FRANKLIN UNIVERSITY

NURSE PRACTITIONER SPECIALIZATION HANDBOOK

MASTER OF SCIENCE IN NURSING (MSN)
POST-GRADUATE CERTIFICATE IN NURSING (PGC)
DOCTOR OF NURSING PRACTICE (DNP)

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Preface

The Franklin University Catalog/Bulletin Policies and Procedures, accessible at https://www.franklin.edu/current-students/academic-resources/university-bulletin, contains policies applicable to all students. The student Handbook is provided to all Master of Science in Nursing (MSN), Post-Graduate Certificate (PGC), and Doctor of Nursing Practice (DNP) nurse practitioner students as a supplemental guide related to specialized topics associated with completion of their degree program. The information in this handbook should supplement, not substitute, information published in the Franklin University Academic Bulletin. In any situation of unintended incongruence, the University Catalog/Bulletin takes priority.

Successful matriculation and graduation from an academic program require adherence to all policies, procedures, and regulations as stipulated by the MSN, post-graduate certificate or DNP programs, and the university. If you have any questions regarding requirements or policies, do not hesitate to refer them to your academic advisor, program chair, or other appropriate people.

This handbook presents the policies, procedures, and general information in effect at the time of publication. Students affected by any changes to this handbook will be notified in writing and acknowledgement of receipt is required.

Mission and Purpose Statements

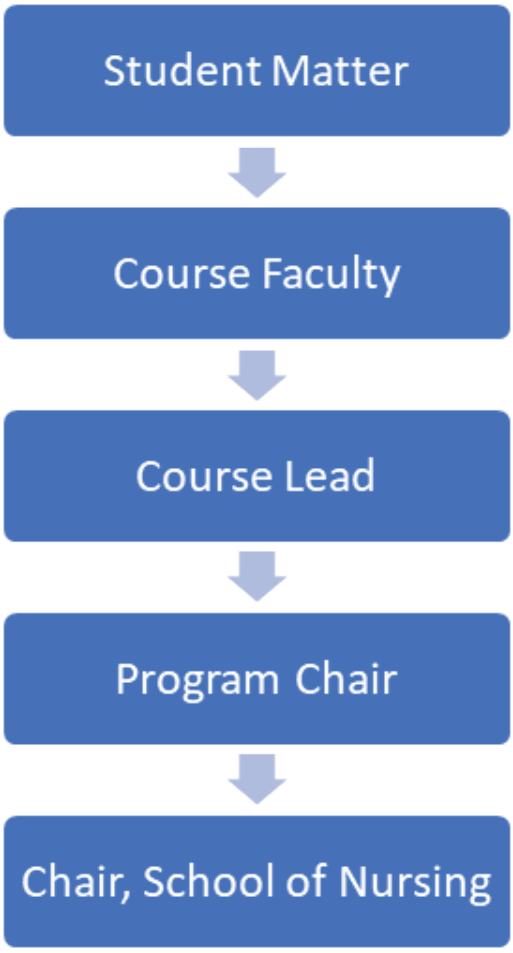
The mission of the College of Health & Public Administration (COHPA), which houses the School of Nursing (SON) and the nursing programs, states that the college will:

- Provide a relevant, high quality, lifelong education that will enable our students to:
- Enhance the quality of healthcare and public service
- Advance healthcare and public service careers
- Succeed in providing leadership that improves the quality of life in communities

The Purpose of the School of Nursing (SON) is:
We transform the future of healthcare through innovation, collaboration, opportunity, enthusiasm, and excellence in nursing education to benefit our students, our partners, and the communities we serve. By embracing diversity, change, and educational excellence based on the values of integrity and compassion, we nurture our students and provide them with robust learning opportunities.

School of Nursing Communication Flow Chart

The communication flow chart establishes appropriate communication channels between students and faculty. This framework ensures that issues and concerns are addressed promptly and appropriately, while promoting a safe and effective learning environment for students.



MSN, DNP and Post-Graduate Certificate OVERVIEW

Graduate education builds upon knowledge and competencies gained in baccalaureate education. Graduate students use critical thinking, creativity and problem-solving skills that require in-depth nursing knowledge and are prepared to coordinate health care programs within complex systems in an era of health care reform. The Advanced Practice Registered Nurse (APRN) curriculum is based upon nursing and related theories and the application of research findings to clinical and administrative nursing issues. Graduate students are also prepared for doctoral study in nursing and continued personal and professional development.

It is a priority at our School of Nursing to support all learners and to actively address bias toward underrepresented minorities including BIPOC, LGBTQIA+, and others. We know that underrepresented learners often experience bias and microaggressions in the educational and clinical environments. We want to help to combat and prevent these experiences. To prevent the risk of burnout from racist, homophobic, or sexist treatment, it is essential that we work to create a sense of belonging and safety while also preparing learners for the realities of practice. Learners who feel they have experienced bias or discrimination are encouraged to report this to their course or clinical faculty, lead faculty, or program chair.

The DNP nurse practitioner concentrations are designed for those nurses who want to translate community factors, social determinants, and health risks into delivering the highest quality patient care. This degree prepares the student to become an APRN who provides healthcare to individuals, families, and communities at various points across the lifespan. In addition, the DNP prepares the graduate to optimize patient care through data, technology, and other clinical and evidence-based practices.

The MSN nurse practitioner tracks are designed for those nurses who want to pursue more advanced positions in today's challenging health care environments. The MSN prepares the student to become an APRN who provides healthcare to individuals, families, and communities at various points across the lifespan. This program blends nursing theory and advanced practice concepts necessary to work within the structure, culture, and mission of a variety of health care organizations.

The Post-Graduate Certificate (PGC)

The post-master's certificates are designed for nurses with an MSN or nursing doctoral degree who wish to increase their scope of practice in a nurse practitioner specialty role as described above.

National Certification:

Graduates of the DNP, MSN, or the PGC are prepared for the national certification examination in their role specialty through the American Nurses Credentialing Center (ANCC) or the American Association of Nurse Practitioners (AANP). (Note: PMHNP certification is currently available only through ANCC).

Program Outcomes

DNP

By completion of the program, graduates will be able to:

1. Apply evidence-based findings to improve clinical practice and healthcare delivery systems.
2. Analyze and evaluate the local and global aspects of a healthcare organization's structure, function, and resources.
3. Strategically lead improvements in health outcomes, quality, safety, and policy.
4. Develop interprofessional teams that promote quality care, reduce risk, and improve complex healthcare delivery systems.
5. Integrate data from information systems and technology to support clinical decision-making for clinical prevention and population health.

MSN and PGC

By completion of the program, graduates will be able to:

1. Synthesize theories and knowledge from nursing and related disciplines to develop a theoretical basis to guide practice in an advanced nursing role.
2. Apply leadership skills and decision making in the provision of high-quality nursing care in diverse settings.
3. Provide leadership across the care continuum in diverse settings to promote high quality, safe, effective patient centered care.
4. Appraise, use, and participate in the extension of nursing knowledge through scientific inquiry.
5. Integrate current and emerging technologies into professional practice.
6. Demonstrate responsive leadership, collaboration, and management to influence the advancement of nursing practice and the profession of nursing and to influence health policy.
7. Employ collaborative strategies and effective communication to advocate for the role of the professional nurse as a member and leader of interprofessional teams.
8. Integrate clinical prevention and population health concepts to provide holistic, comprehensive nursing care for individuals, families, and aggregates.
9. Demonstrate an advanced level of understanding of nursing and relevant sciences and integrate this knowledge into practice.

General Information

MSN/PGC/DNP APRN Curriculum: The curriculum is designed to meet the standards of the profession for graduate nurses. The APRN tracks for the DNP and the PGC programs (family, adult-gerontology primary care, and psych-mental health) are guided and informed by the following professional standards and guidelines: Criteria for Evaluation of Nurse Practitioner Programs (National Task Force on Quality Nurse Practitioner Education [NTF], 2016), Population-Focused Nurse Practitioner Competencies (National Organization of Nurse Practitioner Faculty [NONPF], 2013), Adult-Gerontology Acute Care and Primary Care NP Competencies (NONPF, 2016), Common Advanced Practice Registered Nurse Doctoral-Level Competencies (NONPF, 2017), and the American Nurses Association Scope and Standards of Care for Psychiatric-Mental Health Nursing 2nd Edition (2014). Detailed information for the MSN, PGC and DNP curricula are located on the Franklin University website.

Resources and Guides: Franklin University offers extensive resources to all students. Each course provides links to general and course-specific resources. Students are expected to become familiar with all resources, policies, and expectations as outlined in the University Catalog (Bulletin).

APA Format and Writing Mechanics: Unless otherwise stated, all assignments are in APA format (American Psychological Association (2020) Publication manual of the American Psychological Association (7th ed.). Students are expected to be familiar with, and correctly use this format. Numerous resources are available through the Franklin University library (https://www.franklin.edu/library/research-guides)
Students are expected to use correct grammar, spelling, paragraph structure, and writing formats. Writing services and tutoring are available through Franklin University's Learning Commons.
Grammarly, a writing feedback application, is also available. Students are expected to submit papers and assignments in Microsoft Word (unless otherwise instructed).

Course Examinations: Examinations may be required in some graduate nursing courses. These examinations will be proctored. A fee may be associated with each proctored exam. It is the student's responsibility to pay the associated fee and schedule the appropriate exam within the course in a timely manner.

Academic Integrity: As members of Franklin's campus community, all students are expected to uphold and abide by its published standards of conduct, embodied within a set of core values that include honesty and integrity, respect for others, and respect for the campus community. Academic-based violations committed in the context of submitted course assignments, group projects, or examinations, or violations of course or program policy included in the syllabus and/or provided to the student are subject to a charge of academic misconduct. Students are expected to become familiar with and adhere to the Community Standards and Student Code of Conduct policies and expectations outlined in the University Catalog (Bulletin) and Franklin University Website.

