Assurance of Student Learning 2019-2020	
College of Health and Human Services	*School of Nursing and Allied Health*
Family Nurse Practitioner, Post MSN Certificate 0449	
Eve Main	

Use this page to list learning outcomes, measurements, and summarize results for your program. Detailed information must be completed in the subsequent pages.			
Student Learning Outcome 1:			
Instrument 1	Direct: Subjective Objective Assessment Plan (SOAP) Note		
Instrument 2	Indirect: Analysis of Preceptor Clinical Evaluation on the item “implements health promotion and disease prevention education”		
Instrument 3			
Based on your results, circle or highlight whether the program met the goal Student Learning Outcome 1.		**Met**	**Not Met**
Student Learning Outcome 2:			
Instrument 1	Direct: Family Nurse Practitioner Certification Pass Rate		
Instrument 2			
Instrument 3			
Based on your results, circle or highlight whether the program met the goal Student Learning Outcome 2.		**Met**	**Not Met**
Student Learning Outcome 3:			
Instrument 1	Direct: Analysis of Cultural Subjective Objective Assessment Plan Note in NURS 547 and NURS 549		
Instrument 2	Direct: Analysis of Patient Centered Assessment Method Assignment		
Instrument 3			
Based on your results, circle or highlight whether the program met the goal Student Learning Outcome 3.		**Met**	**Not Met**
Program Summary (Briefly summarize the action and follow up items from your detailed responses on subsequent pages.)			
Overall, the results from this assessment indicate that the program has reached and/or exceeded the self-reported assessment goals in each category. SLO1 outcome results fom SOAP notes and preceptor evaluations will be evaluated by graduate nursing faculty for any identified areas for improvement in Sept 20. SLO2 outcome results including FNP pass rate resuls will be reported to graduate nursing faculty and the program evaluation committee. SLO 3 outcome results from cultural SOAP notes and PCAMs will be reported and evaluated by graduate nursing faculty. Follow-up on the outcome results was delayed related to the pandemid and will occur in Sept 26,2020.			

<table>
<tr><th colspan="4">Student Learning Outcome 1</th></tr>
<tr><td>Student Learning Outcome</td><td colspan="3">The student will integrate theoretical knowledge of health promotion and maintenance and illness/disease prevention to achieve optimal health.</td></tr>
<tr><td>Measurement Instrument 1</td><td colspan="3">Direct: Subjective Objective Assessment Plan (SOAP) Note (see attached)</td></tr>
<tr><td>Criteria for Student Success</td><td colspan="3">Students will score an average of ≥ 42 of 45 pts on NURS 554 (Primary Care Practicum) SOAP on 4 SOAP notes.</td></tr>
<tr><td>Program Success Target for this Measurement</td><td>92%</td><td>Percent of Program Achieving Target</td><td>100%</td></tr>
<tr><td>Methods</td><td colspan="3">NURS 554 SOAP notes are reviewed each semester. Student clinical documentation includes SOAP notes which include:Subjective (chief complaint, history of present illness, past medical history, family history, personal/social history, and review of systems); Objective (vital signs, physical examination, laboratory and radiology tests; Assessment (differential diagnosis, final diagnosis, and screenings appropriate for age); Plan (non-pharmacologic, pharmacologic, health promotion/patient education, follow-up visit, and referral); Pharmacology Note, and Ethical, Genetic, Cultural or Spiritual considerations. NURS 554 SOAP notes (n =10) in F19 and SP20 were reviewed and 100% of students scored an average of ≥ 42 pts on the four SOAP notes with an overall average score of 43.1.</td></tr>
<tr><td>Measurement Instrument 2</td><td colspan="3">Indirect: Final preceptor clinical evaluations of students enrolled in NURS 554-Primary Care Practicum (see attached)</td></tr>
<tr><td>Criteria for Student Success</td><td colspan="3">Students enrolled in NURS 554 (Primary Care Practicum) will score ≥ 9 pts on the preceptor clinical evaluation section of “Plan of care and implementation of treatment.”</td></tr>
<tr><td>Program Success Target for this Measurement</td><td>100%</td><td>Percent of Program Achieving Target</td><td>100%</td></tr>
<tr><td>Methods</td><td colspan="3">NURS 554 is the final clinical course for family nurse practitioner certificate students. Final preceptor evaluations are completed by the clinical preceptor and reviewed each semester by clinical faculty and the program coordinator. Each student is assessed on a 4 point Likert scale with competency not met (1); inconsistent performance, preceptors assistance more than expected (2); consistently improving in this area, preceptor assistance as expected (3); and consistently demonstrates competency (4) by the clinical preceptor on the preceptor evaluation form. Students are expected to score ≥ 3 pts on each clinical evaluation item. The preceptor evaluation section of plan of care and implementation of treatment includes three items: “formulates patient care management plan in collaboration with preceptor”; “implements health promotion and disease prevention education”; and “recommends referral for those patients beyond the NP scope of practice” for a maximum score of 12 pts. Preceptor evaluations for NURS 554 (Primary Care Practicum) were reviewed in F19 and Sp20 (n = 3). The average score for “plan of care and implementation of treatment” was 12 of 12 pts with no student scoring less than 9 pts on this section. The subsection item average scores were 4.0 (formulates patient care management plan in collaboration with preceptor, 4.0 (implements health promotion and disease prevention education), and 4.0 (recommends referral for those patients beyond the NP scope of practice).</td></tr>
<tr><td colspan="2">Based on your results, highlight whether the program met the goal Student Learning Outcome 1.</td><td>Met</td><td>Not Met</td></tr>
<tr><td colspan="4">Actions (Describe the decision-making process and actions for program improvement. The actions should include a timeline.)</td></tr>
<tr><td colspan="4">The clinical SOAP notes and final preceptor evaluations in relation to SLO1 were reviewed in Su 20.</td></tr>
<tr><td colspan="4">Follow-Up (Provide your timeline for follow-up. If follow-up has occurred, describe how the actions above have resulted in program improvement.)</td></tr>
<tr><td colspan="4">Follow-up was delayed by the pandemic and will occur in Sept 26, 2020. SLO1 outcome results fom the SOAP notes and preceptor clinical evaluation will be evaluated by graduate nursing faculty for any actions for improvement</td></tr>
<tr><td colspan="4">Next Assessment Cycle Plan (Please describe your assessment plan timetable for this outcome)</td></tr>
<tr><td colspan="4">SLO 1 through the artifacts of SOAP notes and preceptor clinical evaluations will be assessed in F20 and Sp 21. Currently, Eve Main is responsible for data collection, evaluation, and reporting.</td></tr>
</table>

