IM 2 Simulated Patient Clinical Video Grading Rubric

Student Name: Makenzie Lovato Video: 2 Date: 12/17/2021

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.)	M	
Critical Thinking	**Assessment:** See NII for critical elements pertaining to selected assessment(s)		U
	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	
	Medication delivery	M	
Documentation	**Teach Patient:**		
	Medication	M	
	Procedure	M	
	Scan patient	M	
	Scan medication	M	
	Save med documentation	M	
	Document assessment findings	M	
	Document procedure	M	
	Save all documentation	M	
Human Caring and Relationship	Respect, active engagement, authenticity, empathy, etc.	M	
Professional Role Performance	Appearance, preparation, behaviors, resource management, etc.	M	

Comments:

1. I touched my pen when I wrote on the label for Morphine. I would do hand hygiene and put new gloves on before preparing the Tdap syringe in order to maintain asepsis and to keep my patient from getting any type of infection
2. I did have trouble getting the clamp open and clamp closed because the previous nurse did not move the clamps down before putting the new dressing on. I would move the clamps down on the lumen before replacing the new CVAD dressing so that I am able to access for medication or assessment. If the clamps are left up towards the site, it would cause potential problems for the site to be infected due to having to move

the clamps down and replacing the dressing every time. Which would then potentiate the patient to having a systemic infection.

3. I walked away from the patient when I went to put the Tdap syringe and needle into the sharps container and I didn't put the bed rail up. I would have put the bed rail up so that my patient doesn't fall out of bed. The patient could have fallen out of bed and further injured herself if I left the bed rail down.
4. I walked away from the patient when I moved my material and equipment to the other bed side table and I left the bed rail down. I would have put the bed rail up so that my patient doesn't fall out of the bed. I put my patient at risk for fall injury and we don't want that to happen to the patient.
5. When I removed my first set of sterile gloves, I didn't remove them properly. I should have taken one off first, then the second one would be skin to skin. That would prevent me from contaminating myself with the patient's blood or drainage.
6. I contaminated my sterile field when I opened my CVAD kit up; the edge came towards the inside of the sterile field. At that point, I would start over with a new kit in order to maintain sterility and to keep my patient safe by not introducing any bacteria into the field or to the equipment needed for the sterile dressing change.
7. After taking the patient's mask off and moving the pillow back behind her head, I would perform hand hygiene again to ensure asepsis when I am assessing her body as well as putting a new pair of gloves on. Performing hand hygiene and putting new gloves on would maintain asepsis so myself and the patient are safe from any bacteria.
8. When I moved around the bed to perform the assessment, I left the bed rail down and that would put my patient at risk for a fall or injury. I would put the bed rail up before moving down or around the bed so that my patient doesn't fall or put herself at risk for injury. The patient could have fallen and caused more harm to herself.
9. I didn't assess the capillary refill when doing my assessment. I would assess the capillary refill to ensure that blood flow is good in her lower extremities.
10. I didn't assess both radial pulses bilaterally and I didn't assess the pedal pulses bilaterally. I would assess both of them at the same time so that I know that are equal bilaterally to ensure that they are the same so I know that there are no other complications.
11. I didn't educate my patient about constipation due to the Morphine I gave her. I would teach my patient about signs and symptoms of constipation so that we could get ahead of the problem before it gets worse.
12. I didn't educate my patient about the CVAD dressing and what not to do to the area. I should have told her not to touch it, let me know if it gets wet or if there are any other problems like blood, drainage or redness. I would do that so that my patient doesn't end up having a systemic infection or possible death from bacteria.
13. I did not ask the patient for consent to give the Tdap vaccine. I would ask the patient to sign for consent before I gave her the Tdap vaccine because it is optional.