NURSE PRACTITIONER PROGRAM PROGRESSION, READMISSION, AND GRADUATION POLICIES

Progression Requirements for Nurse Practitioner Students

1. An MSN, DNP, or post-graduate certificate student must achieve a “B” or better in each course required to earn the degree or post-graduate certificate. Franklin University considers the grade of “B” (3.0) (B+ or B) or higher as representing “mastery” criteria. Students earning a B- or lower in a course leading to the MSN or DNP degree or post-graduate certificate must repeat the course and may repeat the course only one time. A maximum of two courses may be repeated in the program.
2. For nurse practitioner courses only - students must complete the clinical component with a “meets expectation” AND earn a “B” or better in the course grade to pass the class.
3. Students in the MSN or DNP degree or post-graduate certificate must maintain a minimum grade point average (GPA) of 3.0 (B). If a student’s cumulative grade point average falls below a 3.0, the Academic Standard for Probation and Dismissal will go into place. This policy can be found in the Franklin University Bulletin.
4. In lieu of academic dismissal, MSN or DNP degree or post-graduate certificate students who do not satisfy these standards will have the option to change to a different graduate program, provided they satisfy the admission requirements for that program and are in compliance with the University's academic standards for graduate students.
5. Academically dismissed graduate students seeking reinstatement to Franklin University may submit an appeal to the Graduate Council. (Please see the Academic Standards policy in the Academic Catalog).
6. Students in nurse practitioner courses may only take an "I" incomplete due to verifiable (documented) extenuating circumstances as long as there are no greater than 30 clinical hours remaining to be completed. The “I” grade cannot be used to allow a student to complete additional didactic course work to raise a deficient grade or to repeat a course. The “I” must be resolved within 30 days of the beginning of the next trimester or will be converted to an “IF”. Students may not progress to any course which lists the incomplete course as a pre-requisite until the “I” is resolved with a “B” or better.
7. Students must maintain an unencumbered registered nurse license in all states where they are currently licensed throughout the duration of the graduate program and in the state(s) where they fulfill clinical course requirements. If at any time during enrollment in the graduate program a student’s nursing license becomes encumbered, suspended, or revoked, the student must immediately report this to the Program Chair. If a student’s registered nurse license is suspended or revoked, or if the student fails to report any changes in licensure status, the student will be administratively withdrawn from the graduate program. A student’s ability to continue enrollment in the graduate program with an encumbered license will be reviewed on an individual basis considering the restriction/limitations placed on the student’s practice as a registered nurse by the board of nursing in the state issuing the encumbered license.

(Approved April 2023)

Clinical Policies for All NURSE PRACTITIONER Students

Clinical and Practicum Placement: Students are expected to locate their own preceptor and clinical/practicum site. The goal is to ensure a strong working relationship between the preceptor and student, as well as to avoid the need to travel long distances or incur travel-related expenses. Students have better luck when they visit a potential site/preceptor in person and bring along the information and paperwork. Often the preceptor and/or office manager will agree to complete the paperwork during the visit. The student should approach this initial visit as an "interview" as well as an excellent opportunity to "sell" their abilities/interest for becoming a leader in the organization or nurse practitioner. The practice site may be an excellent opportunity for future employment and/or valuable professional connections. Another option is direct messaging providers/preceptors via LinkedIn. Students may also have professional relationships in the workplace, community group, church, etc. who may be able to serve as a preceptor or personally introduce them to someone who may be available.

If students encounter difficulty finding a site/preceptor after multiple documented attempts, we offer assistance and support to ensure students can access the clinical and practicum experiences they need. Please contact clinicals@franklin.edu for any questions. Nurse practitioner students are expected to have a site identified and secured six (6) months prior to the first clinical course.

Clinical/Practicum sites, if outside of the student's state of residence, must be in a state where Franklin is authorized to host a practicum experience. Please contact a clinical coordinator at Clinicals@Franklin.edu if you have any questions about a potential location and state approval.

At their discretion, clinical sites may charge a fee for service. Students are responsible for any cost related to clinical placements. An honorarium of up to $300 may be available from the School of Nursing to offset clinical placement costs. Please contact a clinical coordinator for more information.

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Student Health: Illness/Injury During Clinical

1. In the event of a medical emergency, hazardous materials exposure, needle stick or sharp object injury, or other clinical-related injury as defined by the clinical preceptor, the student should be sent to the nearest emergency room. The student will be responsible for any charges incurred for these events. The preceptor and student will immediately notify the course faculty of any such events.

2. In non-emergency situations, the student may verbally tell the course instructor faculty that they elect to seek care from a private health care provider/clinic. Any expenses incurred will be the responsibility of the student. The student and/or preceptor will notify the course instructor and clinical supervising faculty of these events as soon as possible.

Clinical Disruption Policy

The Clinical Disruption Policy applies to any student who is a qualified individual with a documented disability causing a temporary lapse in progress within their clinical coursework

Procedure

1. Students should alert the Lead Faculty/Program Chair regarding a temporary or permanent disability that would necessitate a temporary lapse in their clinical coursework.
2. Students must contact and register with the Office of Disability Services and provide appropriate documentation regarding the need for accommodation.
3. The Office of Disability Services will engage in the interactive process with the student in order to determine the appropriate accommodation to support the documented disability. This may involve engagement with the Faculty/Department Chair to assess the appropriate and acceptable accommodation.
4. Office of Disability Services will contact Lead Faculty/Program Chair officially identifying the recommended accommodation to be provided to the student.
5. Lead Faculty/Program Chair will implement and oversee the applicable accommodation(s).

Policy Details

- Students will be provided with the appropriate amount of time as is medically necessary to navigate their disability with required clinical coursework. Keeping this in mind, the time provided to assist the student cannot fundamentally alter the requirements of the clinical assignment.
- This policy is specific to the Family Nurse Practitioner Program at Franklin University. As such, it does not override any legislation or policies current with the American Nurses Association or applicable Clinical Site Provider Policies.
- Faculty will demonstrate flexibility in working with students who follow the above mentioned procedure.

- Standard accommodations may include but are not limited to: (1) Allowance of a student to achieve a grade of Incomplete ("I") in a course should the student have forty (40) clinical hours left to complete. Students would be required to complete all clinical course hours by a date predetermined by the Lead Faculty/Program Chair. (2) Allowance of a student to withdraw from a course at no charge via application for a Tuition Fee Waiver should it be deemed that they do not meet the hour threshold for receiving an Incomplete or are unable to complete the course due to their recorded disability.
- All students seeking medically based extensions or accommodations to clinical requirements or coursework in the Nurse Practitioner program are required to obtain and provide medical clearance documentation to continue in or return to clinical coursework. A health care provider providing treatment for the documented disability must provide documentation.

Policy Notes

- Students who receive a grade of Incomplete can begin a subsequent clinical course. Should the student fail to complete the course by the predetermined date, they are not permitted to continue into the subsequent course. Students in this scenario will be dropped from the subsequent course at no charge.
- Students should work with the Program Chair/Lead Faculty and Clinical Site to determine how to complete the remaining hours in the course. Appropriate alternatives will be explored by all parties to help the student.

(Approved May, 2020)

Impaired Student Policy: Perception of Impairment

Should the preceptor, nursing faculty, or other individuals perceive that a student is mentally, or physically impaired, immediate action must be taken to relieve the student of his/her duties and place the student in a safe area away from the clinical setting. The immediate goal is to provide for the safety of patients, the public, other students, and the student who is suspected of being impaired.

If the student is perceived to have the odor of alcohol, or marijuana, or observed behaviors such as, but not limited to, slurred speech, unsteady gait, confusion, sharp mood swings/behavior especially after an absence from clinical experience, lack of manual dexterity, excessive health problems, increased absenteeism, tardiness or irritability, severe weight loss, needle track marks especially in the inner elbow, carelessness in appearance and hygiene, or euphoria, which cause the preceptor to suspect the student may be impaired by a substance, the preceptor will immediately inform the student as to why actions are being taken to relieve the student of his/her duties and then notify the clinical supervising faculty for further action.

The preceptor will not send the student home or permit them to leave the building. The clinical supervising faculty must be contacted immediately for instructions. The incident will be documented in the Student Injury and Incident report, which will be completed by the preceptor and clinical supervising faculty. Please review the Franklin University policies on alcohol and drug/controlled substances on the Drug Free Schools and Communities Act web page.

CLINICAL PRACTICUM POLICIES AND PROCEDURES

The nurse practitioner program is offered through an on-line hybrid format. This opportunity provides students with on-line courses, a synchronous assessment and skills laboratory, and 600 hours of clinical practice. Attendance at a synchronous lab experience may be required. Failure to attend will result in an "I" for the course and you will not be able to progress to the next course until NURS 700/NURS 731 is completed. Please consult the Academic Calendar and course syllabus for more information.

As a Franklin University student, you will participate in clinical placement experiences designed to help you meet clinical course competencies. The nurse practitioner placement team will collaborate with you to secure clinical sites and preceptors based upon the course requirements and your location. The nurse practitioner placement team will carefully assess your request to ensure they meet our academic standards and submit to faculty for approval.

IMPORTANT NOTE: Occasionally, a student may need to travel a significant distance for a clinical placement opportunity. Faculty-selected clinical placements enable us to organize clinical learning experiences that meet the high standards and curricula of Franklin University.

Health and Safety

All students participating in clinical/practicum experiences must meet health and safety requirements. Documentation must begin six (6) months prior to the practicum/clinical course and always meet requirements. See Appendix I for all required items. Students will not be able to begin any practicum experience until all requirements and documentation have been submitted to EXXAT and verified by the Clinical Coordinator (clinicals@franklin.edu).

Preceptors and Clinical Sites

Preceptors may be nurse practitioners, MDs, DOs, and physician associates (where approved by the state). For the PMHNP track, Licensed Clinical Social Worker, Psychologist, or Licensed Professional Counselor preceptors may also be utilized. In Nevada and Pennsylvania, physician associates are not allowed. In all cases, physician associate preceptors require prior approval. Please contact the clinical coordinator (clinicals@franklin.edu) for more information.

Clinical sites will be determined by track/role specialization and minimal clinical expectations. Faculty are responsible for making clinical site placements and will communicate these with students prior to the start of each clinical course.

CLINICAL PRACTICUM POLICIES AND PROCEDURES

Qualifications

- The preceptor must have a current unencumbered state license as an APRN, physician, physician associate, Licensed Clinical Social Worker, Psychologist, or Licensed Professional Counselor, and at least one year of experience in an area of practice relevant to the student's clinical needs.
- Nurse practitioners must have a masters or doctoral degree.
- Nurse Practitioners with national certification (based on state board of nursing rules) are preferred.
- Curriculum Vitae/Resume and a copy of the license (and certification as appropriate) are required for faculty approval.

Assignment of preceptors

- Preceptors **may not have more than 1 Franklin University student** during a clinical day (if there are students from other programs and you are not seeing adequate patients/clients please contact your clinical supervising faculty member).
- Students may spend no more than 8-10 hours on a clinical site in one day. Students may be placed in an office or clinic that is owned or managed by their employer. However, this **cannot be the office, clinic, or unit where they are currently employed**. Preceptors cannot be relatives, close friends, or the personal health care provider of the student.
- Students may have more than one preceptor during a single clinical course **with prior faculty approval documented in EXXAT**. This will typically occur in sites that do not have an adequate population for pediatrics and/or women's health. It may also occur for PMHNP students needing group or family experiences not offered by their preceptor.
- Preceptors will be provided with an orientation to each course, progressive expectations, and course outcomes and competencies. The preceptor will provide an acknowledgement and agreement prior to the start of each clinical experience.

Approval of preceptor and clinical site

- Students complete the Preceptor Site Placement Form at least six (6) months prior to the clinical rotation.
- Faculty are responsible for final approval of the preceptor and clinical site.
- The clinical rotation plan (including scheduling) shall only be changed in an emergency need and approved by the faculty member for the course.

Scheduling Clinical Hours

The student should schedule clinical practicum hours that are in keeping with the preceptor's schedule and availability - not the student's schedule or convenience. Prior to beginning the clinical practicum students and preceptors need to agree on the days and times that the student will be in the clinical agency. The student's personal and work schedules are expected to accommodate participation in the required number of clinical hours specified by the clinical course. Students may not begin clinical practicum hours before the first official day of the semester that the course begins.