<table>
<tr><th colspan="2">Student Learning Outcome 2</th></tr>
<tr><td>Student Learning Outcome</td><td>The student will integrate theory and research from nursing and related disciplines as a foundation for advanced practice.</td></tr>
</table>

Measurement Instrument 1	Direct: FNP Certification Examination		
Criteria for Student Success	FNP certificate students will successful pass on first attempt of the Family Nurse Practitioner certification examination.		
Program Success Target for this Measurement	92%	**Percent of Program Achieving Target**	100%
Methods	FNP certification scores from American Nurses Credentialing Center and the American Academy of Nurse Practitioner are reviewed. Family nurse practitioner certification first time pass rates are reviewed each semester for Post Graduate Certificate family nurse practitioner students. All (n = 3) students graduating in F19 and Sp20 passed the family nurse practitioner certification examination on their first attempt.		
Based on your results, circle or highlight whether the program met the goal Student Learning Outcome 2.		**Met** (highlighted)	**Not Met**
Actions (Describe the decision-making process and actions planned for program improvement. The actions should include a timeline.)			
First time pass rates were reviewed (Su19, F19, and Sp20) in relation to SLO 2. There were no problems identified.			
Follow-Up (Provide your timeline for follow-up. If follow-up has occurred, describe how the actions above have resulted in program improvement.)			
Follow-up was by the pandemic and will occur in Sept 26, 2020. SLO1 outcome results fom the first time pass rates will be reported to SONAH graduate faculty and program evaluation.			
Next Assessment Cycle Plan (Please describe your assessment plan timetable for this outcome)			
SLO 2 through the artifacts of first time pass rates will be assessed in Su20, F20, and Sp21. Currently, Eve Main is responsible for data collection, evaluation, and reporting.			

