Stephen F. Austin State University
DeWitt School of Nursing
NURSING CARE OF WOMEN AND CHILDREN II
Course Number: NUR 407
Section Number(s): 001 - 006
Clinical Section(s): 010 – 017
Spring 2019
Course Instructors
Ms. Sheree Barrios, MSN, RN, WHNP-BC
Ms. Shelley Hunt, MSN, RN
Ms. Katy Trotty, MSN, RN, CLC

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IN THE CASE OF COMMISSION, OMISSION, AMBIGUITY, VAGUENESS, OR CONFLICT, THE POLICIES AND PROCEDURES OF THE SCHOOL OF NURSING SHALL CONTROL.

EACH STUDENT SHALL BE RESPONSIBLE FOR ACTUAL AND/OR CONSTRUCTIVE KNOWLEDGE OF THE POLICIES AND PROCEDURES OF THE SCHOOL OF NURSING AND FOR COMPLIANCE THEREWITH.

THE STUDENT IS RESPONSIBLE FOR ALL INFORMATION IN THIS SYLLABUS.

This syllabus is provided for information purposes only.
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Class meeting time and place: See Course Calendar for time and location.

Required Textbooks and Materials
vSim Access if you didn’t purchase in 2nd semester

Recommended:
HESI Review Book
Any Drug Book

Course Description
Four semester hours, two hours didactic and six hours clinical practicum. Course builds upon Women and Children I and previous, concurrent and prerequisite courses. Emphasis on critical thinking, nursing theory, research and practice with clients from birth to adolescence, and women and their families in the intrapartum and postpartum periods. Acute and complex health needs will be explored. Care of the high-risk family, labor, birth, and role of the nurse and teaching are highlighted.
**Unabridged Course Description**
This course builds upon Women and Children I and previous, concurrent, and prerequisite courses. This course provides students the opportunity for critical thinking and the acquisition and application of nursing theory, research, and practice with clients from birth to adolescence, and women and their families in the intrapartum and postpartum periods. Acute and complex health needs of the perinatal period, neonates, and children will be explored. Issues related to care of the high risk family, as well as those experiencing uncomplicated labor and birth, will be discussed. The role of the nurse as an integral part of the interdisciplinary health care team and the rich opportunities for client and family teaching are highlighted. Students will utilize the nursing process when providing holistic care of women, children, and their families of diverse spiritual, ethnocultural, and socioeconomic backgrounds.

**Number of Credit Hours**
4 semester hours (2 hours didactic; 6 hours clinical practicum)

**Prerequisites and Co-requisites**
**Prerequisites:** NUR 330, NUR 331, NUR 332  
**Co-requisites:** NUR 406, NUR 408

**Placement Rationale**
First Semester Senior Year  
Builds on previous nursing courses

**Credit Hour Distribution**
4 credit hours (2 lecture/6 clinical practicum)

**Program Learning Outcomes**
Graduates of the program will:
1. Apply knowledge of the physical, social, and behavioral sciences in the provision of nursing care based on theory and evidence based practice.
2. Deliver nursing care within an established legal and ethical parameters in collaboration with clients and members of the interdisciplinary health care team
3. Provide holistic nursing care to clients while respecting individual and cultural diversity.
4. Demonstrate effective leadership that fosters independent thinking, use of informatics, and collaborative communication in the management of nursing care.
5. Assume responsibility and accountability for quality improvement and delivery of safe and effective nursing care.
6. Serve as an advocate for clients and for the profession of nursing.
7. Demonstrate continuing competence, growth, and development in the profession of nursing.

**General Education Core Curriculum Objectives/Outcomes**
None

**Student Learning Outcomes**
The student will
1. Relate concepts and principles of the arts, sciences, humanities, and nursing as a
source for making nursing practice decisions with clients and families.

2. Demonstrate responsibility and accountability using consistent behavior patterns and professional communication.

3. Evaluate research for applicability of findings to nursing practice of women and children with complex health needs.

4. Incorporate the nursing process as a template to formulate and implement individualized plans of care for clients and families.

5. Incorporate moral, ethical, economic, and legal issues in provision of nursing care to clients and families.

6. Assess the relationship between growth and development and other health issues.

7. Collaborate with families experiencing health stressors surrounding acute and complex needs of women and children as well as the normal processes of labor, birth, and the postpartum period.

8. Relate risks, health seeking behaviors, pharmacology, family situations, morbidity and mortality, and end of life issues to neonates, children, adolescents, and women with complex health needs.

9. Implement developmentally appropriate teaching strategies for women and children.

10. Collaborate with the interdisciplinary healthcare team respecting holistic, socio-economic, spiritual, and ethno-culturally diverse characteristics of women, children, and families with complex health needs.

Differentiated Essential Competencies (DEC’s)
The Richard and Lucille DeWitt School of Nursing prepares graduates to demonstrate the Differentiated Essential Competencies of Graduates of Texas Nursing Programs Evidenced by Knowledge, Clinical Judgments, and Behaviors (DECs). The competencies are based upon the preparation in the program of study. In nursing education, the DEC’s serve as a guideline and tool for curriculum development and revision, a tool for benchmarking and evaluation of the program, and statewide standard to ensure graduates will enter practice as safe and competent nurses. The DEC’s are incorporated into every course in the SON to ensure uniformity and continuity of standards.

Please refer to the Texas BON website for additional information
https://www.bon.texas.gov/pdfs/differentiated_essential_competencies-2010.pdf

COURSE REQUIREMENTS

Course Calendar Refer to Course Calendar at end of document.

Grading Policy

EVALUATION and GRADING CRITERIA

It is necessary to obtain a weighted mean test score of 75 in the class exam grades to pass this course. A weighted mean test score below 75 or a class average below 75 constitutes failure and will result in a grade of “F” on the transcript.