All required supervised practice hours must be complete by the end of the semester unless the course faculty authorizes an extension, in writing.

Clinical hour scheduling for the trimester must be completed in EXXAT no later than the 3rd day of the first week of the course. Any changes must be communicated to the clinical supervising faculty member via email at the same time the change is made in EXXAT.

Number of Clinical Hours Required

This information is specifically discussed in the course syllabus, which is sent to preceptors prior to the start of the academic semester. The student will notify the clinical supervising faculty regarding how clinical time will be scheduled, e.g., ten-hour shifts, one day per week, or blocks of time, following discussion with the preceptor. Students are not permitted to be in the clinical site during weekends, holidays, or other times when the university is not in session, without written approval of the clinical supervising faculty member at least 2 weeks in advance of the scheduled time.

Student Attendance on Scheduled Clinical Days

The student must attend the number of clinical hours consistent with the program requirements regardless of when they reach the minimum required hours for the course. If a student reaches the required number of clinical hours prior to the last week of the course, they are expected to continue attending clinical at least once a week for 8 hours. **Any deviation from these expectations requires written approval by the clinical supervising faculty at least one week in advance of the schedule change.** Hours more than the course minimum do not count towards the number of hours required for any other course.

Students should not assume that, should they fail to complete the required number of clinical hours for the term, they will be permitted to make up clinical hours with their preceptor. The clinical supervising faculty and course instructor must provide approval for extending clinical hours beyond the semester in which the course is taken. If a student cannot complete the required hours due to an unforeseen event, the student must notify the clinical supervising faculty immediately to determine if the situation warrants an extension of the clinical practicum and under what conditions this will occur.

If a student is to be absent for a scheduled clinical day (due to illness or an emergency), the student should notify the preceptor prior to the beginning of the clinical day. On the first clinical day, students should identify the procedure for contacting the preceptor in case of absence. Additionally, it is the student's responsibility to notify the clinical supervising faculty and course instructor of the absence and negotiate make-up clinical time with the preceptor. If the student is not attending clinical days/hours as scheduled, the preceptor should notify the clinical supervising faculty and the course instructor promptly. In the event of a planned absence of the preceptor, they will plan for a qualified back-up preceptor. **The clinical placement coordinator and course instructor will determine credentialing needs for back-up preceptor if this is anticipated for more than 1 (one) day.**

Professional Dress and Behavior

Students are expected to dress appropriately (business casual) and always behave in a professional manner consistent with Occupational Safety and Health Administration (OSHA) standards. The clinical site may specify an alternative dress code (i.e., scrubs) in accordance with OSHA and state law considerations. Nurse Practitioner students are required to wear a Franklin picture identification nametag identifying them as a Nurse Practitioner student. Lab coats are required. Lab coats are purchased at the student's own expense and should be clean, ironed, and in good condition always. **Students must wear their Franklin University picture identification nametag and always introduce themselves as a Nurse Practitioner Student while in the clinical setting.**

Preparation

The student should prepare for the clinical experience as recommended by the preceptor, course instructor, clinical supervising faculty, and the Program Chair. This preparation includes understanding and meeting course learning objectives, conferring with faculty on areas of weakness that need to be reviewed and seeking independent learning experiences that will promote self-confidence and competence. It is further recommended that prior to starting the clinical experience the preceptor will discuss with the student and supervising clinical faculty the patient population and most common health problems the student can expect to encounter at the clinical site. The student is expected to prepare for the clinical experience by reviewing reference materials that are relevant to the patient population and diagnoses they may encounter in the clinical setting.

On the first day of the clinical experience, the preceptor will orient the student to the clinical practice setting, facility policies and procedures, and required safety and learning modules.

Patient Care Responsibility and Medical Record Documentation

The student is expected to document in the patient medical records (paper or electronic) and sign all entries with their first and last name **followed by student designation (i.e., Jane Doe, Nurse Practitioner Student).** Since the preceptor maintains the legal responsibility to examine the patient, establish the diagnosis, and determine the treatment and evaluation plan, they must also sign the medical record and all billing documentation. In some settings, students are not permitted to document in official patient medical records and will need to provide alternative sample documentation to the preceptor. Patient confidentiality, consistent with the Health Insurance Portability and Accountability Act (HIPAA) must be observed. **At no time may patient records be copied, photographed, or removed from the clinical site. Any infraction of this policy will result in a failure of the course and a written notice in the student file.**

Clinical Logs

Students are required to keep a log of all patient encounters and clinical hours throughout their clinical courses. A handwritten log will be completed along with the EXXAT record.

Students maintain an official clinical log in an electronic format. For this purpose, Franklin University utilizes EXXAT. The use of EXXAT enables students to track the number of patient encounters, procedures, diagnoses and ICD codes, diagnostic testing ordered, and medications prescribed. Students enter their clinical data into EXXAT following each patient encounter or at the end of their clinical day. Entries later than 72 hours will not be considered valid.

All FNP/AGPCNP students must complete 150 hours as verified by your clinical supervising faculty member and required case logs in EXXAT to pass the course.
All PMHNP students must complete 75 hours for NURS 732 and 175 hours each for NURS 733, 734, and 793, as verified by your clinical supervising faculty member, and required case logs in EXXAT to pass the course.

It is the responsibility of the clinical supervising faculty to routinely evaluate the clinical case and time logs. When determining learning needs, or to evaluate a student's previous experience, it may be helpful for preceptors to review the student's clinical log. Students should encourage preceptors to periodically examine the contents of their log by logging in to EXXAT and pulling a report. Patient confidentiality, consistent with the Health Insurance Portability and Accountability Act (HIPAA) must be observed. Specifically, the information in EXXAT will disclose no patient identifiers. Students will receive information and instructions on the use of EXXAT during orientation to the clinical experience.

Evaluation of the Preceptor and Clinical Site

Following the clinical practicum, the student will give feedback to the preceptor regarding their satisfaction with the quality of their learning experience. Students will complete an evaluation of the preceptor and clinical site. This evaluation will be available and completed in EXXAT. Preceptors receive a log in and password from EXXAT, reminders are sent out via the preceptor email address on record when evaluations are due to be completed. The preceptors will fill out a midterm and final evaluation on the student each term.

CLINICAL SUPERVISING FACULTY RESPONSIBILITIES

Overall Responsibility

The clinical supervising faculty maintains the ultimate responsibility for the student's clinical experience in a specific course. Responsibilities for faculty who provide either direct or indirect supervision of students in the clinical setting will vary by course. The course syllabus details specific requirements and evaluation criteria for successful student performance. In addition, courses may have specific guidelines describing clinical faculty responsibilities for a particular course and faculty is expected to comply with those guidelines.

Student and Preceptor Contact

Frequent contact with the student and preceptor in the clinical setting is necessary for the supervising faculty to understand how the student is performing. Frequent contact also facilitates early intervention when a student's performance is not at the level expected for that course. A minimum of three contacts per course are expected between the clinical supervising

faculty, student, and preceptor. These contacts may be in the form of a phone call, video conferencing (i.e., Zoom), and/or in person.
Clinical supervising faculty are responsible for the evaluation of the student using their own assessment data and input from the preceptors and posting the final grade for the clinical component of the course.

Site Visits

The purposes of a site visit include observation and evaluation of the student in an actual patient care situation and observation of the student's interaction with preceptors and staff. In addition, it provides the clinical supervising faculty, the preceptor, and the student with an opportunity to discuss the student's progress. Site visits will occur between weeks 5-6 and 8-10 in a 12- week course (or weeks 6-8 and 13-15 in a 16-week course). This will permit sufficient time for remediation and additional site visits. if needed. Clinical supervising faculty will make one to two site visits per term (depending on the course level) and not more than three unless circumstances warrant additional visits. The date and time of the visits are confirmed in advance with the student, and it is the student's responsibility to facilitate the meeting with the preceptor.

Site visits may occur via virtual media such as Zoom. It is the student's responsibility to have an appropriate electronic device (i.e., Smart Phone or Tablet) and adequate data available for an electronic site visit. These visits may be recorded and available to the student for review upon request.

During the site visit, the clinical faculty will evaluate the student's progress towards clinical requirements (see Appendix II), provide feedback to the student, evaluate the clinical site and the preceptor, and communicate the student's status to the course lead faculty member. Monitoring EXXAT entries to assess student progress in meeting the course requirements and competencies will be done during the site visit and routinely throughout the semester to ensure that hours and documentation are being properly recorded and in a timely manner.

Written documentation of the site visit is required, and at the conclusion of the visit the evaluation form will be signed by the student and clinical supervising faculty member. Instructions for submitting these forms in the course and saving them to your EXXAT portfolio will be provided in the course instructions.

Availability

The clinical supervising faculty will maintain contact with the student and preceptor at times other than the site visit and will be available by phone on the days students are in the clinical site. Should a scheduling conflict or emergency arise, it is the responsibility of the clinical supervising faculty to plan with another member for coverage and to notify the lead course faculty member of the change.

NURSE PRACTITIONER STUDENT RESPONSIBILITIES

1. Submit to the Clinical Placement Request Form at least six (6) months prior to the start of a clinical course as instructed by the clinical coordinator.
2. Students are assigned to clinical sites by Franklin University Nursing faculty after appropriateness of site and preceptor have been determined. Franklin University requires an affiliation agreement to be in place prior to student attendance at the clinical site. Preceptors are required to complete credentialing and preceptor statement of agreement for each student. For a preceptor to be approved, documentation of the preceptor's license, certification, resume or curriculum vitae, and acknowledgment of receipt of preceptor handbook must be on file. Students are not permitted to attend clinical experiences in sites not approved by the nursing department.
3. Clinical experiences are Monday through Friday during regular business hours. Evenings, weekends, and holidays are not permitted unless prior arrangements have been made with the clinical supervising faculty, clinical coordinator, and lead course faculty member at least two weeks in advance. **All FNP/AGPCNP students must complete 150 hours as verified by your clinical supervising faculty member and required case logs in EXXAT to pass the course. All PMHNP students must complete the required clinical hours for each course as verified by your clinical supervising faculty member and required case logs in EXXAT to pass the course**.
4. Students are expected to begin clinical experiences in the first week of classes and attend all the way through finals week, unless otherwise notified by the lead course faculty member. This may lead to more hours than required for the course and provides some flexibility in case of student or preceptor illness, vacation, or unexpected days off. Hours in excess of course requirements do not count towards another course.
5. Maintain patient confidentiality. Comply with HIPAA standards per clinical agency and course syllabi policy. Under no circumstance may records be copied, photographed, or removed from the agency.
6. Adhere to all clinical agency policies and procedures. **Students are required to identify themselves and sign any medical records as a Nurse Practitioner Student.**
7. Maintain all required documentation including current Basic Life Support (BLS) or MTN, immunizations, health care insurance, and student professional liability insurance in EXXAT.
8. Adhere to all Franklin University policies and procedures and your state Board of Nursing rules. Failure to exhibit integrity, ethical conduct, professional standards, or any violation of the responsibilities listed herein may result in a failing grade and/or dismissal from the nursing program and the University. Student conduct in the clinical setting must be in a manner that demonstrates safety, adherence to professional standards, and reflects positively upon Franklin University. Furthermore, the student will notify the clinical supervising faculty immediately of any unprofessional behavior or breach of contract by the preceptor.
9. Comply with all health documentation and other professional requirements of the clinical agency *prior* to the start of the clinical experience, including any request for a drug screen or additional background check.

