IM 2 Simulated Patient Clinical Video Grading Rubric

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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	met	
	Identify patient (2 patient identifiers)	Met	
	AIDET	Met	
	Allergies	Met	
	4 P's	met	
	Fall Bundle		unmet
	Medication Administration: Medication, dosage, route, reason, assessment of route site(s), medication delivery equipment (IV pump, etc.)	Met	
Critical Thinking	**Assessment:** See NII for critical elements pertaining to selected assessment(s)	Met	
	Procedure Assess, Plan, Implement, Evaluate (APIE) (Selection of appropriate equipment, time management, organization, etc.)	Met	
Standard Precaution	**Asepsis:**	----	-----
	Hand hygiene	Met	
	Don and change gloves (as indicated)	Met	
	Clean equipment (stethoscope, pulse ox, bedside table, med tray, etc.)	Met	
	Sterile procedure	Met	
	Medication preparation	Met	
	Medication delivery	Met	
Documentation	**Teach Patient:**	---	----
	Medication	Met	
	Procedure		Unmet
	Scan patient	Met	
	Scan medication		Unmet
	Save med documentation	Met	
	Document assessment findings	Met	
	Document procedure	Met	
	Save all documentation	Met	
Human Caring and Relationship	Respect, active engagement, authenticity, empathy, etc.	Met	
Professional Role Performance	Appearance, preparation, behaviors, resource management, etc.	Met	
Comments: In the med room I should have stated out loud before I started getting the insulin ready that I checked the patient's			

blood glucose level earlier (which was 400) and that the EMAR on the sliding scale it said for 400 glucose level the patient needs 10units (and to call doctor). I knew I had to do that but didn't do a good job of vocalizing it on the video.

O2=

At the beginning I told the patient I was going to give them "air" instead of "O2" I have no idea why I said that…

-I should had stated out loud when telling the patient to sit up and cough that I was "trouble shooting" seeing if trying different things like sitting up and taking deep breaths would help raise the o2 of the patient before I had to out the nasal canula.

-I did not check the integrity of patient skin prior to putting the nasal canula and then document it. Rational; I don't want to cause the patient harm or skin breakdown. They could have had skin issues prior that needed to be addressed.

-I did not teach the patient about the hazards to keep away when being on a O2 device like the nasal canula. I should of taught the patient, "Please keep petroleum products away from it including petroleum chapsticks etc, no aerosol sprays, and no smoking. These all are flammable and dangerous when being used while on O2." Rational; Patient safety, it's a safety risk for the patient because they can get harmed by getting burned if they try to do any of those things because they didn't know.

-I did not tell the patient they were going to be receiving the O2 through a nasal canula and then I should have explained what it was. Even though they had COPD and have more than likely used the device I should never assume incase they refuse. Rational; The patient needs to know how they will be receiving the O2 in case they refuse of it interferes with something they have. Rational; Patient safety.

-I did the respiratory assessment after administering the O2 to see if the medication (o2) helped the patient. I should had done a respiratory assessment before and after administering o2. Rational; To make sure the lungs were in a place to be given O2 through a nasal canula. Patient Safety I don't want to give a medication without knowing whats is going on in the place its going to be affecting.

-I would listen to lung sound in each location for 1 full breath. When auscutating lung sounds I should had done a better job at placement, the point was to mirror after each spot to make sure they sound the same. I failed to properly do a respiratory assessment. Rational; this could hurt my patient if I don't know what is going on in their lungs before administering medication.

On flow meter I need to have vocalized and check to make sure the ball line was right between it on the 2L mark to make sure it is the right amount.

Insulin:

I needed to tell the patient not teach touch or rub the area where I injected the insulin. Rational; Patient safety, so the medication doesn't spread and also so we don't infect the area since we did break the skin by puncturing it.

-I need to stay bunching the skin the whole time to make sure all the insulin goes to the correct location (subQ). They need all they can get or there glucose will stay high.

-I need to make sure I warm the insulin between my hands before administering it because it could cause shock to the patient. I failed to rotate the insulin vial gently to mix the medication. Rational patient safety.

Reglan:

- When doing the abdominal assessment I need to go much higher when assessing for the bruits. It should be right below the ziphoid process. Failing to properly assess this could cause harm to patient especially if I were to have palpated and there was an aneurism.

-I should have put a blue sticker label on Reglan. The rational is so that way I'm positive it's the right drug.

-I failed to address I was checking the expiration dates + integrity of the reglan and sterile water. Rational; Physical safety of patient could had been jeopardized if the dates were expired or the medication could have lost components to it.

-I need to vocalize things more. I stated " I will go ahead and inspect this while I'm here" when I was looking at the J tube. I mean to say or what I should have said was " I am inspecting the J tube while I am here to check if its intact for placement. There should be no drainage and the button should be against the stomach to know its not disloged." Rational: We always check placement and patency" before putting anything in the J tube.

-I need to scan the sterile water right after explain it to them and before using it, I did not do. Rational; Patient Safety so the documents show that I flushed it and that I flushed with sterile water and not just tap water.

-Before I gave my medication I said “flush with 30mL’ but I should had added on I do this to check for patency” because we always check for patency (and placement) before we give a medication into a J tube.
-I should have placed the sterile water in the syringe first and then turned the Lopez valve on. Rational; to not get air inside patient.
-I need to place towel on patient under the jtube when administering medication to the Jtube this is for patient comfort so that way sterile water and medication doesn’t get on their clothes if it were to have spilled.

FINAL-
I forgot to lower the bed down and make sure they had non slip socks on. Rational; Patient safety; so they don’t fall and hurt themselves.
I need to check to make sure there is no kinks in the nasal canula before I leave- Rational; so there O2 don’t drop again.
I NEED TO MAKE SURE I AM ACTUALLY LOOKING AT THE EMAR. I said I was looking at it but I need to actually have the paper in-front of me to mimic the real one.