

IM 2 Simulated Patient Clinical Video Grading Rubric

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Video: 1

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There are three (3) ways to receive credit for the video:

1. Perform the scenario with all critical elements in each area of the grading tool
2. Verbalize a breach or mistake in real time and provide the nursing intervention to correct the breach or mistake then proceed with the video
3. When reviewing the video, honestly evaluate the nurse. Recognize all (if any) breaches or mistakes, record them as "unmet" and provide a nursing intervention to correct the breach or mistake

Universal Competency	Critical Elements	M	U
Safety (physical and emotional)	Introduce self	M	
	Identify patient (2 patient identifiers)	M	
	AIDET	M	
	Allergies	M	
	4 P's	M	
	Fall Bundle	M	
	Medication Administration: Medication, dosage, route, reason, assessment of route site(s), medication delivery equipment (IV pump, etc.)		
Critical Thinking	Assessment: See NII for critical elements pertaining to selected assessment(s)	M	
	Procedure Assess, Plan, Implement, Evaluate (APIE) (Selection of appropriate equipment, time management, organization, etc.)	M	
Standard Precaution	Asepsis:		
	Hand hygiene		U
	Don and change gloves (as indicated)	M	
	Clean equipment (stethoscope, pulse ox, bedside table, med tray, etc.)	M	
	Sterile procedure		U
	Medication preparation	M	
Documentation	Medication delivery	M	
	Teach Patient:		
	Medication	M	
	Procedure	M	
	Scan patient	M	
	Scan medication	M	
	Save med documentation	M	
	Document assessment findings		U
	Document procedure	M	
Save all documentation		U	
Human Caring and Relationship	Respect, active engagement, authenticity, empathy, etc.	M	
Professional Role Performance	Appearance, preparation, behaviors, resource management, etc.	M	

Comments:

1. Before entering the med room and pulling meds, I would do hand hygiene.
2. When I looked at the dressing site the first time, I touched the dressing. I would not touch the dressing site at all without sterile gloves.
3. I would wash my hands before touching the patient at all.
4. I would count the respirations for 30 seconds and times them by two or, count for one minute.
5. Before giving the insulin shot, I would inform the patient about getting the injection.
6. After the respiratory assessment I would save the assessment on the chart before moving on to the dressing

change.

7. I did not touch the dressing again while moving the pillow away from the site. If and when I did, I would be wearing gloves and adjust the patients hair then.
8. While donning the sterile gloves, I would keep my hands above waist level.
9. After touching the lumens while taking off the dressing, I will not use that hand anymore because it is not sterile after touching the exposed lumens.
10. While opening my sterile field, I would open it using my bottom one inch borders, not the middle because I would be crossing my sterile field.
11. While opening my sterile gloves, the gloves folded back causing them to not be sterile anymore. I would get a new set of gloves and start that process over again.
12. While taking the chg sponge out of the package, I would only touch my sterile field to help me get the sponge out.
13. I am able to see my sterile field the whole time by not turning my back.
14. I would educate my patient to not touch the site and to report any itching, burning to the site. I would also educate the patient to not get the dressing wet.
15. I would save all of my dressing change to the chart.