Student Learning Outcome 3			
Student Learning Outcome	The student will demonstrate an understanding and appreciation of human diversity.		
Measurement Instrument 1	Direct: Analysis of Cultural Subjective Objective Assessment Plan Note in NURS 547 and NURS 549 (see attached)		
Criteria for Student Success	Students will score ≥ 42 of 45 pts on the cultural SOAP note completed in NURS 554.		
Program Success Target for this Measurement	92%	**Percent of Program Achieving Target**	100%
Methods	All NURS 554 SOAP notes with a cultural focus are reviewed each semester (see previous description of SOAP notes). The cultural consideration section includes the student prompts of "Clearly state the consideration in this patient, support your discussion with evidence-based literature, discuss how the consideration was addressed, and how it influenced the care of the patient." An analysis revealed that 100% (3/3) of students scored ≥ 42 pts.		
Measurement Instrument 2	Direct: Patient Centered Assessment Method (PCAM) Assignment: Health Literacy and Communication		
Criteria for Student Success	Students will document a reflection in the PCAM on the item "how well does the client now understand their health and well-being and what do they need to do to manage their health." A client's health literacy and communication can be affected by language and cultural differences.		
Program Success Target for this Measurement	**92%**	**Percent of Program Achieving Target**	**100%**
Methods	PCAM assessments are completed in the clinical courses of NURS 505 (Advanced Health Assessment), NURS 547 (Primary Care of the Infant, Child, and Adolescent), NURS 549 (Primary Care of the Adult), and NURS 554 (Primary Care Practicum.). The PCAM item "how well does the client now understand their health and well-being and what do they need to do to manage their health" prompts the student to assess the patient, document potential issues, and report their findings to the clinical preceptor. All students (n = 6) completed reflections identifying their assessment of the patient's understanding and engagement in their health care, identified barriers to care, and reviewed the assessment with their clinical preceptor receiving 100% agreement.		
Based on your results, circle or highlight whether the program met the goal Student Learning Outcome 3.		**Met** (highlighted)	**Not Met**
Actions (Describe the decision-making process and actions for program improvement. The actions should include a timeline.)			
SOAP notes and PCAM Assignments were reviewed in relation to SLO3 in Su20 from the semesters of Su19, F19 and Sp20.			
Follow-Up (Provide your timeline for follow-up. If follow-up has occurred, describe how the actions above have resulted in program improvement.)			
Follow-up was delayed by the pandemic and will occur in Sept 26, 2020. SLO3 outcome results from SOAP notes and PCAMs will be reported to SONAH graduate faculty and program evaluation.			
Next Assessment Cycle Plan (Please describe your assessment plan timetable for this outcome)			

SLO3 through the artifacts cultural SOAP notes and PCAMS will be assessed in Su20, F20, and Sp21. Currently, Eve Main is responsible for data collection, evaluation,

Clinical Note Rubric
Pediatric
NURS 547

Patient age: **Gender:**

All SOAP notes need to include one of the following considerations. Please indicate which of your notes includes the consideration. Each consideration should be used if possible, if not, you may use the same consideration in two different notes. You must use at least two of the following during this semester.

SOAP Note Considerations (denote the focus of each note submitted):

Clinical Note #1	**Ethical**	**Genetic**	**Cultural**	**Spiritual**
Clinical Note #2	**Ethical**	**Genetic**	**Cultural**	**Spiritual**
Clinical Note #3	**Ethical**	**Genetic**	**Cultural**	**Spiritual**
Clinical Note #4	**Ethical**	**Genetic**	**Cultural**	**Spiritual**

Clinical Notes are required to be presented on the topics in NURS 546 that are acute or chronic conditions, no well-child visits. All clinical notes should observe HIPAA requirements for confidentiality. Clinical notes are based on *Seidel's Guide to Physical Examination.*

	Possible Points	Points Earned
Subjective: **CC**: "Patient/informants own words" **HPI:** Narrative form, include each component in parentheses. Onset, Location, Duration, Character, Aggravating/Associated factors, Relieving factors, Temporal factors, and Severity of symptoms. The HPI is specific to the patient and the chief complaint. Refer to Seidel for specific information to contain.	4	
PMH/PSH: (must also include patient's **allergies with reactions** and current prescribed and OTC **medications**) (Must include immunization status, birth history, chronic illness, hospitalizations, injuries, and **LNMP** if applicable) **(Include immunization list, next routine immunization and due date, and what education did you give or should you give for vaccine(s) given.** If no vaccine was given, include education needed for next routine immunization. If patient is not up to date on vaccinations, please explain why and include any education you provided on vaccinations.)	3	
FH: (Must include 3 generations) Include any congenital anomalies/hereditary disorder.	1	
SH: Note who the primary caregiver is and the relation to the patient. Please provide as much information about the family structure: Who is living in the home (siblings, grandparents, etc)- Parent involvement (include both parents and marital status)- Parents/caregiver occupation and education- Child care providers- Family stressors (past or present)- Use of Tobacco, alcohol, and/or drugs in home- Spiritual – Cultural – Environmental (focus on injury prevention: firearms, smoke detectors, seat belts, etc)– Nutrition (breast-feeding past or present, formula feeding, introduction of solids, food diary may be needed for older children)– Fitness/activity (is child meeting developmental milestones) – Sleep (where, how long, night waking, etc)–	2	
ROS: (Must be pertinent to the CC and contain short succinct statements. Do not use sentences.) **Please include the bolded systems in all clinical notes:**	5	