Policy 66 (effective June 1, 2017) for all courses:

1. Rounding is confined to the final course grade.

Grades on individual exams (including comprehensive or HESI), assignments, quizzes, and projects are recorded in the gradebook (D2L) in their original form without rounding.
2. Final course grades are rounded to the closest whole number using the 0.5 math rule and using one decimal point to the right of the whole number. If the final course grade is not a whole number, the following rounding rules apply:

   a. If the decimal attached to a whole number is 0.5 or greater, then round up to the next whole number (equal to or greater than 85.50 = 86)

   b. If the decimal attached to a whole number is less than 0.5, then round down to the previous whole number (equal to or less than 85.49 = 85).

3. The grading schedule for all Nursing Courses is as follows:

   - 90-100 = A
   - 80-89 = B
   - 75-79 = C
   - Less than 75 = F

Clinical will be graded as a Pass/Fail. You must pass both the class and clinical in order to pass Nursing 407.

Didactic

<table>
<thead>
<tr>
<th>Percentage</th>
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<tbody>
<tr>
<td>Exam 1</td>
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<td>Exam 2</td>
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<tr>
<td>Exam 3</td>
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<tr>
<td>Exam 4</td>
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<tr>
<td>HESI (counts as a test grade)</td>
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Tests - Composed of 50 questions (multiple formats) and a possible 5 pilot questions over specified material. All tests will be computerized and taken in the testing classroom. If computerized testing is not feasible, a paper and pencil test may be substituted. 1.36 minutes per question (NCLEX allotment). Students will be able to review any incorrect questions and rationales at the time of the test. Any further review will need to be scheduled with your clinical instructor. Unexcused absences from exams will not be made up. Please call before exam to make arrangements. Faculty reserve the right to substitute alternate exam format for make-up exams. Students are responsible for all lectures and reading assignments.

Testing Expectations: Students are to remain outside of the testing room until allowed in by faculty. Upon entering the testing room, all personal belongings will be left at the front of the room. No watches, hats, drinks, food, calculators, sunglasses, iPods, and note cards with information on content are allowed. Backpacks and personal belongings will be placed in a designated area in testing room. Cell phones must be turned off and left with backpack. Earplugs and a pencil are allowed. Scratch paper will be provided. Please visit the restroom before the test. Students who arrive late will complete the test without time extension within the allotted testing period. For test security, if a student has already submitted the test and left the testing room, the student that is late will not be able to begin the test. Bring headphones to every test for questions with sound components.

Test Remediation Policy: Students that make less than 75 on any exam are required to make an appointment to review the exam with their clinical instructor prior to the next exam.
**Hesi Review:** We will be reviewing the semester’s material for the HESI. See calendar for date.

**Classroom attendance:** Refer to SON Policies. Students are adult learners. Therefore, it is up to the student to make the decision to attend class or not. However, we recommend that students attend class regularly and are responsible for all materials assigned and/or presented in each class, any information presented by your classmates, and all announcements (verbal and D2L mail). Talking among students during lecture will not be tolerated. It is disruptive to other students trying to learn.

Active and informed participation in classroom discussion is expected. Students are responsible for content, announcements (verbal and Email/D2L) and all other information presented as a part of this class.

**CLINICAL REQUIREMENTS**

**Clinical attendance:** In order to pass the course, you must also pass clinically. Passing clinically means meeting clinical expectations, objectives, hours, and points as outlined below.

Attendance is mandatory for all clinical hours. Clinical hours are those hours spent with clients assessing, planning, implementing, and evaluating in the health-care setting and simulation lab, those in case studies, and all other assignments given clinical credit as seen in the table below. Total clinical absences are not to exceed 10%. Absences over 10% could result in failure of the course and must be petitioned with the Student Affairs Committee using the Petition form found online. See Policy and Procedure # 21 and Clinical Expectations toward the end of this syllabus for more details.

You must receive **225 out of a possible 300 points (75%)** to pass. Points will be deducted in full unless otherwise specified on grading rubric. Points will be deducted for:

1. arriving late to clinical site or opportunity (includes hospital clinical, skills lab, clinical on campus, layered learning, simulations, EBP discussion)
2. Any assignment/paperwork submitted late, incomplete, or failure to turn in by due date and time.
3. Hospital orientation(s) submitted late, incomplete, or failure to turn in by due date.
4. Preceptor agreements not completed and/or submitted as directed in the Longview Clinical Instructions for Students Packet.
5. Preceptor evaluations not completed and/or submitted as directed in the Longview Clinical Instructions for Students Packet.
6. Less than 75% satisfactory ratings for observed behaviors on preceptor evaluation.
7. Not meeting criteria on Clinical Documentation. (See SimChart Documentation Rubric for possible points deducted for Clinical Documentation.)

<table>
<thead>
<tr>
<th>Clinical Requirements</th>
<th>Hours</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Orientations</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>Nacogdoches Clinical Day 1</td>
<td>8</td>
<td>10</td>
</tr>
</tbody>
</table>
See course calendar for specific dates of clinical rotations, simulations, and assignment due dates.

Clinical Days

Students will arrive to assigned clinical site prepared and on time. A Skills Checklist will be available in D2L content and completed/updated each clinical day and turned in at clinical evaluations at the end of the semester.

You have been given a list of medications for NUR 407. This list can also be found in D2L under Clinical Info. You are responsible for knowing about these medications and should be able to discuss them when asked. Inability to do so may incur a clinical F day.