Students who are unable to successfully complete these requirements will not be permitted to complete the MSN, PGC, or DNP Nurse Practitioner track. In addition, each site may have unique requirements which the student is responsible for fulfilling.

10. Be prepared to work the day(s) and hours of the preceptor, and as agreed upon between the student, the preceptor, and the clinical supervising faculty. Students may have an occasional opportunity to work with an additional practitioner on site. The primary preceptor must be on site during this experience. All preceptors must be approved and credentialed prior to extended periods of supervision.
11. Maintain a clinical log per course syllabi in EXXAT Entries are required within 72 hours of a clinical day.
12. Attend all scheduled clinical days or notify the supervising clinical faculty and the clinical preceptor if an absence is necessary. Arrange for make-up time.
13. Collaborate with the clinical preceptor and clinical supervising faculty to develop specific learning goals for this clinical experience; set up virtual site visits; ensure mid-term and final preceptor evaluation of student are completed (See Appendix III).
14. Demonstrate to the preceptor competence of specific skill(s) prior to performing them on the patient without direct supervision.
15. Maintain the student nurse practitioner role. **At no time is the student to assume a fully independent role in seeing patients** without appropriate collaboration and reporting to the preceptor per the progressive expectation algorithm.
16. Arrange appointments, either in person or electronically, with the supervising clinical faculty to discuss progress toward goal achievement.
17. **Check Franklin University email account at least 3 times a week for messages**. Your Franklin student email does not reach the Canvas LMS inbox.
18. Simulation experiences may be available for clinical hours and/or additional practice with permission from clinical supervising faculty.

Appendix A Clinical/Practicum Documentation

All students participating in clinical / practicum experiences must meet the following health and safety requirements to be enrolled in clinical courses. To ensure that documentation always meets requirements, students must provide evidence prior to the start of each semester. For example, if a CPR card expires in September the card needs to be renewed before the start of the fall semester in August **Influenza vaccines must be received or a declination received no later than two (2) weeks from the time students are notified that they are available. Failure to keep documents up to date may result in an administrative withdrawal from the course or prohibition from attending clinical until the deficit is corrected.**

SUBMITTED ONCE	SUBMITTED EVERY YEAR (AS APPLICABLE)
Tuberculin* 2-Step TST **OR** QuantiFeron Gold **OR** T-SPOT TB blood tests are not affected by the BCG vaccine	**Tuberculin*** 1-Step Annual TST **OR** T-Spot **OR** QuantiFeron Gold **OR** known positive annual symptom check from health care provider Tuberculosis Chest X-Ray: required only for a first-time positive TB test
COVID 19 Some sites require COVID vaccines and booster for attendance. Students will need to comply with the requirements of their site.	
Hepatitis B Choice of either the 2 or 3 dose series documentation (and any boosters) and post vaccination anti- HBs titer level showing immunity **OR** Recent anti- HBs titer showing immunity **OR** Non-responder documentation **OR** Signed declination	**Influenza** Effective dates: 10/1-4/30 annually **OR** Signed declination (Note: clinical/practicum facility has the right to refuse access to the site or require masks at their discretion)
Measles, Mumps, Rubella (MMR) 2 dose series documentation OR Titre **Tetanus/Diphtheria/Pertussis** Tdap OR Td vaccination with date within 10yr **Varicella** (Chicken Pox) vaccine OR immunity by titer	**Professional Liability Insurance** must be current through a semester to be placed in clinical/practicum
BLS American Heart Association (AHA) BLS provider or Military Training Network (MTN) course (must be current through a semester to be placed in clinical/practicum)	**Background Check** National Criminal Background Check including excluded Provider Search on OIG and GSA. (clinical/practicum facility has the right to request additional background checks including monthly OIB & GSA and drug screens at student cost)
Authorization for Release of Record to clinical/practicum site	**Additional Requirements: this list may change as clinical/practicum sites may require more than**
General Waiver and Release of Liability form	

Required Education each healthcare institution will communicate to faculty and students any required educational content to be completed prior to participating in clinical/practicum experience	**our standard minimum. Changes will be communicated to you in writing within 10 days of notification to the University**

License must be active and unencumbered in the student primary licensing state as well as the state of clinical placement, as applicable, throughout the nurse practitioner program. Licenses will be verified prior to each clinical rotation.

Health Insurance must be maintained in active status throughout clinical courses.

***TB Screening and Testing of Health Care Personnel:**

https://www.cdc.gov/tb/topic/testing/healthcareworkers.htm

Appendix B Franklin University FNP and ACPCNP Clinical Requirements

This chart represents the recommended minimum requirements for clinical hours, visits, and procedures for completion of the FNP or AGPCNP Clinical Competencies

Population	Total Hours (Recommended)	Minimum Number of Visits (Recommended)	Procedures/Visits (Recommended)	Percent of Time	Course Focus
Lab	16 hours prep and activities		Suturing, biopsy, toenail removal, I&D	0%	NURS 700
Pediatric	50-100 hours	50 total		15%	NURS 701, 702, 703, 790
Newborn (0-4 weeks) exams		5			
Well child (5 weeks – 5 years)		15	15 well child exams		
School age (5-12 years)		15	5 well child exams		
Adolescents (13-17)		15	5 wellness exams or sports PE		
Adult	300-500 hours	300 total		60%	NURS 701, 702, 703, 790
Ages 18-65 and Geriatric 66+			150 episodic, acute and wellness exams 150 chronic care		
Women's Health	50-100 hours	50 visits		15%	NURS 701, 702, 703, 790
			5 pelvic examinations		
Specialty **	100 hours		See below for options.	10%	NUR 790

Potential sites include clinics, medical offices, mobile clinics, rural health centers, telehealth, retail health (limited), long-term care settings, school or college health centers, employee health, health department, and other settings that are appropriate for the course and content.

Women's Health Visits may include well-woman examinations, dysmenorrhea, STI testing, pelvic pain, breast mass, menopause and menopause related problems, contraception, pregnancy, and post-partum.

**Specialty areas may include dermatology, urgent care, cardiology, pulmonary, long-term care, additional rotations in pediatrics, women's health and gerontology, and other common specialties. The application for a specialty rotation must be pre-approved and submitted 6 weeks prior to the end of NURS 703.

Appendix C Family Nurse Practitioner or Adult Gerontological Primary Care Nurse Practitioner Preceptor Evaluation of Student

NOTE THIS INFORMATION IS COLLECTED ELECTRONICALLY VIA EXXAT

FAMILY OR ADULT-GERONTOLOGY NURSE PRACTITIONER STUDENT CLINICAL PRACTICUM

Clinical Competency Evaluation

Student Name: _____ Preceptor Name: _____

Practicum dates: _____ to _____ Course Number: _____

The midterm and final evaluations are based on accepted nurse practitioner competencies* and provide individualized feedback to students regarding strengths and areas for growth. The faculty has established expected averaged competency levels **for each domain** that students should meet by the **END of each clinical course:**

NURS 701 3.0 average
NURS 702 3.0 average
NURS 703/710 4.0 average
NURS 790/791 4.5 average

FOR MID-TERM EVALUATION: IT IS NOT EXPECTED THAT THE STUDENT WILL REACH THE END OF COURSE AVERAGES. PLEASE MARK ACCORDINGLY AND PROVIDE COMMENTS DETAILING AREAS FOR IMPROVEMENT.

PLEASE EVALUATE THE STUDENT'S PERFORMANCE BY SCORING EACH ELEMENT USING THE FOLLOWING CRITERIA:

NA = Not applicable or not observed

1 = **Omits** element or achieves **minimal competence** even with assistance

2 = Needs a **lot of direct supervision**

3 = Needs **some direct supervision**

4 = Needs **minimal direct supervision**

5= **Mostly independent** practice

Competencies

DOMAIN I.A: ASSESSMENT OF HEALTH STATUS	1	2	3	4	5	NA
1. **Obtains and accurately documents a relevant health history** for patients of all ages and in all phases of the individual and family lifecycle using collateral information, as needed.						
2. **Performs and documents complete or symptom-focused physical examinations** on patients of all ages, (including developmental and behavioral screening, physical exam, and mental health evaluations).						
3. **Demonstrates proficiency in family assessment**, including identification of health and psycho-social risk factors of patients across the lifespan and families in all stages of the family life cycle.						
4. Assesses **specific family health needs** and identifies and plans **health promotion interventions** for families at risk, within the context of community.						
5. **Assesses the impact of acute and/or chronic illness or common injuries** on the family.						
6. **Distinguishes between** normal and abnormal changes across the lifespan.						
Comments:						

DOMAIN I.B: DIAGNOSIS OF HEALTH STATUS	1	2	3	4	5	NA
1. **Identifies signs and symptoms of acute or chronic physical and mental illnesses** across the lifespan.						
2. **Manages diagnostic testing** through the ordering and interpretation of age-, gender-, and condition-specific tests and screening procedures, with consideration of the costs, risks, and benefits to the individual.						
3. Applies theoretical knowledge and current research findings in **analyzing and synthesizing data to make clinical judgments and decisions,** individualizing care for individuals and families.						
4. **Formulates comprehensive differential diagnoses** and prioritizes health problems, considering epidemiology, life stage development and environmental and community characteristics.						
5. Assesses decision-making ability, consults, **and refers, appropriately**						
Comments:						

DOMAIN I.C: PLAN OF CARE AND IMPLEMENTATION OF TREATMENT	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Uses knowledge of family theories and development stages** to individualize care provided to individuals and families.						
2. **Treats common acute, chronic, or acute exacerbations of physical and/or mental illnesses** across the lifespan, to minimize complications and promote function and quality of living, including women's reproductive health, perinatal care, and end of life issues.						
3. **Prescribes medications,** understanding altered pharmacodynamics and pharmacokinetics with special populations, such as infants and children, pregnant and lactating women, and older adults.						
4. **Prescribes therapeutic devices** with consideration of the costs, risks, and benefits to the individual.						
5. **Manages individual and family responses to the plan of care** through evaluation, modification and documentation that includes response to therapies and changes in condition.						
6. **Evaluates coping and support systems, lifestyle adaptations and resources** for patients and families, **facilitates transition and coordination of care** between and within health care settings and the community and **initiates appropriate referrals** to other healthcare professionals.						
7. **Adapts interventions to meet the complex needs** of individuals and families arising from aging, developmental/life transitions, comorbidities, psychosocial, and financial issues.						
8. **Facilitates** family decision-making about health.						
9. Performs primary care procedures.						
Comments:						
DOMAIN II: NURSE PRACTITIONER-PATIENT RELATIONSHIP & **DOMAIN III: TEACHING COACHING FUNCTION**						**NA**
1. **Maintains a sustainable partnership with individuals and families and communicates effectively** with the individual and the family, provides anticipatory guidance and facilitates decision-making.						
2. **Analyzes the impact** of aging and age-and disease-related changes in sensory/perceptual function, cognition, confidence with technology, and health literacy on the ability and readiness to learn and tailor interventions accordingly.						
2. Applies principles of **self-efficacy/empowerment** in promoting behavior change.						