General: **HEENT:** **CV:** **RESP:** **GI:** GU: MS: NEURO: **PSYCH:** SKIN: ENDOCRINE: HEMATOLOGIC:		
<u>Developmental assessment:</u> Please include social, physical, and emotional development.	3	
<u>Objective:</u> Any v/s completed at visit. **ALWAYS** include: • Percentile on growth chart for height and weight • Head circumference percentile for children age 2 and under **PE:** (Must be pertinent to your CC and differential) **Please include the systems bolded below in all notes:** **General:** **HEENT:** **CV:** **RESP:** ABD: GU: MS: NEURO: PSYCH: SKIN:	5	
LABS: (Must include name of test(s) and results) **RADIOLOGY:** (Must include name of test(s) and results) (Briefly describe what the results indicate. If no test were done, list what test could help with diagnosis. If results are not back, list what you are expecting to find and the significance.)	2	
ASSESSMENT: List 3 differential diagnoses. (Must include the actual diagnosis as one of the 3 differential diagnoses). **<u>Please do not list more than 3 differentials.</u>** **Differential Diagnosis #1:** **Differential Diagnosis #2:** **Differential Diagnosis #3:** *Describe under each of the 3 differential diagnoses, the <u>subjective symptoms and objective findings</u> that *support this potential diagnosis. Then describe how the potential diagnosis was ruled in or ruled out as the actual diagnosis for this patient.* **Must include APA citation(s) in this section and include reference(s) under reference section.* **Final Diagnoses: List all with CPT code.**	3	
SCREENINGS APPROPRIATE FOR AGE: (Document age appropriate screenings even if you did not screen this patient.) **Document screenings appropriate for this patient's age and how often the screenings need to be performed. Document your patient's Risk Factors and any necessary additional or more frequent screening(s) that need to be done.*	1	

• **Must include APA citation(s) in this section and include reference(s) under reference section.*		
PLAN: **Non-pharmacologic:** * **Pharmacologic:** **Health Promotion/Prevention/Patient Education:** * **Follow up visit:** **Referral/Consult:**	5	
Patient Care Team List all appropriate team members (actual referral and potential referral) and discuss how collaboration will impact care. This is based on patient centered care model. **Must include APA citation(s) in this section and include reference(s) under reference section.*	1	
PHARMACOLOGY NOTE: * Trade and generic name of medication: Class of medication: Medication used for patient's diagnosis of: Educate patient on the following adverse medication reactions: Medication interactions with patient's other medication(s): Pregnancy category (if patient is female and of child bearing age): Pharmacology of medication: (metabolized by liver and/or kidney; half-life of medication) Estimated cost of medication (treatment regiment for short-term treatment or monthly for long term treatment): Can the patient afford this medication? (will insurance cover or can afford out of pocket cost): (If you did not prescribe any medications for this patient, what could you have given?) **Must include APA citation(s) in this section and include reference(s) under reference section.*	4	
Ethical, Genetic, Cultural, or Spiritual Consideration: **Clearly state** the ethical, genetic, cultural or spiritual consideration associated with this patient. Discuss stated consideration **in depth** and support your discussion with **evidenced-based literature**. Describe how this was addressed with the patient and how it influenced care. If, it did not influence care, you may not use the situation. (*Must address at least 2 of the 4 considerations within the four SOAP notes during the semester; if not 5 points will be deducted from the final SOAP note for each consideration not addressed*.)	4	
References: *All references should be in APA format.* *1 reference should be from an EBP article.*	2	
Total points	45 points	

Journal

Students are required to submit one journal with each soap note. The journal should be 1-2 paragraphs in length and discuss students' individual clinical experience including, challenges, accomplishments, observations, and/or self-assessment. The journal should serve as a reflection of your clinical journey.

