior (including father): _____

MEDICATIONS (**List all routine and prn meds given)**

Drug name/mg How prescribed Purpose

_____

_____

_____

_____

___

TEACHING/LEARNING

Educational background (mother/father): _____

Previous childbirth experience: _____

In Hospital/Discharge Teaching(by you or your nurse)

_____

_____

_____

Obstetrical Simulation

***Submit pre-simulation in Blackboard where indicated prior to your scheduled time.**

***Post simulation work should be submitted in Blackboard within one week.**

Simulation 1

Pre-Simulation

1. Watch Postpartum Assessment YouTube videos and Gestation Assessment Videos on Blackboard under NUR 3805
2. Review Postpartum BUBBLE He sheet provided in class

Post-Simulation

*3. Describe the proper nursing assessment techniques utilized during the first 24 hours using BUBBLE HE for vaginal and caesarean section.

*4. Define Fundus and discuss techniques and deviations to assess.

a. Discuss Involution and expected progression.

b. Define Lochia and discuss stages?

Simulation 2

Pre-Simulation

1. Complete asterisk* areas on Fetal Heart Monitor Strip Worksheet if you have not done so already for clinical.

*2. Discuss Spinal versus Epidural for a C-section. Discuss nursing interventions for a patient undergoing a cesarean section.

Post-Simulation

*3. Discuss pre and post-op teaching related to the patient undergoing a cesarean section.

*4. Discuss the nursing care related to the patient undergoing elective induction.

Simulation 3

Pre-Simulation

* 1. Discuss nursing interventions related to Pregnancy Induced Hypertension.

*2. Discuss nursing assessments and interventions for Post-Partum hemorrhage

Post-Simulation

3. Complete a care plan with your clinical group for Pregnancy Induced Hypertension and Post-Partum hemorrhage. (Turn in to Mrs. Maggard.)

NURSING CARE PLAN

DATE	NURSING DIAGNOSIS	PLAN (Outcome)	IMPLEMENTATION	RATIONALE	EVALUATION

The student is expected to maintain a drug card, or mark in drug book, on each of the medications ordered for their assigned client. It is the responsibility of the student to know and understand the drugs. The following lists are some of the common drugs used.

DRUGS		
Nursery Meds	**Post-partam/Labor & Delivery Meds**	**Post-partam/Labor & Delivery Meds**
* Aquamephyton/Phytonadione (Vit K)	Alka-Seltzer Gold	* MMR
* Erythromycin ointment	* Anaprox DS/Anaprox (Naproxen)	Morphine
* Hep B	Benadryl (Diphenhydramine)	* Penicillin G
Narcan (Naloxone)	Ancef (Cefazolin)	Docusate Sodium
	Brethine (Terbutaline)	* Phenergan
	* Calcium Gluconate	*Pitocin(Oxytocin)
	Misoprostol	* Reglan (Metaclopramide)
	Methergine (Methylergonovine)	* Rhogam
	Hemabate (Carboprost Tromethamine)	Stadol
	*Ephedrine	Hydrocodone
	Dulcolax (Bisacodyl)	Oxycodone
	FESO4	Xylocaine
	Procardia Nifedipine	Zofran
	Labetalol	*TDAP
	*Magnesium Sulfate	Dilaudid
	Dinoprostone	*Fentanyl
		Bupivacaine

The above medications with an asterisk (*) should be reviewed in detail. Expect to administer and verbalize drug information to instructor. You will be giving these medications more frequently.

PREP FORM FOR NEWBORN NURSERY

1.	**Discuss the risk for heat loss in the newborn and what nursing interventions are used to prevent them.**
2.	**Discuss the pathophysiology in terms a parent would understand. Also discuss the different types(physiologic and pathologic)/causes of jaundice and treatment. Discuss warning signs of jaundice and risks.**
3.	**Discuss elimination patterns of the newborn (voiding and stooling). Also discuss the difference in stooling between breast vs. bottle feeding.**
4.	**Complete the clinical significance for the assessment of the newborn including normals and abnormals. (PRIOR TO CLINICAL)**
5.	**Describe the process of assigning APGARS at birth including the five criteria of assessment.**
6.	**Summarize the indication and use of Vitamin K, Hepatitis B, and Erythromycin. (Including site of administration and proper equipment)** **(Discuss why the infant needs vitamin K and Erythromycin)**
7.	**Discuss CCHD(Critical Congenital Heart Disease), how to screen for it, and findings in the newborn.**
8.	**Discuss hypoglycemia criteria and treatment in the newborn.**
9.	**Discuss feeding methods and timing in the newborn. (breast, bottle, gavage)**
10.	**Discuss common skin conditions found in the newborn.**

Be prepared to answer questions, verbally or by quiz, during the clinical day.