3. Develops **educational interventions** appropriate to individual and/or family needs, language and cultural beliefs, values, and cognitive level; reinforces positive health behaviors and incorporates self-care activities.						
4. Demonstrates knowledge and skill in **addressing sensitive issues**, such as sexuality, finances, mental health, terminal illness, and substance abuse and **provides anticipatory guidance, teaching, counseling, and education for self-care.**						
5. **Assesses and promotes** self-care in patients with disabilities.						
6. **Plans and orders** palliative care and end-of-life care, as appropriate.						
Comments:						
DOMAIN V: MANAGING / NEGOTIATING HEALTHCARE DELIVERY SYSTEMS & REGULATIONS	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Maintains current knowledge regarding state and federal regulations and programs for family healthcare.**						
2. **Monitors specialized care coordination** to enhance effectiveness of outcomes for individuals and families.						
Comments:						

PRECEPTOR COMMENTS:	STUDENT COMMENTS:		FACULTY COMMENTS:

* National Organization of Nurse Practitioner Faculties (2013). Population-Focused Nurse Practitioner Competencies. Washington, DC: Author.

* National Organization of Nurse Practitioner Faculties (2017). Nurse Practitioner Core Competencies. Washington, DC: Author.

Appendix D Family Nurse Practitioner Progressive Clinical Expectations

Nursing 701 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-12
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.	1	2	2	3
6. Reviews chart prior to encounter.	1	2	2	3
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues.	1	2	2	3
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. ***Student will see at least 4 through midterm and no more than 6 (after midterm) adult patients in an 8-10 hour clinical day.***	1	2	2	3
9. Performs appropriate and accurate physical examination on the **adult patient (18+)** for the presenting problem using correct techniques and equipment.	1	2	2	3
10. Identifies appropriate diagnostic testing as appropriate.	1	2	2	3
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	1	2	2	3
12. Arrives at correct diagnosis based on clinical data.	1	2	2	3
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care.	1	2	2	3
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	1	2	2	3

15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	1	2	2	3
16. Chooses appropriate medication and therapeutic dosage.	1	2	2	3
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	1	2	2	3-4
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	1	2	2	3-4
19. Presents patients to preceptor in a thorough, concise, and organized manner.	1	2	2	3-4
20. Identify patients whose health needs require urgent or emergent care.	1	2	2	3-4
21. Completes patient encounter in a timely manner. New patient or complete exam (90 minutes); Chronic or complex visit (60 minutes); Acute episodic visit (45 minutes).	1	2	2	3-4
22. Incorporates cost in decision-making.	1	2	2	3
23. Correctly uses ICD coding for diagnosis documentation.	1	2	2	3
Nursing 702 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-15
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	3	3	3	3
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Communication incorporates knowledge of child growth and development.*	3	3	3	3

8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. ***Student will see 6 through midterm and no more than 8 (after midterm) adult and adolescent patients in an 8-10 hour clinical day.***	3	3	3	3
9. Performs appropriate and accurate physical examination on **adult and adolescent patients (13-17 only)** for the presenting problem using correct techniques and equipment. *Performs examination considering the patient's age and stage of development.*	3	3	3	3
10. Identifies appropriate diagnostic testing as appropriate.	3	3	3	4
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	3	3	3	4
12. Arrives at correct diagnosis based on clinical data.	3	3	3	4
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care. *Incorporates knowledge of growth and development in development of treatment plan.*	3	3	3-4	4
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	3	3	3-4	4
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	3	3	3-4	3-4
16. Chooses appropriate medication and therapeutic dosage. *Can calculate medication dosage for pediatric patients.*	3	3	3-4 3-4	4
17. Determines health care maintenance and screening needs for adult and pediatric patients utilizing USPSTF recommendations.	3	3	3-4	3-4
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	3	3	3	3-4
19. Presents patients to preceptor in a thorough, concise, and organized manner.	3	3	3	3-4

20. Identify patients whose health needs require urgent or emergent care.	3	3	3	3-4
21. Completes patient encounter in a timely manner. New patient or complete exam (60 minutes); Chronic or complex visit (45 minutes); Acute episodic visit (30 minutes).	3	3	3	3-4
22. Incorporates cost in decision-making.	3	3	3	3-4
23. Correctly uses ICD coding for diagnosis documentation.	3	3	3	3-4
Nursing 703 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-15
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	5	5	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Evaluates and incorporates communication challenges (vision and hearing deficits).*	5	5	5	5
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. *Considers co-morbidities and chronic illness when obtaining data*. ***Student will see 8-10 adult, pediatric, and geriatric patients in an 8-hour clinical day. Primary focus woman and men's health, birth to 12, and older adult***	5	5	5	5
9. Performs appropriate and accurate physical examination on **patients across the life span** for the presenting problem using correct techniques and equipment.	3	4	4	4-5
10. Identifies appropriate diagnostic testing as appropriate.	3	4	4	4-5

	3 4			
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	4	4 4	4	4-5
12. Arrives at correct diagnosis based on clinical data.	3	4	4	4-5
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care. *Considers functional status and polypharmacy when developing treatment plan.*	3	4	4	4-5
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	3	4	4	4-5
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	3	4	4	4-5
16. Chooses appropriate medication and therapeutic dosage.	3	4	4	4-5
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	3	4	4	4-5
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4	4	4	4-5
19. Presents patients to preceptor in a thorough, concise, and organized manner.	4	4	4	4-5
20. Identify patients whose health needs require urgent or emergent care.	4	4	4	4-5
21. Completes patient encounter in a timely manner. New patient or complete exam (45 minutes); Chronic or complex visit (30-45 minutes); Acute episodic visit (15-30 minutes).	3-4	4	4	4-5
22. Incorporates cost in decision-making.	4	4	4	4-5
23. Correctly uses ICD coding for diagnosis documentation.	4	4	4	4-5

Nursing 790 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-15
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	5	5	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Evaluates and incorporates communication challenges (speech, vision, and hearing deficits).*	5	5	5	5
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. *Considers co-morbidities and chronic illness when obtaining data.* ***Student will see 10-12 patients in an 8-hour clinical day.*** ***Specialty rotations limited to 6-7 patients and expectation level 3-4***	4-5	4-5	5	5
9. Performs appropriate and accurate physical examination on **adult, pediatric, and geriatric patients** (specific components) for the presenting problem using correct techniques and equipment.	4-5	4-5	5	5
10. Identifies appropriate diagnostic testing as appropriate.	4-5	4-5	5	5
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	5	5	5	5
12. Arrives at correct diagnosis based on clinical data.	5	5	5	5
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for				

follow-up care. *Considers functional status and polypharmacy when developing treatment plan.*	4-5	4-5	5	5
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	4-5	4-5	5	5
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	4-5	4-5	5	5
16. Chooses appropriate medication and therapeutic dosage.	4-5	4-5	5	5
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	4-5	4-5	5	5
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4-5	5	5	5
19. Presents patients to preceptor in a thorough, concise, and organized manner.	5	5	5	5
20. Identify patients whose health needs require urgent or emergent care.	5	5	5	5
21. Completes patient encounter in a timely manner. New patient or complete exam (45 minutes); Chronic or complex visit (30 minutes); Acute episodic visit (15 minutes).	4-5	4-5	5	5
22. Incorporates cost in decision-making.	4-5	4-5	5	5
23. Correctly uses ICD coding for diagnosis documentation.	4-5	4-5	5	5

Levels of independence

1. Observation only	
2. Performance and decision making done with preceptor present	*Requires detailed assistance
3. Performance and decision making done in collaboration with preceptor	*Requires moderate assistance
4. Performance and decision making done with minimal assistance from preceptor	*Requires minimal assistance
5. Performance and decision making done independent of preceptor	*Requires no assistance; ALL cases reviewed and approved by preceptor

Adapted from:

Pearson, T., Garrett, L., Hossler, S., McConnell, P, & Walls, J. (2012). A progressive nurse practitioner student evaluation tool. *Journal of the American Academy of Nurse Practitioners, 24* (6).

Based on:

National Organization of Nurse Practitioner Faculties (2013). Population-Focused Nurse Practitioner Competencies. Washington, DC: Author.

National Organization of Nurse Practitioner Faculties (2017). Nurse Practitioner Core Competencies. Washington, DC: Author.

Progressive Clinical Expectations AGPCNP

Nursing 701 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-12
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.	1	2	2	3
6. Reviews chart prior to encounter.	1	2	2	3
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues.	1	2	2	3
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. ***Student will see at least 4 through midterm and no more than 6 (after midterm) adult patients in an 8–10-hour clinical day.***	1	2	2	3
9. Performs appropriate and accurate physical examination on the **adult patient (18+)** for the presenting problem using correct techniques and equipment.	1	2	2	3
10. Identifies appropriate diagnostic testing as appropriate.	1	2	2	3
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	1	2	2	3

12. Arrives at correct diagnosis based on clinical data.	1	2	2	3
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care.	1	2	2	3
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	1	2	2	3
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	1	2	2	3
16. Chooses appropriate medication and therapeutic dosage.	1	2	2	3
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	1	2	2	3-4
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	1	2	2	3-4
19. Presents patients to preceptor in a thorough, concise, and organized manner.	1	2	2	3-4
20. Identify patients whose health needs require urgent or emergent care.	1	2	2	3-4
21. Completes patient encounter in a timely manner. New patient or complete exam (90 minutes); Chronic or complex visit (60 minutes); Acute episodic visit (45 minutes).	1	2	2	3-4
22. Incorporates cost in decision-making.	1	2	2	3
23. Correctly uses ICD coding for diagnosis documentation.	1	2	2	3
Nursing 702 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-15
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				

4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	3	3	3	3
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Communication incorporates knowledge of adolescent growth and development.*	3	3	3	3
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. ***Student will see 6 through midterm and no more than 8 (after midterm) adult and adolescent patients in an 8–10-hour clinical day.***	3	3	3	3
9. Performs appropriate and accurate physical examination on **adult and adolescent patients (13-17 only)** for the presenting problem using correct techniques and equipment. *Performs examination considering the patient's age and stage of development.*	3	3	3	3
10. Identifies appropriate diagnostic testing as appropriate.	3	3	3	4
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	3	3	3	4
12. Arrives at correct diagnosis based on clinical data.	3	3	3	4
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care. *Incorporates knowledge of growth, development, and aging in treatment plan.*	3	3	3-4	4
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal	3	3	3-4	4

symptoms for which they should seek treatment.				
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	3	3	3-4	3-4
16. Chooses appropriate medication and therapeutic dosage. *Can calculate medication dosage for patient population.*	3	3	3-4 3-4	4
17. Determines health care maintenance and screening needs for adult and adolescent patients utilizing USPSTF recommendations.	3	3	3-4	3-4
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	3	3	3	3-4
19. Presents patients to preceptor in a thorough, concise, and organized manner.	3	3	3	3-4
20. Identify patients whose health needs require urgent or emergent care.	3	3	3	3-4
21. Completes patient encounter in a timely manner. New patient or complete exam (60 minutes); Chronic or complex visit (45 minutes); Acute episodic visit (30 minutes).	3	3	3	3-4
22. Incorporates cost in decision-making.	3	3	3	3-4
23. Correctly uses ICD coding for diagnosis documentation.	3	3	3	3-4