Clinical Documentation

<table>
<thead>
<tr>
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<th>8</th>
<th>10</th>
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</thead>
<tbody>
<tr>
<td>Nacogdoches Clinical Day 2</td>
<td></td>
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<tr>
<td>Nacogdoches Clinical Day 3</td>
<td></td>
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<tr>
<td>Longview Clinical Day 1</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Longview Clinical Day 2</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Nac Day 1 Clinical Documentation</td>
<td>3</td>
<td>25</td>
</tr>
<tr>
<td>Nac Day 2 Clinical Documentation</td>
<td>3</td>
<td>25</td>
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<tr>
<td>Nac Day 3 Clinical Documentation</td>
<td>3</td>
<td>25</td>
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<tr>
<td>Preceptor Agreements (2)</td>
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<tr>
<td>Preceptor Evaluations (2)</td>
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<td>10/10</td>
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<tr>
<td>Preclinical Conference</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Clinical Skills Lab</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Clinical Skills Documentation</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>OB-EFM and OB-Labor Simulation</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>NRP Lab Practice</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>OB-Emergency Simulation and Simulation Ticket</td>
<td>4</td>
<td>10</td>
</tr>
<tr>
<td>Pedi Simulation</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>vSim – Sabina Vasquez</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>vSim – Eva Madison</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>vSim – Brittany Long</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>vSim – Jackson Webber</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Layered Learning</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Clinical on Campus</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>EBP Clinical Analysis Attendance</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td><strong>Total Points</strong></td>
<td><strong>90</strong></td>
<td><strong>300</strong></td>
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</table>
Documentation will be completed after each hospital clinical in Nacogdoches. It will be submitted via SimChart by the Friday following the clinical day by 0800. See D2L for documentation instructions.

It is unacceptable to turn in any portion of someone else’s work without crediting the author of that work, if the source of that work is not the course text. It is also unacceptable to write for or with another student on any course assignment, even if you shared the same patient.

Precepted Longview Clinical Guidelines

Students will have two precepted clinicals in Longview, Texas. Refer to D2L→Content→Clinical Information→Precepted Clinicals for guidelines. Students will represent the DeWitt School of Nursing to the highest standard. The student will be responsible for turning appropriate documentation into the instructor as directed. Please complete evaluations in Typhon of your preceptors and clinical sites and any paper hospital evaluations of your preceptor after completion of your precepted clinical rotation. If preceptor’s name does not appear in Typhon, please let course coordinator know.

Hospital Orientation(s)

Orientation is mandatory for each clinical facility that you are assigned. See D2L for instructions. See calendar for due date.

Preceptor Agreements and Evaluations

Refer to the Longview Clinical Instructions for Students Packet for instructions on completing preceptor agreements and evaluations appropriately. This packet is very important. It includes information for your preceptor and the Preceptor Agreement and Preceptor Evaluation of you. Pay close attention to the instructions so that you will receive all possible clinical points for that day. You will need two packets and two envelopes to take with you when you do your clinical rotation in Longview. Your preceptor agreement must be signed and completed by the same RN that completes the preceptor evaluation. Ensure that your preceptor signs the back of the preceptor agreement. Remind the preceptor to enclose your evaluation in the envelope provided, seal it, and sign over the seal. The preceptor agreements and evaluations are to be turned in to the class box at the front desk of the administration building by Wednesday at 0800 following the precepted clinical. Clinical points will be deducted for failure to follow instructions given in the Longview Clinical Instructions for Students Packet or if turned in late or incomplete.

Preclinical Conference

Students will meet with clinical instructor to discuss clinical. Uniforms not required. See calendar for date and time.

Clinical Skills Lab, Simulations, Layered Learning, NRP Lab Practice

Student groups will complete skills and simulations in the lab setting. Wear uniforms. Groups and dates will be assigned by the instructors. Check D2L for schedule, how to prepare, and instructions. Information concerning preparation for the labs will be given prior to the lab dates. Failure to complete pre-simulation assignments will result in inability to participate in the
simulation and loss of clinical hours and clinical points. Please complete evaluations in Typhon after completion of each simulation and layered learning.

**vSim**

Students will complete four vSims outside of class/clinical time. See D2L and course calendar for further instructions.

**Clinical On Campus**

Wear comfortable clothes. We will be discussing care of the laboring patient, newborn, postpartum patient, and pediatric patient.

**Evidence Based Practice (EBP) Clinical Analysis**

Students will attend the EBP Clinical Analysis. Discussion of evidence based practice, barriers in the clinical setting toward the EBP, and suggestions on how to overcome these barriers based on research will occur. The goal of this analysis is for students to compare current practices with current evidence.

**CROSS-UNIT OBJECTIVES**

All course content will give consideration to the care of women and children by the nurse in collaboration with other members of the healthcare team.

1. Incorporate cultural considerations in the nursing care of women and children.
2. Explore the ethical and legal dilemmas arising in women and children’s health in nursing practice.
3. Practice communication techniques that facilitate the group process and Nursing Process.
4. Apply teaching-learning principles to the care of the client and family.
5. Utilize the Nursing Process.
6. Examine research findings that improve women and children’s health in nursing practice.
7. Incorporate growth parameters and developmental characteristics in the nursing process of women and children.
8. Apply principles of pharmacotherapeutics in women and children’s health populations.
9. Demonstrate nutritional considerations specific for women and children’s health populations.
10. Examine the relationship among mind, body, and spirit in the client and family.
11. Explore the phenomena of interdisciplinary care of the client and family in women and children’s health populations.

**UNIT OBJECTIVES**

**UNIT I**

**Labor and Birth Processes, Gestational Conditions, Pain Management, and Fetal Assessment in Labor**

Labor and Birth Processes Objectives

1. Gather an accurate history of the pregnant patient.
2. Identify the phases and stages of labor and guide the patient and family through each one.
3. Demonstrate components of a systematic intrapartum assessment.
4. Recognize expected values for vital signs and blood pressure, deviations from normal findings, and probable causes of the deviations in the intrapartum period.
5. Prioritize care needs in the first, second, and third stages of labor for the laboring client and support person.
6. Predict expected physiologic and anatomic changes and nursing interventions for the laboring client.
7. Analyze fetal positions that would be favorable or unfavorable for normal progression through labor and delivery.
8. Identify and interpret the findings upon vaginal exam.
9. Compare and contrast true and false labor.
10. Prepare a plan for intrapartum teaching relating to the labor process.