LABOR/POSTPARTUM PATIENT

The information should be written on additional pages.

1. **Discuss a postpartum assessment for a vaginal and a cesarean section patient (including fundus, lochia, bladder…)**

2. **Complete asterisk* areas on Electronic Fetal Monitoring(EFM) Worksheet. Be ready to discuss early, variable, and later decelerations in clinical.**

3. **List normals in the following statistics:**

Blood pressure: **Temp:**

Pulse:

Fetal heart rate:

Respirations:

4. **Be able to define terms: Presentation, position, dilation, station, effacement, contraction, duration, frequency , intensity and variability.**

5. **Discuss the different types of anesthesia (spinal, epidural, general) and analgesia (IV narcotics) during labor and possible effects to mother and/or baby.**

6. **Discuss breast care for the lactating and non-lactating mother.**

7. **Discuss pitocin for induction vs. use during the recovery period. Discuss Magnesium Sulfate for the pre-eclamptic pt vs. the preterm patient. Discuss assessment and risk factors for both pitocin (oxytocin) and magnesium sulfate. Identify the antidote for magnesium sulfate toxicity**

8. **Discuss the risks for pre-term labor, the current means for identifying patients at risk, and the identification and protocols for group B strep.**

9. **Discuss the use of MMR and TDAP vaccines in the Prenatal or Postpartum period. Also discuss the indications, dosing, and administration of Rhogam. (Discuss appropriate sites and needle size and length.)**

10. **Discuss the care of the episiotomy site, including comfort measures.**

Be prepared to answer questions, verbally or by quiz, during the clinical day.

WORKSHEET
Electronic Fetal Monitoring (EFM)

Patient Initials:	**Date**

1. Fetal Heart Rate - Beats per minute?

Check one of the following: Indicate criteria for all.

_____Tachycardia *Criteria:

_____Average *Criteria:

_____Bradycardia *Criteria:

2. What is the baseline variability? What is the significance of reading? *

_____Absent variability: 0 to 2 bpm.

_____Minimal variability: 3 to 5 bpm.

_____Average/Moderate: 6 to 25 bpm.

_____Marked: greater than 25 bpm.

3. Are there any periodic changes in the FHR?

_____Accelerations

_____Early deceleration -- Usual cause : *

_____Late deceleration -- Usual cause: *

_____Variable Deceleration -- Usual cause: *

4. Looking at uterine contractions, determine the following:

USE ADDITIONAL PAGES

_____Frequency: Define term: *

_____Duration: Define: *

5. * Nursing interventions utilized for all 3 types of decelerations.

USE ADDITIONAL PAGES

6. Summarize the significance of your patient's strip.

USE ADDITIONAL PAGES

*** Please complete the above noted areas prior to clinicals**

ASSESSMENT OF THE NEWBORN

Patient's INITIALS:		**DATE:**
IDENTIFICATION PLACEMENT:		
DELIVERY DATE:	**EDC:**	**APGAR: (1 m) (5 m)**
METHOD OF DELIVERY:		**Est. Gest. Age:**

	FINDING(Avoid the word normal)	**CLINICAL SIGNIFICANCE ***
Weight		
Length		
Posture		
Head Circumference		
Chest Circumference		
Temperature		
Resp:Rate, Quality & Effort		
Heart-rate murmurs		
Sucking, rooting, palate		

*** Discuss normals and abnormals. <u>Have this column prepared prior to nursery day</u>.**

NEWBORN ASSESSMENT
(continued)

ITEM	FINDING	CLINICAL SIGNIFICANCE *
Eyes/Ears		
Moro		
Skin: **Color**		
Birthmarks		
Lanugo		
Head **Fortanelles** **Size/Shape**		
Pulses (Brachial/Femoral)		
Umbilicus		
Genitals		
Plantar creases **Reflexes:** **Grasp** **Plantar** **Babinski**		

