Engaging DNP Nurse Practitioner Students in Professional Writing: Self Publishing an e-Book

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Objectives

- Participants will be able to describe one method for providing an opportunity for successful publication of practice focused scholarship and formulate other similar possibilities

Why Can't Students Write?

- — Students do not read very much in their leisure time.
- — They spend more time playing videogames and watching TV.
- — Their skills are eroded by texting and social media formats.
- — Their communication habits are reinforced by peer groups.
- — For some students, English is not their native language.

Nolop, 2013 Wall Street Journal

Background

- Nursing leaders have called for more dissemination of practice based scholarship

Driscoll & Driscoll 2002; Nelms, 2004; Murray & Newton, 2008

Background

- **BSN-DNP curriculums focus on preparing expert clinicians with the knowledge and skills to provide direct patient care and implement evidence based practice change. However, little focus is placed on professional writing and providing opportunities to gain the confidence needed to achieve scholarly dissemination beyond the educational setting**

Keen, 2007; Siclair, 2010; Taylor, Lyon & Harris, 2005

Background

- Opportunities to write and revise as requirements of professional scholarship are limited in most practice-based curriculums. Some programs offer "how-to" or scientific writing courses but they don't always provide the emotional support needed by novice writers

- While, traditional venues for publication are encouraged, the outcome of getting published is not guaranteed and confidence can be shattered at an early stage.

Baldwin & Chandler, 2002; Stone et al., 2009

Purpose

- The purpose of this extracurricular project was to provide a professional writing experience for novice, unpublished DNP student writers with a guaranteed positive outcome of publication.

Editor-Contributor Process

- **Unifying Theme: Diagnostic Reasoning Process**
- **Method: Case Studies**
- **Uniformity: Template**

Template

Case Presentation

Question 1: What are the top two – four (depending on the problem) differential diagnoses?

- For each differential diagnoses provide a brief overview (not too brief) with presenting symptoms/signs with an evidence based citation. Then report what about this patient's presentation either refutes or supports the differential.

Question 2: Is further testing needed?

- If so, what and why? If not, why? Be sure to explain how the recommended test supports or refutes the specific differential. Provide test results (if you don't really know them or think it would make a better case if the results were different feel free to change that here)
- **Complete Diagnostic Reasoning Table**

Question 3: Based on the information you have been provided so far, what is the most likely diagnosis?

Question 4: What is the evidenced based approach to managing this diagnosis?

- Patient / family psychoeducation/ education
- Medications if recommended
- Referrals
- Follow up
- *Must have the highest level of evidence available to support this plan (references)*

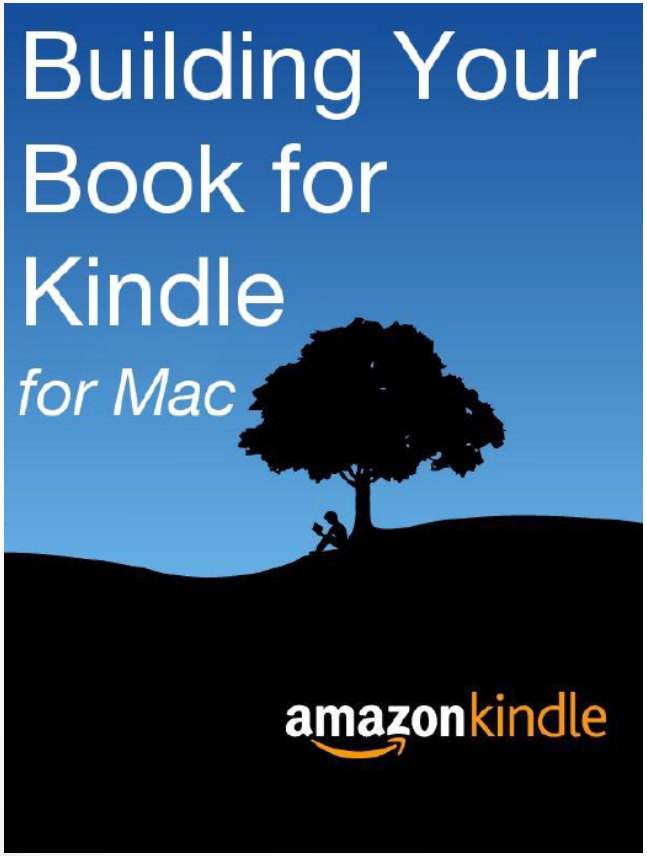
Resources - electronic (websites)