Nursing 710 (150 hours)	Weeks 1-3	Weeks 10-15	Weeks 7-9	Weeks 10-15
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				

6. Reviews chart prior to encounter.	5	5	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Evaluates and incorporates communication challenges (vision and hearing deficits).*	5	5	5	5
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. *Considers co-morbidities and chronic illness when obtaining data.* ***Student will see 8-10 adult, pediatric, and geriatric patients in an 8-hour clinical day. Primary focus woman and men's health, adolescents 13-17, and older adult***	5	5	5	5
9. Performs appropriate and accurate physical examination on **patients across the life span** for the presenting problem using correct techniques and equipment.	3	4-5	5	5
10. Identifies appropriate diagnostic testing as appropriate.	3 3	4-5	5	5
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	4	4-5	5	5
12. Arrives at correct diagnosis based on clinical data.	3	4-5	5	5
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care. *Considers functional status and polypharmacy when developing treatment plan.*	3	4-5	5	5
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	3	4-5	5	5
15. Provides anticipatory guidance, teaching, counseling, and specific information about the	3	4-5	5	5

diagnosis. Provides written information to patients when appropriate.				
16. Chooses appropriate medication and therapeutic dosage.	3	4-5	5	5
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	3	4-5	5	5
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4	4-5	5	5
19. Presents patients to preceptor in a thorough, concise, and organized manner.	4	4-5	5	5
20. Identify patients whose health needs require urgent or emergent care.	4	4-5	5	5
21. Completes patient encounter in a timely manner. New patient or complete exam (45 minutes); Chronic or complex visit (30-45 minutes); Acute episodic visit (15-30 minutes).	3-4	4-5	5	5
22. Incorporates cost in decision-making.	4	4-5	5	5
23. Correctly uses ICD coding for diagnosis documentation.	4	4-5	5	5

Nursing 791 (150 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-15
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	5	5	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Evaluates and incorporates communication challenges (speech, vision, and hearing deficits).*	5	5	5	5

8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), past medical history (PMH), medications, family history (FH), and relevant social history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. *Considers co-morbidities and chronic illness when obtaining data.* ***Student will see 10-12 patients in an 8-hour clinical day.*** ***Specialty rotations limited to 6-7 patients and expectation level 3-4***	4-5	4-5	5	5
9. Performs appropriate and accurate physical examination on **adult, pediatric, and geriatric patients** (specific components) for the presenting problem using correct techniques and equipment.	4-5	4-5	5	5
10. Identifies appropriate diagnostic testing as appropriate.	4-5	4-5	5	5
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	5	5	5	5
12. Arrives at correct diagnosis based on clinical data.	5	5	5	5
13. Creates an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, and plan for follow-up care. *Considers functional status and polypharmacy when developing treatment plan.*	4-5	4-5	5	5
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	4-5	4-5	5	5
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	4-5	4-5	5	5
16. Chooses appropriate medication and therapeutic dosage.	4-5	4-5	5	5
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	4-5	4-5	5	5
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4-5	5	5	5
19. Presents patients to preceptor in a thorough, concise, and organized manner.	5	5	5	5

20. Identify patients whose health needs require urgent or emergent care.	5	5	5	5
21. Completes patient encounter in a timely manner. New patient or complete exam (45 minutes); Chronic or complex visit (30 minutes); Acute episodic visit (15 minutes).	4-5	4-5	5	5
22. Incorporates cost in decision-making.	4-5	4-5	5	5
23. Correctly uses ICD coding for diagnosis documentation.	4-5	4-5	5	5

Levels of Independence

(1) Observation only.	
(2) Performance and decision-making done with preceptor present.	*Requires detailed assistance
(3) Performance and decision-making done in collaboration with preceptor.	*Requires moderate assistance
(4) Performance and decision-making is done with minimal assistance from preceptor.	*Requires minimal assistance
(5) Performance and decision-making is done independent of preceptor.	*Requires no assistance; ALL cases are reviewed and approved by preceptor

Adapted from:

Pearson, T., Garrett, L., Hossler, S., McConnell, P, & Walls, J. (2012). A progressive nurse practitioner student evaluation tool. *Journal of the American Academy of Nurse Practitioners, 24* (6).

Based on:

National Organization of Nurse Practitioner Faculties (2013). Population-Focused Nurse Practitioner Competencies. Washington, DC: Author.

National Organization of Nurse Practitioner Faculties (2017). Nurse Practitioner Core Competencies. Washington, DC: Author.

Appendix F Psychiatric Mental Health Nurse Practitioner Clinical Requirements

This chart represents the recommended minimum requirements for clinical hours, visits, and procedures for completion of the PMHNP Clinical Competencies

Population	Total Hours (Recommended)	Minimum Number of Visits (Recommended)	Procedures/Visits (Recommended)	Percent of Time	Course Focus
Lab	16 hours prep and activities		Therapeutic communication and interviewing skills; differential diagnosis of psychiatric conditions	0%	NURS 731
Child/Adolescent	50-100 hours	100 total	Minimum 2 intake encounters 50 acute or follow-up encounters 5-10 group and/or family encounters	9-17%	NURS 732, 734, 793
Adolescents (13-17)		60	Minimum 3 intake encounters 3-5 group and/or family encounters		
Child (up to age 13)		40	Minimum 3 intake encounters 2-3 group and/or family encounters		
Adult	300-425 hours	500 total		50-70%	NURS 732, 733, 793
Ages 18-65	300-350	350	300 encounters-acute or follow up Minimum 10 intake encounters 5-10 group and/or family encounters		
Geriatric 66+	100-200	150	100 encounters-acute or follow up Minimum 5 intake encounters 3-5 group and/or family encounters		
Therapy across the lifespan	75 hours required Up to 75 hours optional	Additional 25-75		12.5%	NURS 731, 732, 733, 734,793

*Potential sites include Psychiatric inpatient, intensive outpatient programs, partial hospitalization programs, residential treatment facilities, outpatient psychiatry or therapy practice, long term care facilities, inpatient recovery programs, outpatient recovery programs, correctional facilities, K-12 schools, college or university health centers, neuropsychological practices, integrated health clinics, shelters/clinics for vulnerable populations, refugee or immigrant clinics, any group therapy setting involving professional psychotherapies, and other settings that are appropriate for the course and content. Non-professional led settings such as Alcoholics Anonymous and community support groups are not appropriate. No more than 5 hours can be used for participating in procedures such as transcranial magnetic stimulation or electroconvulsive therapy.

Appendix G Psychiatric Mental Health Nurse Practitioner Preceptor Evaluation of Student

NOTE THIS INFORMATION IS COLLECTED ELECTRONICALLY VIA EXXAT

Psychiatric Mental Health Nurse Practitioner Student Clinical Practicum

Clinical Competency Evaluation

Student Name: _____ Preceptor Name: _____

Practicum dates: _____ to _____ Course Number: _____

The midterm and final evaluations are based on accepted nurse practitioner competencies* and provide individualized feedback to students regarding strengths and areas for growth. The faculty has established expected averaged competency levels **for each domain** that students should meet by the **END of each clinical course:**

NURS 731 3.0 average
NURS 732 3.0 average
NURS 733 4.0 average
NURS 793 4.5 average

FOR MID-TERM EVALUATION: IT IS NOT EXPECTED THAT THE STUDENT WILL REACH THE END OF COURSE AVERAGES. PLEASE MARK ACCORDINGLY AND PROVIDE COMMENTS DETAILING AREAS FOR IMPROVEMENT.

PLEASE EVALUATE THE STUDENT'S PERFORMANCE BY SCORING EACH ELEMENT USING THE FOLLOWING CRITERIA:

NA = Not applicable or not observed

1 = **Omits** element or achieves **minimal competence** even with assistance

2 = Needs a **lot of direct supervision**

3 = Needs **some direct supervision**

4 = Needs **minimal direct supervision**

5= **Mostly independent** practice

Competencies

DOMAIN I.A: ASSESSMENT OF HEALTH STATUS	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Obtains and accurately documents a relevant health history** for clients of all ages and in all phases of the individual, family, or group lifecycle using collateral information, as needed.						

2. **Analyzes and interprets psychiatric/mental health history**, including presenting symptoms, physical findings, and diagnostic information to develop appropriate differential diagnoses.						
3. **Assess impact of acute and chronic medical problems on psychiatric treatment.**						
4. Uses **advanced assessment skills to differentiate between normal, variations of normal and abnormal findings.**						
Comments:						

DOMAIN I.B: DIAGNOSIS OF HEALTH STATUS	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Employs screening and diagnostic strategies** in the development of diagnoses.						
2. Applies theoretical knowledge and current research findings in **analyzing and synthesizing data to make clinical judgments and decisions,** individualizing care for individuals, groups, and families.						
3. **Formulates comprehensive differential diagnoses** and prioritizes mental health problems, considering epidemiology, life stage development, and environmental and community characteristics.						
4. Assesses decision-making ability, **consults, and refers, appropriately.**						
Comments:						