SAME DAY SURGERY PREP SHEET

1. Review Chapter 18, 19, 20 in Brunner & Suddarth

2. Prepare drug cards or list for:

- **a. Alka Setzer Gold**
- **b. Zantac**
- **c. Versed Syrup**
- **d. Valium**
- **e. Zofran**
- **f. Reglan**
- **g. Atropine**
- **h. Chloral Hydrate**
- **i. Phenergan**
- **j. Lovenox**

Include action, major side effects, and reason given to surgical patients.

List references used

3. Prepare a pre and postoperative teaching plan for a child undergoing a tonsillectomy. All interventions must have a referenced rationale. Information can be found in Brunner & Suddarth, London & Ladewig and on-line.

You must use APA format for listing sources and references.

4. Calculate the preoperative medication for a child weighing 22 lbs.

PAM 0.5 ml per kilogram
available premixed in 10 ml syringe

Atropine 0.01 mg per kilogram
available in 0.4 mg/ml vial

5. Include discharge teaching for four patients, the discharge teaching must have have rationales that are referenced. Briefly discuss procedure and patient history rationales that are referenced. Briefly discuss procedure and patient history and instructions for self care at home.

6. Include a log for each day of clinical.

Diagnostic Recovery Paperwork

1. Prior to your **first day in Diagnostic Recovery** (DR), prepare a written drug list for:
    a. Versed (midazolam)
    b. Fentanyl (sublimaze)
    c. Demerol (meperidine)
    d. Robinul (glycopyrrolate)
    e. Valium (diazepam)
    f. Plavix (clopidogrel)
    g. Decadron / Hexadrol (dexamethasone)
    h. Benadryl (diphenhydramine)
    i. Narcan (naloxone)
    j. Romazicon (flumazenil)
    k. Aspirin (acetylsalicylic acid)

2. Review how to place a peripheral IV and a foley catheter. You will start several IVs and may be required to place a foley in DR. Be prepared to answer questions prior to being allowed to perform these procedures.

3. Look up the Aldrete (or modified Aldrete) score. Be familiar with its purpose.

4. **Start working on the following teaching plans prior to first clinical day in DR.** You will fine tune these during DR clinical time. Turn completed plans in on Monday (by 0830) after **last clinical day in DR**:
    a. Prepare a pre- and post-procedure teaching plan for a patient undergoing a colonoscopy.
    b. Prepare a pre- and post-procedure plan for a patient undergoing a cardiac catheterization for shortness of breath, chest pain, and abnormal ECG.

5. Review and be able to discuss administration of packed red blood cells (PRBC) during clinicals. **Include the following in your written paperwork to be turned in after clinical rotation**:
    a. Explain what labs should be drawn prior to administration of PRBCs.
    b. Most patients who are going to receive blood products are also given diphenhydramine and/or dexamethasone IV prior to administration. Please give a brief explanation as to why these drugs are given.
    c. Describe signs and symptoms of a transfusion reaction and what you as a nurse would need to do if this were to happen to your patient. What is the absolute most important thing to do if a reaction is suspected?

6. Cardiac cath patients have the following labs drawn prior to their procedure: CBC, BMP (basic metabolic panel), lipids, PT/PTT with INR. Give a brief explanation of what you think they are looking for in these labs and why they are important. Also, why is it important to do an ECG prior to a cardiac cath? **Include this information with the teaching plans and transfusion information listed above.**

7. **During clinicals,** explore how to write an RN note for recovery following a GI procedure (these are done on paper, not on the computer, at St. Mary's).

***Prep work must be completed and turned in the morning of your first day in DR! Failure to bring completed prep work may result in you being sent home from clinicals.**

ARKANSAS T ECH UNIVERSITY
Department of Nursing
Evidence Based Family Paper Agreement

NOTE: Agreement due to Assigned Faculty member on or before assigned date.

You May Not Use a Family Member or Another Nursing Student's Family.