Gestational Conditions Objectives
1. Identify risk factors for gestational conditions that place the pregnant woman and fetus at risk.
2. Describe pathophysiology of common gestational conditions.
3. Explain how common gestational conditions affect the fetus.
4. Assess the pregnant patient for signs and symptoms of gestational conditions.
5. Plan appropriate nursing care of the pregnant patient with a gestational condition in effort to decrease risk of mortality of pregnant patient and fetus.
6. Implement appropriate nursing interventions and care to treat the gestational condition identified.
7. Teach pregnant patients about the signs and symptoms, risk factors, treatment plans, and follow up care needed.
8. Explain how surgical procedures are affected due to pregnancy in a female patient.
9. Explain how trauma during pregnancy can affect the fetus.
10. Discuss the effect of domestic violence on pregnant women.

Pain Management Objectives
1. Assess the patient’s pain level and ability to cope with pain in labor.
2. Compare and contrast nonpharmacologic and pharmacologic pain management.
3. Employ nonpharmacologic nursing interventions for the patient declining pharmacologic interventions.
4. Role model how to care for the laboring patient declining pharmacologic interventions for the support person.
5. Demonstrate positions conducive to decreasing the patient’s pain level and helping labor progress.
6. Differentiate between intravenous analgesia and anesthesia and the care associated with them.
7. Identify the therapeutic effects, side effects, and adverse effects of analgesia and anesthesia related to the laboring patient and fetus/neonate.
8. Intervene appropriately for a patient with physiologic side effects of epidural or spinal anesthesia.
10. Develop a teaching plan for the patient receiving epidural or spinal anesthesia.

Fetal Assessment in Labor Objectives
1. Discuss the different methods of fetal monitoring and advantages and disadvantages of each one.
2. Interpret the fetal heart rate strip including baseline, accelerations, decelerations, variability, and category.
3. Recognize expected values for fetal heart rate baseline, deviations from normal findings, probable causes of the deviations, and intervene appropriately.
4. Differentiate between the appearance and cause of early, late, and variable decelerations and intervene appropriately in the first and second stage of labor.
5. Differentiate between the appearance and cause of absent, minimal, moderate, and marked variability and intervene appropriately.
6. Implement appropriate interventions for category two and three fetal heart rate strips and tachysystole.
7. Interpret the contraction pattern on the fetal monitor including frequency, duration, intensity, and resting tone.
8. Compare and contrast the care of the patient with external and internal monitors.
9. Develop a teaching plan for the patient and family regarding fetal monitoring.
10. Document the fetal heart rate and contraction pattern thoroughly and accurately.

UNIT II
Labor and Birth Complications, Postpartum, and Newborn Nutrition

Labor and Birth Complications Objectives
1. Recognize unexpected findings and deviations from normal in the pregnant patient and intervene appropriately.
2. Prioritize care of patients in labor and delivery.
3. Formulate a plan of care for a patient in preterm labor/preterm rupture of membranes.
4. Identify the pharmacologic interventions, rationale behind administration, therapeutic effects, side effects, and signs of toxicity for the woman receiving tocolytics.
5. Calculate intravenous rates correctly for high alert medications.
6. Predict care for the patient with risk factors that could lead to an obstetric emergency.
7. Discuss nursing interventions for the family experiencing perinatal grief and loss.
8. Advocate for the patient having an obstetric procedure.
9. Discuss the purpose, rationale, nursing interventions, and teaching for obstetric procedures.
10. Communicate therapeutically with a patient that has had an unplanned experience.

Postpartum Objectives
1. Demonstrate components of a systematic postpartum assessment.
2. Recognize expected values for vital signs and blood pressure, deviations from normal findings, and probable causes of the deviations in the postpartum period.
3. Prioritize care needs in the fourth stage of labor.
4. Predict expected physiological changes, psychosocial outcomes, and nursing interventions for the postpartum client and family.
5. Identify signs of potential complications in the postpartum woman.
6. Explain causes, signs and symptoms, possible complications, and medical and nursing management of postpartum hemorrhage.
7. Describe thromboembolic disorders, including incidence, etiology, signs and symptoms, and management.
8. Differentiate among postpartum psychologic complications, including incidence, risk factors, signs and symptoms, severity, and management.
9. Identify parental and infant behaviors that facilitate and those that inhibit parental attachment and describe ways in which the nurse can help facilitate parent-infant adjustment.
10. Prepare a plan for postpartum teaching for self-management.

Newborn Nutrition Objectives
1. List the current recommendations for infant feeding.
2. Explain the nurse’s role in helping families choose an infant feeding method.
3. Discuss benefits of breastfeeding for infants, mothers, families, and society.
4. Summarize nutritional needs of infants.
5. Understand anatomic and physiologic aspects of breastfeeding.
7. Identify maternal and infant indicators of effective breastfeeding.
8. Implement nursing interventions to facilitate and promote successful breastfeeding.
9. Explain common problems associated with breastfeeding and interventions to help resolve them.
10. Develop a teaching plan for the formula-feeding family.

UNIT III
Assessment and Care of Normal Newborn and High-Risk Newborns, and Hospitalized or Long-term Care Pediatric Clients with Respiratory and Gastrointestinal Disorders

Newborn Objectives
1. Identify normal physiological adjustments expected in a newborn within the first hours of life.
2. Identify variations of normal physiological adjustments that may need additional assessment findings to rule out pathological causes.
3. Appropriately perform a head to toe assessment on the newborn.
4. Perform nursing interventions to facilitate the newborn’s transition to extrauterine life.
5. Plan appropriate nursing care of the newborn.
6. Assess for bonding and psychosocial issues that may affect the care of the newborn.
7. Teach parents about care of the newborn throughout the hospital stay.
8. Develop a discharge teaching plan to parents for newborn care.