DOMAIN I.C: PLAN OF CARE AND IMPLEMENTATION OF TREATMENT	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Develops an individualized treatment plan for mental health problems and psychiatric disorders** in partnership with individual, family, or group based on biopsychosocial theories, evidence-based standards of care, practice guidelines						

and considering client values and beliefs, preferences, developmental level, coping style, culture and environment, available technology, and recovery goals.						
2. Plans care for **common acute, chronic, or acute exacerbations of mental illnesses** across the lifespan to minimize complications and promote function and quality of life using treatment modalities including but not limited to psychodynamic, cognitive behavioral, supportive interpersonal therapies and psychopharmacology.						
3. **Prescribes medications for clients with mental health problems and psychiatric disorders,** understanding altered pharmacodynamics and pharmacokinetics with special populations, such as children, pregnant and lactating women, and older adults.						
4. **Assesses and manages individual, group, and family responses to the plan of care** including evaluation of therapeutic and adverse effects, appropriate modification of plan, and **documentation that includes diagnostic and laboratory test results, outcomes measures, response to therapies, and changes in condition**.						
5. **Evaluates coping and support systems, lifestyle adaptations and resources** for patients, groups, and families, **facilitates transition and coordination of care** between and within health care settings and the community, and **initiates appropriate referrals** to other healthcare professionals.						
6. **Adapts interventions to meet the complex needs** of individuals, groups, and families arising from aging, developmental/life transitions, comorbidities, genetics, psychosocial, and financial issues.						
7. **Manages psychiatric emergencies** across all settings.						
Comments:						
DOMAIN II: NURSE PRACTITIONER-PATIENT RELATIONSHIP & DOMAIN III: TEACHING COACHING FUNCTION	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Applies therapeutic relationship strategies and counseling techniques** based on theories and research evidence to develop a sustainable partnership with the						

individual, group, or family, reduce trauma and emotional distress, facilitate cognitive and behavioral change, foster personal growth, and decision making.						
2. **Identifies and maintains professional boundaries** to preserve the integrity of the therapeutic process.						
3. **Delivers ethical and compassionate care** in a manner that preserves and protects patient autonomy, dignity, and rights.						
4. Applies principles of **self-efficacy/empowerment** in promoting relationship development and behavior change.						
5. **Develops health promotion and teaching interventions** appropriate to individual, group, or family needs, recovery goals, language and cultural beliefs, values, motivation, cognitive level, and socioeconomic status.						
6. Demonstrates ability to address sexual/physical abuse, substance abuse, sexuality, and spiritual conflict across the lifespan and **provides anticipatory guidance, teaching, counseling, and education for self-care.**						
7. **Explains the therapeutic and potential adverse effects, risks and benefits, costs, and any alternatives of treatment** to the patient and their family.						
8. **Therapeutically concludes the nurse-patient relationship**, as appropriate.						
Comments:						
DOMAIN V: MANAGING / NEGOTIATING HEALTHCARE DELIVERY SYSTEMS & REGULATIONS	**1**	**2**	**3**	**4**	**5**	**NA**
1. **Maintains current knowledge regarding state and federal regulations and programs for psychiatric and mental health care.**						
2. **Collaborates in planning transitions** across the continuum of care.						
Comments:						

PRECEPTOR COMMENTS:	STUDENT COMMENTS:		FACULTY COMMENTS:

NOTE: all evaluations are completed in EXXAT

* National Organization of Nurse Practitioner Faculties (2013). Population-focused nurse practitioner Competencies. Washington, DC: Author.

* National Organization of Nurse Practitioner Faculties (2017). Nurse practitioner core competencies. Washington, DC: Author

*American Nurses Association. (2014). Psychiatric mental health nursing: Scope and standards of practice (2nd ed). Silver Spring, MD: Author.

Appendix H Psychiatric Mental Health Nurse Practitioner Progressive Clinical Expectations

PMHNP Progressive Clinical Expectations

Nursing 732 (75 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-12
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.	1	2	2	3
6. Reviews chart prior to encounter.	1	2	2	3
7. Demonstrates effective communication with patients, families, or groups including ability to recognize cultural nuances and manage sensitive or emotional issues.	1	2	2	3
8. Obtains subjective assessment: chief complaint, history of present illness (HPI), psychiatric review of systems (ROS), relevant medical history, medications, family history (FH), and relevant social/ecological history (SH) for patients presenting for psychotherapy visits. Demonstrates logical systematic methodology in obtaining subjective patient data. ***Student will see at least 3 through midterm and no more than 5 (after midterm) patients in an 8–10-hour clinical day. Student will engage in at least 5 family and 5 group sessions during the semester.***	1	2	2	3
8a. *For group therapy:* Obtains assessment of group structure and population, therapeutic factors (cohesion, universality, self-disclosure, interpersonal learning, etc), negative factors, working or developmental stage (forming, storming, norming, performing, adjourning), and processes.	1	2	2	3
8b. *For family therapy:* Obtains assessment of family using Bowen's family systems theory to determine family triangulation, self-differentiation, nuclear family emotional processes, projection, multigenerational transmission processes, emotional cutoff, sibling position, and societal emotional processes.				
9. Performs appropriate and accurate mental health examination on individuals, families, and groups for the presenting	1	2	2	3

problem using appropriate evidence-based diagnostic criteria and screening tools.				
10. Formulates a list of differential diagnoses (considers at least three diagnoses for *most* patients).	1	2	2	3
11. Arrives at correct diagnosis based on clinical data.	1	2	2	3
12. Creates an evidence-based psychotherapeutic treatment plan that includes consideration of developmental stage, cognitive ability, risk assessment, prognosis, expected outcomes, possible referrals, and plans for follow-up evaluation.	1	2	2	3
12a. *For group/family therapy*: Develops an evidence-based treatment plan appropriate for the group/family structure, goals, and therapeutic modality.	1	2	2	3
13. Engages in therapeutic communication appropriate to diagnosis, therapeutic modality, patient, family, or group readiness and motivation.	1	2	2	3
13. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which patient should seek treatment.	1	2	2	3
14. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	1	2	2	3
15. Determines appropriate tools for measurement-based care based on diagnosis.	1	2	2	3-4
16. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	1	2	2	3-4
16a. *For group/family therapy*: Document group/family therapy session, including purpose of session, interventions used, interactions among group/family members, and the impact of the session on members, in a clear, organized way that demonstrates appropriate use of medical terminology.	1	2	2	3-4
17. Identify patients whose mental health needs require urgent or emergent care.	1	2	2	3-4
18. Correctly uses ICD coding for diagnosis documentation.	1	2	2	3-4
19. Correctly uses CPT codes for billing.	1	2	2	3-4
Nursing 733 (175 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-12
1. Completes facility orientation and reviews relevant policies and procedures.				

2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	3	4	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Adjusts for visual and hearing impairment.*	3	4	4	4
8. Obtains subjective assessment: chief complaint, history of present illness (HPI), psychiatric review of systems (ROS), relevant medical history, medications, family history (FH), and relevant social/ecological history (SH) for patients presenting for psychiatric treatment. Demonstrates logical systematic methodology in obtaining subjective patient data. *Considers co-morbidities and chronic illness when obtaining data.* ***Student will see 6 through midterm and no more than 8 (after midterm) adult and geriatric patients in an 8-10 hour clinical day.***	3	4	4	4
9. Performs appropriate and accurate mental health examination on **adult and geriatric patients** for the presenting problem using evidence-based diagnostic criteria and screening tools. *Performs evaluation considering the patient's age, cognitive ability, and functional status.*	3	3	4	4
10. Formulates a list of differential diagnoses (considers at least three diagnoses for *most* patients).	3	3	4	4
11. Arrives at correct diagnosis based on clinical data.	3	3	3	4
12. Creates an evidence-based treatment plan that includes pharmacological and non-pharmacological modalities and considers developmental stage, cognitive ability, risk assessment, prognosis, expected outcomes, possible referrals, appropriate drug monitoring, and plans for follow-up evaluation.	1	2	2	3
13. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	4	4	4	4
14. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	4	4	4	4

15. Chooses appropriate medication and therapeutic dosage given the diagnosis, medication history, genomics, and possible interactions with medications taken for physiological conditions interactions with medications taken for physiological conditions. *Considers functional and cognitive status, and AGS Beers Criteria®.*	1	2	2	3
16. Determines appropriate tools for measurement-based care based on diagnosis.	4	4	4	4
17. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4	4	4	4
18. Presents patients to preceptor in a thorough, concise, and organized manner.	4	4	5	5
19. Identify patients whose health needs require urgent or emergent care.	4	4	5	5
20. Completes patient encounter in a timely manner. New patient or complete exam (60 minutes); Chronic or complex visit (45 minutes); Acute episodic visit (30 minutes).	3-4	4	4	4
21. Incorporates cost in decision-making.	4	4	5	5
22. Correctly uses ICD coding for diagnosis documentation.	4	4	5	5
23. Correctly uses CPT codes for billing documentation.	4	4	5	5
Nursing 734 (175 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-12
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	5	5	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues.	4	4	4	4

8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), relevant medical history (PMH), medications, family history (FH), and relevant social/ecological history (SH) for patients presenting psychiatric treatment. Demonstrates logical systematic methodology in obtaining subjective patient data. ***Student will see 8-10 adult, pediatric, and geriatric patients in an 8-hour clinical day. Primary focus pediatric and adolescent mental health.***	4	4	4	4
9. Performs appropriate and accurate psychiatric examination on **patients across the life span** for the presenting problem using evidence-based diagnostic criteria and screening tools	4	4	4	4
10. Formulates a list of differential diagnoses (considers at least three diagnoses for *most* patients).	4	4	4	4
11. Arrives at correct diagnosis based on clinical data.	4	4	4	4
12. Creates an evidence-based treatment plan that includes pharmacological and non-pharmacological modalities and considers developmental stage, cognitive ability, risk assessment, prognosis, expected outcomes, possible referrals, appropriate drug monitoring, and plans for follow-up evaluation. *Considers developmental stage.*	3	3	3	3-4
13. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	4	4	4	4
14. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	4	4	4	4
15. Chooses appropriate medication and therapeutic dosage given the diagnosis, medication history, genomics, and possible interactions with medications taken for physiological conditions. *Calculates appropriate pediatric dosing.*	3	3	3	3-4
16. Determines appropriate tools for measurement-based care based on diagnosis.	4	4	4	4
17. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4	4	4	4
18. Presents patients to preceptor in a thorough, concise, and organized manner.	5	5	5	5
19. Identify patients whose health needs require urgent or emergent care.	5	5	5	5
20. Completes patient encounter in a timely manner. New patient or complete exam (45 minutes); Chronic or complex visit (30-45 minutes); Acute episodic visit (15-30 minutes).	4	4	4	4