- For clinicians
- For Families

References

Electronic Book or Document

- **Kindle Direct Publishing on Amazon ®**



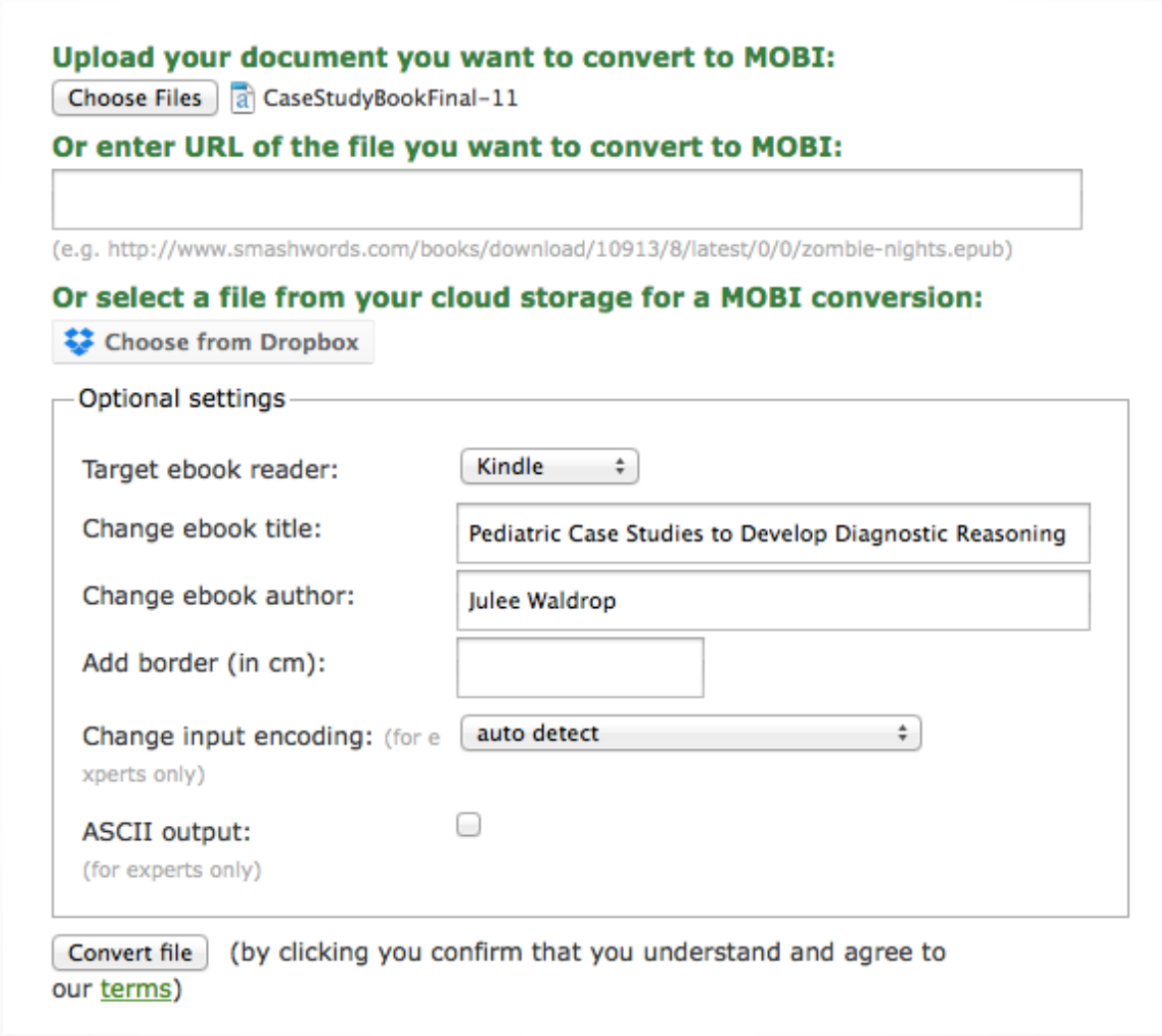
Preparing your Document

- Follow word formatting to the letter!
- Cool eBook features like linking TOC to chapters
- Active links to patient and parent resources
- When CPG change, you can update

Design Challenges

- Tables are difficult to format
- Photos need to be transformed to specific formats
- Cover Design can be challenging

Converting Your Files



Preview as Seen in e-Reader

Kindle Previewer

As many experienced clinicians will tell you, the basis of any good diagnosis is a good history. Diagnosis is 90% history and 10% physical exam, tests and procedures. The history starts with the chief complaint, which should be whatever the patient declares it to be, the reason for the visit today. Most times, the chief complaint alone will start the clinician's differential diagnostic abilities flowing. It can be for example, very specific: "he shut the car door on his hand and now his thumb is swollen and purple and it hurts" to very vague " I am so tired all the time." Both bring to mind possible diagnoses but one has a much smaller number of possibilities than the other. Getting the rest of the story is how the clinician begins to narrow down the possibilities.