High-Risk Newborn Objectives
1. Identify common high-risk newborn disorders.
2. Identify signs and symptoms of high-risk newborn disorders during a head to toe assessment.
3. Plan appropriate nursing care of the high-risk newborn.
4. Perform nursing interventions to prevent and treat high-risk newborn disorders.
5. Identify bonding and psychosocial issues that may affect the health of the high-risk newborn.
6. Develop individualized teaching plans for care of the high-risk newborns.

Hospitalized Child Objectives
1. Identify the stressors of illness and hospitalization for children during each developmental stage.
2. Demonstrate nursing interventions that support parents, siblings, and family and minimize stress during a child’s illness and hospitalization.
3. Plan nursing interventions for children that are admitted to special units such as the ICU, day surgery, or emergency department.
4. Implement play in therapeutic procedures.
5. List various types of pain assessment tools for use with children and pain management strategies to reduce pain in children.
6. Design a care plan for the child with cognitive impairment that promotes optimal development, including during hospitalization.
7. Revise care for children with visual and/or hearing impairment, including during hospitalization.
8. Discuss nursing interventions that promote the family’s optimal adjustment to the child’s chronic disorder.
9. Support the family during the events surrounding and time of pediatric death.

Respiratory Objectives
1. Describe common conditions affecting the respiratory system that require hospitalization in children.
2. Interpret normal and abnormal assessment findings in the child with respiratory illness.
3. List the major signs of respiratory distress in infants and children.
4. Formulate a care plan for a child hospitalized with a respiratory illness.
5. Implement appropriate nursing interventions for children with respiratory illness.
7. Explain appropriate technique for oxygen use in children.
8. Teach families about care of the child with respiratory illness.

Gastrointestinal Objectives
1. Describe common conditions affecting the gastrointestinal system that require hospitalization in children.
2. Interpret normal and abnormal assessment findings in the child with gastrointestinal illness.
3. Formulate a care plan for a child hospitalized with a gastrointestinal illness.
4. Implement appropriate nursing interventions for a child with gastrointestinal illness.
5. Predict potential complications of gastrointestinal illness in children.
6. Outline preoperative and postoperative care of the child with surgical treatment for gastrointestinal illness.
7. Teach families about care of the child with gastrointestinal illness.

UNIT IV
Assessment and Care of Hospitalized or Long-term Care Pediatric Clients with Cardiac Disorders, Cancer and Hematologic Issues, Immune, Genitourinary, Musculoskeletal, Integumentary, and Neurological Disorders

Cardiac Objectives
1. Describe cardiac structures present in the fetus and the problems that occur if they persist after birth.
2. Identify risk factors for and conditions associated with congenital heart defects.
3. Differentiate between the categories of congenital heart defects and identify the symptoms associated with them.
4. Illustrate the congenital heart defects and blood flow through them.
5. Categorize the symptoms of heart failure.
6. Formulate a plan of care including pharmacologic interventions for children with cardiovascular disorders.
7. Prioritize nursing interventions for a child with emergent conditions.
10. Communicate therapeutically with the family and child with a congenital heart defect.
11. Develop a teaching plan for families administering medications at home.

Cancer, Hematology, Immune Objectives
1. Identify common childhood hematologic or immunologic disorders.
2. Plan appropriate nursing care of the hospitalized child with hematologic or immunologic disorders.
3. Demonstrate appropriate nursing care of the hospitalized child with hematologic or immunologic disorders.
4. Develop teaching plans for the hospitalized child with hematologic or immunologic disorders.
5. Identify common childhood cancers.
6. Describe nursing care for the hospitalized child with cancer.
7. Explain important teaching points for the hospitalized child with cancer.
8. Identify psychosocial needs for the parents and child with cancer.

Genitourinary Objectives
1. Describe common conditions affecting the genitourinary system that require hospitalization in children.
2. Interpret normal and abnormal assessment findings in the child with genitourinary illness.
3. Formulate a care plan for a child hospitalized with a genitourinary illness.
4. Implement appropriate nursing interventions for a child with genitourinary illness.
5. Predict potential complications of genitourinary illness in children.
6. Outline preoperative and postoperative care of the child with surgical treatment for genitourinary illness.
7. Teach families about care of the child with genitourinary illness.
8. Compare the types of renal dialysis and determine which are most appropriate for the pediatric patient.

Musculoskeletal Objectives
1. Describe common conditions affecting the musculoskeletal system that require hospitalization in children.
2. Interpret normal and abnormal assessment findings in the child with musculoskeletal illness.
3. Formulate a care plan for a child hospitalized with a musculoskeletal illness.
4. Implement appropriate nursing interventions for a child with musculoskeletal illness.
5. Predict potential complications of musculoskeletal illness in children.
6. Outline preoperative and postoperative care of the child with surgical treatment for musculoskeletal illness.
7. Teach families about care of the child with musculoskeletal illness.
8. Explain techniques to care for a child immobilized with an injury or a debilitating condition.
9. Explain the functions of the various types of traction and appropriate nursing care of the child in traction.
Neurological Objectives
1. Describe the various modalities for assessment of cerebral function.
2. Differentiate among the stages of consciousness.
3. Describe common conditions affecting the neurological system that require hospitalization in children.
4. Interpret normal and abnormal assessment findings in the child with neurological illness.
5. Formulate a care plan for a child hospitalized with a neurological illness.
6. Implement appropriate nursing interventions for a child with neurological illness.
7. Predict potential complications of neurological illness in children.
8. Teach families about care of the child with neurological illness.