Clinical Note
Adult - NURS 549

Patient age: **Gender:**
All SOAP notes need to include one of the following considerations. Please indicate which of your notes includes the consideration.
SOAP Note Considerations (denote the focus of each note submitted):
Clinical Note #1 Ethical Genetic Cultural Spiritual
Clinical Note #2 Ethical Genetic Cultural Spiritual
Clinical Note #3 Ethical Genetic Cultural Spiritual
Clinical Note #4 Ethical Genetic Cultural Spiritual

Clinical Notes are required to be presented on the topics in NURS 548 that are chronic conditions. All clinical notes should observe HIPAA requirements for confidentiality. Clinical notes are based on *Seidel's Guide to Physical Examination*

	Possible Points	**Points Earned**
Subjective: **CC:** "Patient/informants own words" **HPI:** Narrative form, include each component in parentheses. Onset, Location, Duration, Character, Aggravating/Associated factors, Relieving factors, Temporal factors, and Severity of symptoms. The HPI is specific to the patient and the chief complaint. Refer to Seidel for specific information to contain.	6	
PMH/PSH: PMH for all patients must include patient allergies with reactions, current prescribed and OTC medications with the corresponding diagnosis. Last menstrual period in women. Immunizations should be included for all patients. Other relevant information as listed in Seidel.	2	
FH: (Must include 3 generations)	1	
Personal and Social History: Minimum of the following information. Other relevant history listed in Seidel. Occupation – Education – Marital status – Tobacco – Alcohol – Drugs – Spiritual – Cultural – Environmental – Nutrition – Fitness – Sleep –	4	

ROS: (Must be pertinent to the CC and contain short succinct statements. Do not use sentences. Must contain all the components for the differential diagnosis rationale). **Please include the bolded systems in all clinical notes:** **General:** **HEENT:** **CV:** **RESP:** **GI:** GU: MS: NEURO: **PSYCH:** SKIN: ENDOCRINE: HEMATOLOGIC:	5	
Objective: **VS:** B/P, Pulse, Respirations, and Pulse oximetry (if completed) **PE:** (Must be pertinent to your CC and differential. List the PE in the order in noted in the text. Positives are listed first, negatives follow). **Please include the systems bolded below in all notes:** **General:** **HEENT:** **CV:** **RESP:** ABD: GU: MS: NEURO: PSYCH: SKIN:	5	
LABS: (Must include name of test(s) and results) **RADIOLOGY:** (Must include name of test(s) and results) (Briefly describe what the results indicate. If no test were done, list what test could help with diagnosis. If results are not back, list what you are expecting to find and the significance.)	2	
ASSESSMENT: List 3 differential diagnoses (Must include the actual diagnosis as one of the 3 differential diagnoses). **Please, do not list more than 3 differentials.** **Differential Diagnosis #1:** **Differential Diagnosis #2:** **Differential Diagnosis #3:** *Describe under each of the 3 differential diagnoses, the subjective symptoms and objective findings that *support this potential diagnosis. Then describe how the potential diagnosis was ruled in or ruled out as the actual diagnosis for this patient.* **Must include APA citation(s) in this section and include reference(s) under reference section.* **Final Diagnoses: List all with CPT code.**	3	
SCREENINGS APPROPRIATE FOR AGE: (Document age appropriate screenings even if you did not screen this patient.) **Document screenings appropriate for this patient's age and how often the screenings need to be performed. Document your patient's Risk Factors and *any necessary additional or more frequent screening(s) that need to be done.* *Use the following website:* http://www.uspreventiveservicestaskforce.org/recommendations.htm	1	

