IM 2 Simulated Patient Clinical Video Grading Rubric

Student Name: _____Destiny Perez_____ Video: 3__ Date: ___1/14/2021_____

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		U
	Fall Bundle	M	
	Medication Administration: Medication, dosage, route, reason, assessment of route site(s), medication delivery equipment (IV pump, etc.)		U
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.)		U
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		U
	Medication delivery	M	
Documentation	**Teach Patient:**		U
	Medication	M	
	Procedure	M	
	Scan patient	M	
	Scan medication		U
	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.		U

Comments:

I want to preface by saying I was having complete brain fog this day. I was not using the right words to explain simple stuff. Which lead to having long pauses to think of the right words.

I did not patient teach enough about the catheter.
Rationale: I would patient teach about the indwelling catheter and communicate everything to not put the patient in psychological harm.

I failed to put on gloves as I was getting the medication out “ready”
Rationale: I would clean my hands then put clean gloves on to prep my medication. To reduce contamination.

I did not “log off” after I was done at thy pyxis.
Rationale: I would log off after I was done at the pyxis, so no one could potentially do stuff through my name.

Scan armband again then scan med before I connect it/administer
Rationale: I would scan it again prior to medication administration for patient safety if the computer were to log out during that time.

There were many moments where I forgot or almost to put clean my hand before and after I put on gloves.
Rationale: I would clean my hand before and after to keep clean from any germs/bacteria.

I failed to say “it verified” when I scanned my patient
Rationale: I would acknowledge and check the patient verified because this would violate patient safety in medication administration (right patient).

I did not scan the medication before I administered it (doing my third check)
Rationale: I would scan prior because this violates patient safety in medication administration (right medication) at the bedside.

I did not look before I palpated.
Rationale: I would look/ assess the skin then palpate for patient safety. So, I don’t press on something right away that could rupture and harm the patient when I could have looked first.

I failed to tell/let the patient know I was going to touch them so they feel comfortable.
Rationale: I would let them know prior I was going to touch them so they feel better and have that trust.

This was a huge mistake on my part. I did not take off the plastic covering over the sterile part of the catheter tip the most crucial part to let sit in the lube before I brought it to the bed.
Rationale: I would take it off immediately before I took the tray to the bed because I ended up breaking sterility which would lead to bacteria and potentially lead to CAUTI. I would have to start again with a new kit.

I broke sterility/contaminated the area by the way I was standing my back to the field, hovering, the catheter tip falling out. I would have to start over.
Rationale: I really need to be very vigilant and aware how my body stance is and how I am standing towards the sterile fields. So I don’t cause contamination. I would start over with a new kit for breaking sterility.

I did not wait to see the medication bag drip.
Rationale: I would make sure to watch it drip so I know the medication is coming out. I violated patient safety and could have put them in harm and pain if the medication was not coming out.

I kept the patient open for more than needed.
Rationale: I would minimize the patient’s exposure for their dignity and modesty.

Eyes were not on sterile field periodically, while donning sterile gloves
Rationale: I broke sterility and would need to start with another kit. That could lead to contamination.

Back was against sterile field while I was pouring bediodine.
R: I broke sterility with could led to contamination.

When wiping with the cleaning wipes, I would put the wipes on something not just bed
R: germs would build up on bed towards the catheter leading to infection. Putting patient in physical harm.

I should have pulled the catheter tube as soon as I took off the syringe
So I know the catheter is in (violated patient safety)

When donning gloves fingers were not put in the glove right
R. could have broken sterility if it flopped out and touched my skin. I would put on a new pair or be very vigilant of my hands during the process.

I did not check the catheter clamp to make sure it was un clamped
Rationale: I would check right as I was setting it up. Patient physical safety was violated because it could have caused the urine to back flow and cause serious harm and CAUTI.

I failed to ask them if they needed to go to the bathroom as it is still part of the 4-p's
I would still ask them to communicate to them and earn their respect.

I failed to communicate with the patient and address in the video the other patients' issues on the SBAR such as the diabetes, infection, urosepsis. As well as doing another assessment such as checking lungs, apical pulse, and radial. In explaining everything it would promote the patients trust and respect towards me.

I failed to check the compatibility of the medication and the Normal saline prior before administering it.
I would check prior and not violate the patient's physical safety. In medication administration.

I would tell them I am giving them mg and not grams. I was unsure if it matters which one and I know we don't tell them mL. Which I had to do some math and convert that to the pump.

I failed to follow all the lines/ tubes that putting the patient in physical safety and make sure all the lines were cleared. I would check them from the machine or bag to the patient all the time.

I should have raised the bed a little more because I do have poor body mechanics leaning over.

I touched the patients' sheets then the patients private area which could have lead to brining bacteria down there.
I would have them set up and opened prior so I don't violate the patients safety. Or changed gloves.

I would have brought the patient the side table but I had to use it to keep the kit on for reusing purposes.

I failed to log off the computer right after I was done saving.
The patient could have went to the computer after I left or another nurse could have went in for whatever reason.
I should have better organized/cleaned my working area as I go so I don't drop things from clutter. AS well as go in with a clear plan.