Typhon Evaluations
At the end of the semester (see calendar for dates), please complete the Student Evaluation of Course, Course Instructors, and SFA Clinical Instructors. If you have not completed them already, please complete the Simulation Evaluation for each simulation, Student Evaluation of Clinical Sites, and Preceptors. See D2L for instructions on accessing Typhon. Your feedback is very valuable to us and for quality improvement.

D2L
Students must have the required computer access and programs to support the on-line course through SFASU Desire 2 Learn.

Logging in: To access Desire2Learn (D2L), visit the following URL, and log in using your mySFA username and password
http://d2l.sfasu.edu

What are the technical requirements to use the system?
You can use any web browser you wish, and it doesn’t matter what version of Java you have. You may experience minor differences in the system in one browser vs. another, though – so if something looks strange, try using a different browser to see if there’s a difference.

How do I get technical help?
Help for students is available online through http://www.sfasu.edu/sfaonline/ just look for the link to “D2L Support & Tutorials” on the left-hand side. Students can also get help by phone by calling 468-1919 or by emailing d2l@sfasu.edu

Academic Integrity (A-9.1)
Academic integrity is a responsibility of all university faculty and students. Faculty members promote academic integrity in multiple ways including instruction on the components of academic honesty, as well as abiding by university policy on penalties for cheating and plagiarism.

Definition of Academic Dishonesty
Academic dishonesty includes both cheating and plagiarism. Cheating includes but is not limited to (1) using or attempting to use unauthorized materials to aid in achieving a better grade on a component of a class; (2) the falsification or invention of any information, including citations, on an assigned exercise; and/or (3) helping or attempting to help another in an act of cheating or plagiarism. Plagiarism is presenting the words or ideas of another person as if they were your own. Examples of plagiarism are (1) submitting an assignment as if it were one's own work when, in fact, it is at least partly the work of another; (2) submitting a work that has been purchased or otherwise obtained from an Internet source or another source; and (3) incorporating the words or ideas of an author into one's paper without giving the author due credit.

Please read the complete policy at http://www.sfasu.edu/policies/4.1-student-academic-dishonesty.pdf

Withheld Grades Semester Grades Policy (A-54)

At the discretion of the instructor of record and with the approval of the academic chair/director, a grade of WH will be assigned only if the student cannot complete the course work because of unavoidable circumstances or for completion of remediation. Students must complete the work within one calendar year from the end of the semester in which they receive a WH, or the grade automatically becomes an F. If students register for the same course in future terms the WH will automatically become an F and will be counted as a repeated course for the purpose of computing the grade point average.

The circumstances precipitating the request must have occurred after the last day in which a student could withdraw from a course. Students requesting a WH must be passing the course with a minimum projected grade of C.

Students with Disabilities

To obtain disability related accommodations, alternate formats and/or auxiliary aids, students with disabilities must contact the Office of Disability Services (ODS), Human Services Building, Room 325, 468-3004 / 468-1004 (TDD) as early as possible in the semester. Once verified, ODS will notify the course instructor and outline the accommodation and/or auxiliary aids to be provided. Failure to request services in a timely manner may delay your accommodations. For additional information, go to http://www.sfasu.edu/disabilityservices/.

Clinical Expectations

- Complete clinical hours. Follow Policy No. 21 for Clinical Absences. To be an excused absence, missed clinical hours related to illness or death of immediate family member or significant other require proper documentation to be given to clinical instructor. Even if absence is expected to be excused, notify clinical instructor at least one hour prior to clinical time. Please, do not come to clinical with fever.
- Follow Policy No 18 for dress code guidelines.
- Tobacco use of any kind is prohibited during clinical and/or in uniform.
- No gum chewing, eating, or drinking in client areas.
- Cell phones are not permitted in the patient care area or in uniform pockets. Must be kept in bag and on silent.
- Do not wear perfume, cologne, aftershave when in the clinical setting.
- Discipline self to prohibit use of slang and expletives in the clinical setting.
- Submit work as directed in syllabus.
• Arrive on time to appropriate area with all required supplies.
• Practice safe care according to the Nurse Practice Act and SFASU School of Nursing Policies and Procedures.
• Notify primary nurse and the instructor in the event of an emergency or change in patient condition.
• Verify all medications and procedures with nurse or clinical instructor.
• Report off to primary nurse before leaving unit for break, lunch, and end of shift.
• Arrange for SFASU nursing student to monitor your patient at any time you will be away from the unit.
• Actively pursue skills and experiences with primary nurse. You should not be sitting with nothing to do or bored.
• Demonstrate continual development of critical thinking skills, in-depth application of nursing process and clinical expertise.
• Arrange conferences with the instructor to discuss progression, processes, and clinical experiences as needed.

Clinical Failure

More than two (2) failed clinical days (2 “Clinical F” days) will result in failing clinical. The following represent one (1) failed day each:

1. Failure to meet any/all of the clinical expectations listed above or clinical objectives on the Clinical Evaluation Tool below.
2. Failure to adhere to all SON policies.
3. Failure to provide care for clients in accordance with the Texas Standards of Nursing Practice Act 217.11
4. Failure to take advantage of opportunities at various clinical sites (i.e. being asked to follow doctors, studying instead of following nurse …) or complaints from clinical sites.
5. Failure to receive 75% satisfactory on observed criteria on preceptor evaluations and/or receive a comment from a preceptor showing the student did not meet clinical expectations and/or met criteria for an F day.
6. Failure to maintain patient confidentiality.
7. Missing report from the off-going nurse.
8. Unexcused absence from clinical.
9. Failure to call clinical instructor at least 1 hour prior to absence from clinical (even if it will be an excused absence due to illness or death in family) is deemed a No Call/No Show.

Clinical failure can also occur if student does not meet clinical points requirement.