Formulating an inquiry strategy starts with a thorough history. By thorough I do not mean that a "complete history" must be taken on every patient at every encounter but the history that is appropriate for the chief complaint be taken thoroughly. The history should then be followed by a thorough physical exam (using the same definition of thorough above). At this point, the clinician will have gathered a good bit of information and hopefully developed some hypotheses about the possible causes of the patient's chief complaint. The set of possible causes and potential diagnoses is traditionally called the differential diagnoses because the most likely one needs to be differentiated from the rest. Sometimes, in order to do this the clinician must go back and take more history or ask more questions or order some tests. Before you do that, however, let's use an example to see how far you can get with just the history and physical exam.

Imagine you are preparing to enter an exam room and picking up the patient's chart or open her electronic health record on your mobile computing device you see that Susie Q., a 16 year old patient known to your practice, but who has not been seen in over a year, is presenting with the chief complaint of "I have not gotten a period yet."

After you exchange greetings with Susie and her mother you ask about the history of her presenting complaint or illness (HPI). In this case, there really is not much to say. She turned 16 last month and read on the Internet that if you have not had a period by age 16 there might be something wrong with you and she told her mother. Her mother then also got worried and made this appointment.

She has a past medical history (PMH) of seasonal allergies and ear infections as a young child.

Upload to Amazon!

Kindle Direct Publishing
http://kdp.amazon.com

Pediatric Case Studies to Develop Diagnostic Reasoning Jul 20, 2014
by Julee Waldrop

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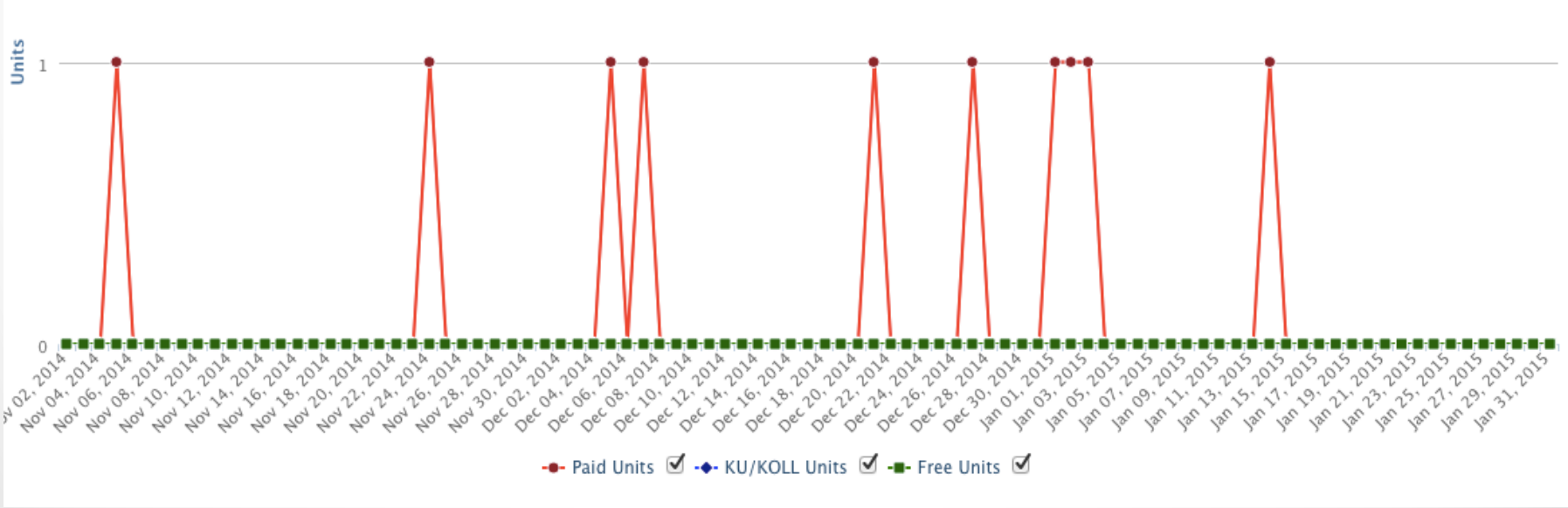

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