Name of Student_____Assigned Faculty Member_____

Name of Male Head of Household_____

Name of Female Head of Household_____

Street Address_____Apt. No._____

City, State, Zip Code_____

Telephone Numbers_____Best Time to Call_____

In the table below, list the names of all persons living in this household, their ages, and relationship to the Head(s) of the household. If additional space is needed, use the back of this form.

Name of Each Individual Living in Household	Age	Relationship to Head(s) of Household

Head(s) of Household, please read the following statement and sign below:

I/We agree to allow the Arkansas Tech University Nursing Student named above to visit us in our home for the purpose of meeting his/her educational objectives in the Nursing Program at Arkansas Tech University. We understand that the student will be interviewing us and may carry out teaching programs and/or other nursing actions provided that we give consent. We understand that the information we provide the student will be kept confidential and will be handled in a professional manner. We understand that we may refuse any teaching or other nursing care at any time. We understand that the student will be visiting us in our home from four to six times over the period of the next several weeks. We understand that this agreement will be terminated the last scheduled visit, or when requested, whichever comes first.

I/We agree to the above statement_____Date_____
_____Date_____
I agree to the above statement_____(Student)Date_____

ARKANSAS TECH UNIVERSITY

NUR 3805 Practicum in Nursing II

Evidence Based Family Paper

Objective:

1. Utilize the nursing process to plan and deliver care to individuals and families.
2. Practice the role of caregiver, communicator, collaborator and teacher in the delivery of holistic care to a family unit.
3. Utilize current evidence based literature to assist families in making positive lifestyle changes.

Selecting a Family:

Seek help from family, friends, church and/or community members to locate a suitable family. The selected family needs to include either children and/or a pregnant family member. Family members, friends, or classmates' families may not be used.

Number of Visits:

The student will visit the family from 4 to 6 times in person.

Written Requirements:

The student will submit a written comprehensive professional paper of between 5 and 8 pages (not including title and reference pages). Current APA guidelines must be followed.

Process:

After selecting a family to use for the paper, the student should:

- Contact the family to schedule the initial visit and obtain a signed "*Family Paper Agreement Contract.*"
- The "*Family Visit Log"* should be initiated on the first visit and updated after each visit throughout the project.
- Initiate the "*Family Assessment*" to determine the needs of the family. Complete the assessment and submit the assessment guide by the due date. Your assessment will determine your planning and intervention for each subsequent visit.
- Identify THREE priority needs for the family from your completed family assessment. These are not nursing diagnoses.
- Utilize journal articles and reputable internet sources (government guidelines, etc.) to gather **evidence-based educational materials** to address the family's priority needs. You will utilize these materials during each planned family visit. Teaching must be based on evidence (evidence based practice). You may use your textbook only for introductory support.
- Evaluate the effectiveness of the intervention for each priority need (three required).
- Terminate the relationship on the last visit and ensure that the family has appropriate referrals in place.
- Complete your family paper by submitting an electronic copy online within the Blackboard practicum course, a paper copy to your instructor along with a grade sheet and copy of teaching materials provided to family.

Arkansas Tech University
Department of Nursing
Evidence Based Family Paper - Level II

Student: _____ Grade: _____

Instructor: _____

Evaluation: (Total Possible Points - 100%)	POINTS
Introduction and Conclusion (5%) Describe family type, purpose and organization of paper. No abstract is necessary.	___ points
Family Visit Log (10%) Detailed description of each visit & plan for future visits (see form)	___ points
Family Assessment Guide (20%) Completed assessment form. Student will make revisions based on instructor comments.	___ points
F**amily summary and identification of three priority needs (15%)** Summarize family assessment and identify three priority needs with supportive evidence.	___ points
Intervention using evidence-based practice and education (25%) Identify interventions for each need utilizing evidence based-practice and education reference materials appropriately in the document and provide a copy of all teaching materials - Must use reputable sources.	___ points
Evaluation and Adaptations (20%) What worked, what didn't, any adaptations made, and why.	___ points
APA Format, Grammar and Spelling (5%)	___ points
Total	___ points

FAMILY VISIT LOG (Make copies- will be longer than one page)

Visit# and Date	**Detailed summary of visit:** What was the purpose of this visit? Did you use any teaching materials? What did/didn't you accomplish (evaluation)? Any adaptation necessary?	**Detailed plan and date for future visit(s)**