Clinical Learning Outcomes

1. Demonstrate understanding and use of the nursing process, critical thinking, and clinical decision-making skills in the care of individuals and/or families.
2. Apply in practice, the standards of the nursing profession with the family in the obstetrical, neonatal, and pediatric inpatient settings.
3. Incorporate the concept of self-care into clinical practice.
4. Provide teaching to individuals and families based on teaching/learning principles after completing an assessment of that individual’s or family’s learning needs.
5. Apply findings from professional literature to the care of women and children in an effort to promote evidence-based practice.
6. Identify ethical and legal issues that arise in the course of care of women and children.
7. Demonstrate knowledge of the following via journal entries and clinical evaluations regarding wellness states:
   a. Pathophysiological processes occurring
   b. Physical assessment parameters
   c. Interventions/procedures needed
   d. Medications and dosages commonly used
   e. Techniques to encourage clients to participate in their care;
   f. Methods and information needed to teach families home care.
8. Develop the ability to work in a spirit of collegiality with others within and outside of the discipline of nursing.
9. Provide care for clients in accordance with Texas Standards of Nursing Practice Act 217.11.
10. Apply safe care according to the Nurse Practice Act and SFASU School of Nursing Policies and Procedures.

**CLINICAL EVALUATION TOOL**
Expected behaviors are based on the AACN competencies. These behaviors are detailed on the Nursing 407 Clinical Evaluation Tool which can also be found on D2L under “Clinical Info.”
Stephen F. Austin State University  
Richard and Lucille DeWitt School of Nursing  
Clinical Evaluation Tool  
NUR 407: Care of Women and Children II

Student: ____________________________ Date  Fall/Spring: __________ 
Instructor(s): ____________________________

Evaluation Criteria: S = Satisfactory  U= Unsatisfactory  

Ongoing clinical feedback will be provided in individual student-faculty conferences throughout the clinical rotation and will be documented on page 3. 

Clinical objectives for evaluation are listed on page 2. 

By the end of the clinical rotation, the student must satisfactorily demonstrate all behaviors described in the clinical objectives to pass the clinical portion of the course.

<table>
<thead>
<tr>
<th>Final Clinical Grade:</th>
<th>Final Instructor Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Pass or Fail)</td>
<td></td>
</tr>
</tbody>
</table>

Instructor Signature 

Student Signature:

Date: ____________________

<table>
<thead>
<tr>
<th>Final Instructor Comments</th>
<th>Final Student Comments</th>
</tr>
</thead>
</table>

Final Student Comments
### Clinical Outcomes

**The student will:**

<table>
<thead>
<tr>
<th>DEC</th>
<th>C. PATIENT SAFETY ADVOCATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>IA</td>
<td>1. Maintain strict infection control measures in clinical settings.</td>
</tr>
<tr>
<td>IIIA</td>
<td>2. Administer medications safely</td>
</tr>
<tr>
<td>IIIE</td>
<td>3. Maintain safety of client, including proper identification, use of side rails, not leaving pediatric patients unattended</td>
</tr>
<tr>
<td>IIIB</td>
<td>4. Maintain a safe practice utilizing facility guidelines</td>
</tr>
<tr>
<td>IID</td>
<td>5. Apply teaching-learning theories that optimize the childbearing family’s potential for wellness with overall consideration of individual(s), families, and groups</td>
</tr>
<tr>
<td>IIC</td>
<td>6. Perform skills safely and efficiently.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEC</th>
<th>D. MEMBER OF THE HEALTH CARE TEAM</th>
</tr>
</thead>
<tbody>
<tr>
<td>IVA</td>
<td>1. Collaborate with the interdisciplinary health care team.</td>
</tr>
<tr>
<td>IVA</td>
<td>A. Implement care for individuals, families, and groups in collaboration with clients and the interdisciplinary health care team.</td>
</tr>
<tr>
<td>IVD</td>
<td>2. Appraise community resources/referrals in the provision of care.</td>
</tr>
<tr>
<td>IVE</td>
<td>B. Refer individuals, families, and groups to the interdisciplinary health care team and community resources for necessary services.</td>
</tr>
<tr>
<td>IVC</td>
<td>A. Perform holistic nursing assessment on assigned client(s).</td>
</tr>
<tr>
<td>IVC</td>
<td>2. Appraise community resources/referrals in the provision of care.</td>
</tr>
<tr>
<td>IVA</td>
<td>B. Refer individuals, families, and groups to the interdisciplinary health care team and community resources for necessary services.</td>
</tr>
<tr>
<td>IIB</td>
<td>3. Establish effective working relationships with clients, faculty, staff, and peers.</td>
</tr>
<tr>
<td>IIC</td>
<td>B. Refer individuals, families, and groups to the interdisciplinary health care team and community resources for necessary services.</td>
</tr>
<tr>
<td>IVB</td>
<td>4. Use appropriate verbal and nonverbal interactions with clients, families, community, and interdisciplinary health care team.</td>
</tr>
<tr>
<td>IIE</td>
<td>5. Compare methods of care in a variety of acute care settings</td>
</tr>
<tr>
<td>IIG</td>
<td>6. Manage resources in the delivery of care to clients and groups.</td>
</tr>
<tr>
<td>IIG</td>
<td>7. Contribute to group development as a member and a leader.</td>
</tr>
<tr>
<td>IVD</td>
<td>8. Formulate reports for staff and faculty on clinical status of client.</td>
</tr>
<tr>
<td>IIE</td>
<td>A. Document care in organized, clearly stated fashion both on paper and electronically</td>
</tr>
<tr>
<td>IIE</td>
<td>9. Critique own and other’s participation in intra/interpersonal communication with individual(s), families and groups</td>
</tr>
<tr>
<td>IIB</td>
<td>B. Complete accurate detailed correlation maps that include plans for development and implementation.</td>
</tr>
<tr>
<td>IIB</td>
<td>10. Analyze problems in delivering health care and act as an advocate for individuals, families, and groups using research based nursing knowledge.</td>
</tr>
</tbody>
</table>