21. Incorporates cost in decision-making.	5	5	5	5
22. Correctly uses ICD coding for diagnosis documentation.	5	5	5	5
23. Correctly uses CPT codes for billing documentation.	5	5	5	5
Nursing 793 (175 hours)	Weeks 1-3	Weeks 4-6	Weeks 7-9	Weeks 10-12
1. Completes facility orientation and reviews relevant policies and procedures.				
2. Communicates effectively with office staff, nurses, and other professionals.				
3. Maintains professional standards including dress, timeliness, and language.				
4. Demonstrates interest and takes initiative in learning.				
5. Has references and uses them effectively and efficiently in the clinical setting.				
6. Reviews chart prior to encounter.	5	5	5	5
7. Demonstrates effective communication with patients and their families including ability to recognize cultural nuances and manage sensitive or emotional issues. *Accommodates for communication challenges (speech, vision and hearing deficits).*	5	5	5	5
8. Obtains subjective assessment date: history of present illness (HPI), review of systems (ROS), relevant medical history (PMH), medications, family history (FH), and relevant social/ecological history (SH) for patients presenting for complete physical examinations and episodic visits. Demonstrates logical systematic methodology in obtaining subjective patient data. *Considers co-morbidities and chronic illness when obtaining data.* ***Student will see 10-12 patients in an 8-hour clinical day.***	4-5	4-5	5	5
9. Performs appropriate and accurate psychiatric examination on **adult, pediatric, and geriatric patients** for the presenting problem using evidence-based diagnostic criteria and screening tools.	4-5	4-5	5	5
11. Formulates a list of differential diagnoses (considers at least three diagnoses for most patients).	5	5	5	5
12. Arrives at correct diagnosis based on clinical data.	5	5	5	5
13. *Creates* an evidence-based treatment plan that includes pharmacologic and non-pharmacologic treatments, lifestyle modifications, referrals, expected outcomes, appropriate				

monitoring, and plan for follow-up care. *Considers functional status and polypharmacy when developing treatment plan.*	4	4-5	5	5
14. Communicates detailed and clinically sound follow-up plan, including relevant and cardinal symptoms for which they should seek treatment.	4-5	4-5	5	5
15. Provides anticipatory guidance, teaching, counseling, and specific information about the diagnosis. Provides written information to patients when appropriate.	4-5	4-5	5	5
16. Chooses appropriate medication and therapeutic dosage given the diagnosis, medication history, genomics, and possible interactions with medications taken for physiological conditions.	4-5	4-5	5	5
17. Determines health care maintenance and screening needs utilizing USPSTF recommendations.	4-5	4-5	5	5
18. Documents patient visits using a SOAP format that demonstrates clarity, organization, and appropriate use of medical terminology.	4-5	5	5	5
19. Presents patients to preceptor in a thorough, concise, and organized manner.	5	5	5	5
20. Identify patients whose health needs require urgent or emergent care.	5	5	5	5
21. Completes patient encounter in a timely manner. New patient or complete exam (45 minutes); Chronic or complex visit (30 minutes); Acute episodic visit (15 minutes).	4-5	5	5	5
22. Incorporates cost in decision-making.	5	5	5	5
23. Correctly uses ICD coding for diagnosis documentation.	5	5	5	5

Levels of independence

1. Observation only	
2. Performance and decision making done with preceptor present	*Requires detailed assistance
3. Performance and decision making done in collaboration with preceptor	*Requires moderate assistance
4. Performance and decision making done with minimal assistance from preceptor	*Requires minimal assistance

5. Performance and decision making done independent of preceptor	*Requires no assistance; ALL cases reviewed and approved by preceptor

Adapted from:

Pearson, T., Garrett, L., Hossler, S., McConnell, P, & Walls, J. (2012). A progressive nurse practitioner student evaluation tool. *Journal of the American Academy of Nurse Practitioners, 24* (6).

Based on:

National Organization of Nurse Practitioner Faculties (2013). Population-Focused Nurse Practitioner Competencies. Washington, DC: Author.

National Organization of Nurse Practitioner Faculties (2017). Nurse Practitioner Core Competencies. Washington, DC: Author.

American Nurses Association. (2014). Psychiatric-mental health nursing: Scope and standards of practice (2nd ed.). Silver Spring, MD: Author.

Appendix I Definitions of Diversity, Equity, Inclusion, and Belonging Terms

Belonging: Belonging is the feeling of security and support when there is a sense of acceptance, inclusion, and identity for a member of a certain group. It is when an individual can bring their authentic self to work: https://diversity.cornell.edu/belonging/sensebelonging#:~:text=Belonging%20is%20the%20feeling%20of,their%20authentic%20self%20to%20work.

Disadvantaged/excluded/marginalized/ vulnerable groups or populations: terms applied to people who, due to factors usually considered outside their control, do not have the same opportunities as more privileged groups in society. For example: "Structural inequalities between members of more advantaged and more disadvantaged population groups are a central feature of all societies. These inequalities are deeply rooted in the past and have been carried forward into the present. Their persistence severely undermines local, national, and global efforts to promote advances in the quality of life and well-being of people at all levels of social, political, and economic organization" Estes R.J. (2014) Disadvantaged Populations. In: Michalos A.C. (eds) Encyclopedia of Quality of Life and Well-Being Research. Springer, Dordrecht. https://doi.org/10.1007/978-94-007-0753-5_742

Diversity: The condition of being different or having differences. Differences among people with respect to age, class, ethnicity, gender, health, physical and mental ability, race, sexual orientation, religion, physical size, education level, job and function, personality traits, and other human differences. https://edib.harvard.edu/files/dib/files/dib_glossary.pdf

Equity: Fair treatment for all while striving to identify and eliminate inequities and barriers. https://edib.harvard.edu/files/dib/files/dib_glossary.pdf

Explicit bias: The traditional conceptualization of bias. This explicit bias, individuals are aware of their prejudices and attitudes toward certain groups. Overt racism and racist comments are examples. https://www.justice.gov/file/1437326/download#:~:text=Explicit%20bias%20is%20the%20traditional,are%20examples%20of%20explicit%20biases

Heterosexism/homophobia: heterosexism and homophobia are closely related but distinct concepts. "[H]omophobia generally refers to an individual's fear or dread of gay men or lesbians, [while] heterosexism denotes a wider system of beliefs, attitudes, and institutional structures that attach value to heterosexuality and disparage alternative sexual behavior and orientation" https://dictionary.apa.org/homophobia and https://dictionary.apa.org/heterosexism

Implicit bias: Implicit bias involves all of the subconscious feelings, perceptions, attitudes, and stereotypes that have developed as a result of prior influences and imprints. https://www.justice.gov/file/1437326/download#:~:text=Explicit%20bias%20is%20the%20traditional,are%20examples%20of%20explicit%20biases

Inclusion: The practice or policy of providing equal access to opportunities and resources for people who might otherwise be excluded or marginalized, such as those who have physical or mental disabilities and members of underrepresented minority groups. https://languages.oup.com/google-dictionary-en/

Macroaggression: Obvious, intentional insult, where there is no chance of a mistake on the part of the transgressor, intended to be provoking, insulting, or otherwise discourteous. https://www.urbandictionary.com/define.php?term=macroaggressions

Microaggression: The everyday verbal, nonverbal, and environmental slights, snubs, or insults, whether intentional or unintentional, which communicate hostile, derogatory, or negative messages to the target person based solely upon their marginalized group membership. Microaggressions are often racially charged "subtle blows" but over time they can take a toll on mental and physical health.
https://www.urbandictionary.com/define.php?term=Microaggressions

Racism: "a form of prejudice that assumes that the members of racial categories have distinctive characteristics and that these differences result in some racial groups being inferior to others. Racism generally includes negative emotional reactions to members of the group, acceptance of negative stereotypes, and racial discrimination against individuals; in some cases, it leads to violence" https://dictionary.apa.org/racism

Safe place: "A safe space is ideally one that doesn't incite judgment based on identity or experience – where the expression of both can exist and be affirmed without fear of repercussion and without the pressure to educate. While learning may occur in these spaces, the ultimate goal is to provide support."
https://alternativebreaks.org/safe-or-brave-spaces/

Brave place: "A brave space encourages dialogue. Recognizing the difference and holding each person accountable to do the work of sharing experiences and coming to new understandings – a feat that's often hard, and typically uncomfortable. We'd be remiss to simply hear the new term brave space and throw the old one out like a mistake we'd like to quickly forget. The reality is: they're different spaces, providing different outcomes."
https://www.naspa.org/images/uploads/main/Policy_and_Practice_No_2_Safe_Brave_Spaces.pdf

Appendix J Avoiding Stereotypes and Bias in Assessment of Learner Performance

Narrative evaluations can contain bias. Focusing on traits associated with certain groups based on race/ethnicity, gender, or other characteristics reinforces stereotypes and can ignore other aspects of learner performance. Avoid these stereotypes by focusing on observed behaviors and describing competency-based performance. Scan your written evaluation to check for any unintended stereotypes.

Caution: avoid this language	**Analysis**	**Instead, consider using this language**
'She was quiet yet participatory.'	'Quiet' can be associated with gender or race/ethnicity.	'She listened well; she participated thoughtfully.'
'She was warm, caring and empathic.' (as the only descriptors)	These are strengths but are also the characteristics that evaluators tend to focus more on for women than men; the evaluator should comment on other competencies as well.	Describe clinical skills, knowledge and interactions with patients and team.
'He worked hard through the rotation.'	Effort is commendable; it is also important to describe performance and connect effort to accomplishments.	'Due to his hard work creating a discharge plan, our team was able to discharge the patient safely to home.'
'He did well despite his many outside responsibilities.' 'Her knowledge grew as she balanced outside family responsibilities.'	Qualified language detracts from the student's accomplishments.	'He contributed to the team by doing….' 'She gained knowledge and applied it to her clinical practice.'
'Compared to other people with his background, his performance was…'	Avoid focusing on comparing students to other students particularly in a stereotyped way; focus on observed performance.	'He successfully performed the following key clinical tasks for this clerkship….'
'He contributed a lot to the team despite being gone from the rotation for weekly appointments.'	Students with approved accommodations to attend medical appointments cannot be penalized for this.	Focus narrative on what student did on the service, not when the student was not there.
'After initially not having a very strong fund of knowledge of our specialty, they seemed to read a lot over the course of the rotation.'	The evaluator may be trying to comment on improvement, but the focus should be on the student's achievement by the end of the rotation, not just on the deficit.	'The student read a lot and achieved the expected fund of knowledge by the end of the rotation. They applied their reading effectively to patient problems in their notes and case discussions.'

Watch for and ask the student and other team members about student contributions you may not have observed.

Student contribution	Competencies	Description
Spending time with a patient explaining a diagnosis that was unclear to the patient on rounds	Interpersonal and communication skills Patient care	'The student spent extra time with the patient explaining his diagnosis and answering questions to ensure his understanding and provide reassurance.'
Working on discharge planning to ensure that the patient will receive all of her medications, have secure housing, and understand her follow up appointments	Systems-based practice Interprofessional collaboration	'The student coordinated discharge planning for a complex patient discharge by working with the pharmacist, case manager, and resident to ensure that the patient understood the discharge plans. This included finding a pharmacy to provide all the prescribed medications, securing temporary housing, and explaining the plans to the patient to confirm her understanding.'
Answering questions from a patient's family about an upcoming procedure	Interpersonal and communication skills	'When a patient's family had questions about an upcoming procedure, the student listened to their questions and concerns with empathy. The student then coordinated with the resident to answer all their questions accurately and thoroughly

Franklin University SON Implicit Bias video: https://youtu.be/s1IuzU_QZLI

Franklin University SON Microaggressions video: https://youtu.be/2WKya4btKJM

Used with permission. https://meded.ucsf.edu/sites/meded.ucsf.edu/files/inline-files/Avoiding%20stereotypes%20in%20assessment.pdf

Other resources:

UCSF School of Medicine. (2021). Bias and Microaggressions in Feedback. https://media.ucsf.edu/media/t/1_fe7uld8i

UCSF Medical School. (2022). Diversity, Equity, Inclusion Tips Sheet for the Clinical Learning Environment. https://wiki.library.ucsf.edu/display/TBS/Clinical+Faculty?preview=/482580148/551938878/DEI%20Tips%20Sheet%202.0%20January%202022.pdf

UCSF School of Medicine. (2020). Equity in Assessment Checklist. https://meded.ucsf.edu/sites/meded.ucsf.edu/files/inline-files/Equity_in_Assessment_Checklist_2020dec14v2.pdf