**Must include APA citation(s) in this section and include reference(s) under reference section.*		
PLAN: Report the plan developed by the preceptor, include references. **Non-pharmacologic:** * **Pharmacologic:** **Health Promotion/Patient Education:** * **Follow up visit:** **Referral/Consult:**	5	
Patient Care Team List all appropriate team members (actual referral and potential referral) and discuss how collaboration will impact care. This is based on patient centered care model. **Must include APA citation(s) in this section and include reference(s) under reference section.*	1	
PHARMACOLOGY NOTE: * Trade and generic name of medication: Class of medication: Medication used for patient's diagnosis of: Educate patient on the following adverse medication reactions: Medication interactions with patient's other medication(s): Pregnancy category (if patient is female and of child bearing age): Pharmacology of medication: (metabolized by liver and/or kidney; half-life of medication) Estimated cost of medication (treatment regiment for short-term treatment or monthly for long term treatment): Can the patient afford this medication? (will insurance cover or can afford out of pocket cost): (If you did not prescribe any medications for this patient, what could you have given?) **Must include APA citation(s) in this section and include reference(s) under reference section.*	4	
Ethical, Genetic, Cultural, or Spiritual Consideration: **Clearly state** the ethical, genetic, cultural or spiritual consideration associated with this patient. Discuss stated consideration in depth and support your discussion with evidenced-based literature. Describe how this was addressed with the patient and how it influenced care. If, it did not influence care, you may not use the situation.(*Must address each one of these considerations within the four SOAP notes during the semester; if not 4 points will be deducted from the final SOAP note for each consideration not addressed.*)	4	
References: *All references should be in APA format.* *1 reference should be from an EBP article.*	2	
Total points	45 points	

Journal

Students are required to submit one journal with each soap note. The journal should be 1-2 paragraphs in length and discuss students' individual clinical experience including, challenges, accomplishments, observations, and/or self-assessment. The journal should serve as a reflection of your clinical journey.

Clinical Note
Adult
NURS 591/554

Student Name:
Date:
Patient age: **Gender:**

All SOAP notes need to include one of the following considerations. Please indicate which of your notes includes the consideration.

SOAP Note Considerations (denote the focus of each note submitted):
Clinical Note #1 Ethical Genetic Cultural Spiritual
Clinical Note #2 Ethical Genetic Cultural Spiritual
Clinical Note #3 Ethical Genetic Cultural Spiritual
Clinical Note #4 Ethical Genetic Cultural Spiritual
Clinical Notes are required to be presented on the topics in NURS 591/554 that are chronic conditions. All clinical notes should observe HIPAA requirements for confidentiality. Clinical notes are based on *Seidel's Guide to Physical Examination.*

	Possible Points	**Points Earned**
Subjective: **CC:** "Patient/informants own words" **HPI:** Narrative form, include each component in parentheses. Onset, Location, Duration, Character, Aggravating/Associated factors, Relieving factors, Temporal factors, and Severity of symptoms. The HPI is specific to the patient and the chief complaint. Refer to Seidel for specific information to contain.	6	
PMH/PSH: PMH for all patients must include patient allergies with reactions, current prescribed and otc medications with the corresponding diagnosis. Last menstrual period in women. Immunizations should be included for all patients. Other relevant information as listed in Seidel.	2	
FH: (Must include 3 generations)	1	
Personal and Social History: Minimum of the following information. Other relevant history listed in Seidel. Occupation – Education – Marital status – Tobacco – Alcohol – Drugs – Spiritual – Cultural – Environmental – Nutrition – Fitness – Sleep –	4	
ROS: (Must be pertinent to the CC and contain short succinct statements. Do not use sentences. Must contain all the components for the differential diagnosis rationale). **Please include the bolded systems in all clinical notes:** **General:** **HEENT:** **CV:**	5	

RESP: **GI:** GU: MS: NEURO: **PSYCH:** SKIN: ENDOCRINE: HEMATOLOGIC:		
Objective: **VS:** B/P, Pulse, Respirations, and Pulse oximetry (if completed) **PE:** (Must be pertinent to your CC and differential. List the PE in the order in noted in the text. Positives are listed first, negatives follow). **Please include the systems bolded below in all notes:** **General:** **HEENT:** **CV:** **RESP:** ABD: GU: MS: NEURO: PSYCH: SKIN:	5	
LABS: (Must include name of test(s) and results) **RADIOLOGY:** (Must include name of test(s) and results) (Briefly describe what the results indicate. If no test were done, list what test could help with diagnosis. If results are not back, list what you are expecting to find and the significance.)	2	
ASSESSMENT: List 3 differential diagnoses (Must include the actual diagnosis as one of the 3 differential diagnoses). **Please, do not list more than 3 differentials.** **Differential Diagnosis #1:** **Differential Diagnosis #2:** **Differential Diagnosis #3:** *Describe under each of the 3 differential diagnoses, the subjective symptoms and objective findings that *support this potential diagnosis. Then describe how the potential diagnosis was ruled in or ruled out as the actual diagnosis for this patient.* **Must include APA citation(s) in this section and include reference(s) under reference section.* **Final Diagnoses: List all with CPT code.**	3	
SCREENINGS APPROPRIATE FOR AGE: (Document age appropriate screenings even if you did not screen this patient.) **Document screenings appropriate for this patient's age and how often the screenings need to be performed. Document your patient's Risk Factors and *any necessary additional or more frequent screening(s) that need to be done. Use the following website:* *http://www.uspreventiveservicestaskforce.org/recommendations.htm* **Must include APA citation(s) in this section and include reference(s) under reference section.*	1	
PLAN: Report the plan developed by the preceptor, include references. **Non-pharmacologic:** * **Pharmacologic:** **Health Promotion/Patient Education:** * **Follow up visit:**	5	