<p>| DEC | | |
|-----| | |
| IIC | | |
| IID | | |
| IIC | | |
| IIC | | |</p>
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
<th>Exceptional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparedness</td>
<td>Comes to clinical unprepared.</td>
<td>Comes to clinical prepared for clinical area, but unprepared to collect appropriate patient information and/or complete documentation for clinical day.</td>
<td>Comes to clinical prepared for clinical area, nursing care, and documentation. Needs occasional assistance from instructor to collect appropriate patient information.</td>
<td>Comes to clinical prepared for clinical area, nursing care, and documentation. Needs no assistance to collect appropriate patient information. Assists peers.</td>
</tr>
<tr>
<td>Initiative</td>
<td>Lacks initiative in the clinical setting. May act disinterested or frozen.</td>
<td>Displays interest in the clinical setting, but does not assist staff or give patient care without prompting.</td>
<td>Displays interest in the clinical setting, assists staff, and gives patient care with occasional prompting.</td>
<td>Displays interest in the clinical setting, assists staff, and gives patient care without prompting.</td>
</tr>
<tr>
<td>Critical Thinking</td>
<td>Unable to recall knowledge appropriate to clinical experience.</td>
<td>Able to recall concrete knowledge, but unable to apply and adapt it to the current clinical experiences.</td>
<td>Able to recall knowledge and apply it to the current clinical experience.</td>
<td>Able to recall knowledge, apply it to the current clinical experience, and synthesize new knowledge to apply in future clinical settings.</td>
</tr>
<tr>
<td>Communication</td>
<td>Unable to communicate with patients, staff and/or instructor. Appears frozen.</td>
<td>Appears nervous, shaky, or disinterested when communicating with patients, staff, and/or instructor. Needs improvement on using appropriate language/nonverbal expression to discuss healthcare topics with patients and staff.</td>
<td>Communicates with patients, staff, and instructor without visible nervousness. Needs guidance on using appropriate language to discuss healthcare topics with patients and staff.</td>
<td>Communicates with patients, staff, and instructor with ease. Able to explain healthcare topics appropriately to patients and communicates with staff using necessary language/nonverbal expression.</td>
</tr>
<tr>
<td>Safety</td>
<td>Unable to perform nursing care safely.</td>
<td>Performs nursing care safely with direct supervision and prompting.</td>
<td>Performs nursing care safely without assistance or supervision.</td>
<td>Performs nursing care safely without assistance or supervision. Able to identify safety hazards in the healthcare setting.</td>
</tr>
<tr>
<td>Skills Performance</td>
<td>Unable to perform skills expected for third semester nursing student.</td>
<td>Performs skills with continuous instruction and supervision.</td>
<td>Performs skills with minimal instruction and supervision.</td>
<td>Performs skills with no instruction or supervision. Assists peers in performing skills.</td>
</tr>
</tbody>
</table>
SimChart Documentation Rubric

Clinical Evaluation Tool
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Unsatisfactory</th>
<th>Needs Improvement</th>
<th>Satisfactory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charting Logistics (4)</td>
<td>Mostly inaccurate; mistakes would have significant legal implications</td>
<td>Fairly accurate; improvement needed to ensure no legal implications</td>
<td>Mostly accurate; any mistakes are minor and unlikely to have legal implications</td>
</tr>
<tr>
<td>Admission History (2)</td>
<td>Mostly inaccurate; mistakes would have significant legal implications</td>
<td>Fairly accurate; improvement needed to ensure no legal implications</td>
<td>Mostly accurate; any mistakes are minor and unlikely to have legal implications</td>
</tr>
<tr>
<td>Pt Care Documentation (6)</td>
<td>Mostly inaccurate; mistakes would have significant legal implications</td>
<td>Fairly accurate; improvement needed to ensure no legal implications</td>
<td>Mostly accurate; any mistakes are minor and unlikely to have legal implications</td>
</tr>
<tr>
<td>Medications (2)</td>
<td>Did not include sufficient info about medications</td>
<td>Includes most info about medications</td>
<td>All pertinent medications are entered completely</td>
</tr>
<tr>
<td>Care Plan Diagnosis, R/T (etiology/patho), AEB (signs and symptoms) (5)</td>
<td>Did not complete 2 care plans and/or missing NANDA nursing diagnoses, R/T, or AEB and/or charting does not support care plan</td>
<td>Completes 2 care plans including NANDA nursing diagnosis, R/T, and/or AEB, charting supports care plan, but has prioritization problems (ex. doesn’t show patient priority needs appropriately, needs are not patient priority, charting shows higher priorities, and/or are not prioritized correctly)</td>
<td>Completes 2 care plans including NANDA nursing diagnosis, R/T, and/or AEB, charting supports care plan, nursing diagnoses are priority needs, and are prioritized correctly</td>
</tr>
<tr>
<td>Care Plan Interventions &amp; Goals (3)</td>
<td>Did not include 5 interventions with one goal for each care plan and/or did not include at least one patient teaching intervention for each care plan</td>
<td>Includes 5 interventions with one goal for each care plan with a pt teaching intervention for each care plan, but did not make interventions applicable to this pt</td>
<td>Includes 5 interventions with one goal for each care plan with a pt teaching intervention for each care plan, and made interventions applicable to this patient</td>
</tr>
<tr>
<td>Care Plan Cohesiveness (3)</td>
<td>Diagnosis, goal, and interventions are unrelated and/or the interventions do not work toward accomplishing the goal and/or the goal does not address the diagnosis; critical thinking is not displayed</td>
<td>Diagnosis, goal, and interventions are related but not all interventions work toward accomplishing the goal; critical thinking needs improvement</td>
<td>Diagnosis, goal, and interventions relate to one another. Interventions work toward accomplishing the goal and the goal addresses the diagnosis; critical thinking is evident</td>
</tr>
</tbody>
</table>