Referral/Consult:		
Patient Care Team List all appropriate team members (actual referral and potential referral) and discuss how collaboration will impact care. This is based on patient centered care model. **Must include APA citation(s) in this section and include reference(s) under reference section.*	1	
PHARMACOLOGY NOTE: * Trade and generic name of medication: Class of medication: Medication used for patient's diagnosis of: Educate patient on the following adverse medication reactions: Medication interactions with patient's other medication(s): Pregnancy category (if patient is female and of child bearing age): Pharmacology of medication: (metabolized by liver and/or kidney; half-life of medication) Estimated cost of medication (treatment regiment for short-term treatment or monthly for long term treatment): Can the patient afford this medication? (will insurance cover or can afford out of pocket cost): (If you did not prescribe any medications for this patient, what could you have given?) **Must include APA citation(s) in this section and include reference(s) under reference section.*	4	
Ethical, Genetic, Cultural, or Spiritual Consideration: **Clearly state** the ethical, genetic, cultural or spiritual consideration associated with this patient. Discuss stated consideration in depth and support your discussion with evidenced-based literature. Describe how this was addressed with the patient and how it influenced care. If, it did not influence care, you may not use the situation. (*Must address each one of these considerations within the four SOAP notes during the semester; if not 4 points will be deducted from the final SOAP note for each consideration not addressed*.)	4	
References: *All references should be in APA format and 1 reference should be from an EBP article*	2	
Total points	45 points	

Journal

Students are required to submit one journal with each soap note. The journal should be 1-2 paragraphs in length and discuss students' individual clinical experience including, challenges, accomplishments, observations, and/or self-assessment. The journal should serve as a reflection of your clinical journey.

Western Kentucky University

DNP Program Family Nurse Practitioner Track
Preceptor Evaluation Form Nursing 554
Final Evaluation

Student Name ______________________________ Date of Evaluation ____
Preceptor Name and Clinical Site ____Total number of hours________
Directions: In each section please rate the student's performance based on these four levels of performance:

- **4 - Consistently demonstrates competency**
- **3 - Consistently improving in this area** Preceptor assistance as expected
- **2 - Inconsistent performance** Preceptor assistance more than expected
- **1 - Competency not met**

		Circle number to indicate rating:			
I. Professional Role					
A.	Communicates effectively with patients, families, and health professionals	4	3	2	1
B.	Demonstrates professionalism in appearance and demeanor	4	3	2	1
II. Assessment of Health Status					
A.	Obtains and accurately documents a relevant history	4	3	2	1
B.	Performs and accurately documents expected physical examination	4	3	2	1
C.	Analyzes client data	4	3	2	1
III. Diagnosis of Health Status					
A.	Identifies clinical presentation of primary care problems in children	4	3	2	1
B.	Selects appropriate diagnostic tests and screening procedures	4	3	2	1
C.	Formulates comprehensive differential diagnosis	4	3	2	1
IV. Plan of Care and Implementation of Treatment					
A.	Formulates patient care management plan in collaboration with preceptor	4	3	2	1
B.	Implements health promotion and disease prevention education	4	3	2	1
C.	Recommends referral for those patients beyond the NP scope of practice	4	3	2	1
V. Clinical Judgment and Decision-making					
A.	Demonstrates sound clinical judgment	4	3	2	1
B.	Collaborates with other health professionals appropriately	4	3	2	1

Comments: ____

Preceptor signature ____
Student signature____

revised 2017

Additional Comments: