

**EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2023**

**Firelands Regional Medical Center School of Nursing
Sandusky, Ohio**

Student:

Final Grade: Satisfactory/Unsatisfactory

Semester: Fall

Date of Completion:

**Faculty: Frances Brennan, MSN, RN; Amy Rockwell, MSN, RN;
Chandra Barnes, MSN, RN; Nick Simonovich, MSN, RN**

Faculty eSignature:

DIRECTIONS FOR USE:

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U), and Not Available (NA)**. The faculty member will initial if in agreement with the student’s evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a “S, NI, U, or NA”. If the student does not self-rate, then it is an automatic “U”. A student who submits the clinical evaluation tool late will be rated as “U” in the appropriate competency(s) for that clinical week. Whenever a student receives a “U” in a competency, it must be addressed with a comment as to why it is no longer a “U” the following week. If the student does not state why the “U” is corrected, it will be another “U” until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. If the final performance code is unsatisfactory or needs improvement in any one of the competencies, a grade of unsatisfactory is given. If a pattern of unsatisfactory performance occurs after performing the competency satisfactorily, this also constitutes a grade of unsatisfactory. An unsatisfactory or needs improvement as a final score in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.

METHODS OF EVALUATION:

- | | |
|--|---------------------|
| Skills Lab Checklists | Faculty Feedback |
| Care Map Grading Rubric | Documentation |
| Administration of Medications | Clinical Reflection |
| Simulation Scenarios | |
| Skills Demonstration | |
| Evaluation of Clinical Performance Tool | |
| Clinical Discussion Group Grading Rubric | |
| Lasater Clinical Judgment Rubric | |

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
Faculty’s Name			Initials
Chandra Barnes			CB
Frances Brennan			FB
Amy Rockwell			AR
Nicholas Simonovich			NS
Heather Schwerer			HS

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

Satisfactory (S): Safe, accurate each time, efficient, coordinated, confident, focuses on the patient, some expenditure of excess energy, within a reasonable time period, appropriate affective behavior, occasional supporting cues, minimal faculty feedback needed related to written clinical work.

UNSATISFACTORY CLINICAL PERFORMANCE

Needs Improvement (NI): Safe, accurate each time, skillful in parts of behavior, focuses more on the skill and self rather than the patient, inefficient, uncoordinated, anxious, worried, and flustered at times, expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues, faculty feedback required in several areas of clinical written work.

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U", the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

***Grey shaded weekly competency boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Objective																		
1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:								N/A		S	S	NA	S	NA				
a. Identify spiritual needs of patient (Noticing).								N/A		S	S	NA	S	NA				
b. Identify cultural factors that influence healthcare (Noticing).								N/A		S	S	NA	S	NA				
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						NA	S	S		S	S	NA	S	NA				
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						NA	S	S		S	S	NA	S	NA				
						FB	NS	NS		AR	HS	AR	HS	HS				
						JB NA	3T, 72			3T 74	3T 84		3T 92					

Clinical Location:
Patient age**

Comments

****Document your clinical location and patient age in the designated box above.**

Week 7 1(c) – You respected your patient's needs and wishes by understanding his reluctance to open about his personal life. You were still able to collect important assessment data while also respecting his preferences. NS

Week 9 (1c)- You discussed hygiene needs with your patient however she knew she was being discharged to home and wanted to perform her care there. This shows that you respected your patient's wishes and needs. Great job. AR

Week 10 (1c)- You were able to assist your patient with bathing on the first day, and on the second day she requested to wait to wash up until returning home because she was told she would be discharged later in the day. On both days you communicated with the patient in order to respect her preferences and needs regarding hygiene care. HS

Week 12 (1c)- You had a challenging start to your day, and you were able to identify that your first patient was not going to be receptive to having a student provide care. You easily adapted to the change and took over care for another patient and who was very busy with different disciplines providing care for him. You were able to adapt and keep preferences in mind and not overwhelming him. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective

1. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:						NA	S	S		S	S	NA	S	NA				
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).								S		S	S	NA	S	NA				
b. Use correct technique for vital sign measurement (Responding).						NA	S	S		S	S	NA	S	NA				
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						NA	U	U		S	S	NA	S	NA				
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).								N/A		S	S	NA	S	NA				
e. Collect the nutritional data of assigned patient (Noticing).								N/A		S	S	NA	S	NA				
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).								N/A		S NA	NA	NA	NA	NA				
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).								N/A		S	S	NA	S	NA				
						FB	NS	NS		AR	HS	AR	HS	HS				

Comments

Week 7 2(c) – Jenny, I see that you gave yourself a “U” for this competency. In the future, when evaluating yourself as unsatisfactory, provide a brief comment as to why you felt that. I will leave this evaluation, as I assume this was something you forgot to do. Be sure to address how this competency will no longer be “U” during your next clinical experience. NS

Week 7 2(a) – Overall nice work with your assessment this week. You were able to identify adventitious lung sounds by auscultating for wheezes. NS

Week 9 I don’t know why I did that. I meant to give myself an S. Thank you for catching that. I was thinking about something else when I was filling out this list. AR

Week 9 (2a-e)- Great job with all your assessment skills this week! Your patient did not have many abnormal findings; however, you were able to discuss those that previously were abnormal and compare them to the present. (2f)- NA as your patient did not have a NG tube. In the future, be sure to carefully read the tool and competencies and evaluate yourself accordingly. (2g)- You noticed the urine culture result which confirmed the UTI diagnosis. Great job! AR

Week 10 (2a)-Nice job with your assessment this week, you were able to identify that the patient’s heart sounds were abnormal because she had a murmur which you identified strictly from your head to toe assessment because that was not communicated to you in report. (2c)- When completing your safety assessment, you identified that your patient was a high fall risk, which had not been implemented prior. Nice job! HS

Week 12 (2a)- Nice job with your assessment this week! You were able to identify he had crackles in his lungs, as well as using the doppler to obtain his pedal pulses and that one pedal pulse was stronger than the other. (2g) Nice job in reviewing the lab values that were completed on your patient and correlating them with his problems and history. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective

2. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:						NA	NA	N/A		S	S	NA	S	NA				
a. Receive report at beginning of shift from assigned nurse (Noticing).						NA	NA	N/A		S	S	NA	S	NA				
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	NA	N/A		S	S	NA	S	NA				
c. Use appropriate medical terminology in verbal and written communication (Responding).						NA	S	S		S	S	NA	S	NA				
d. Report promptly and accurately any change in the status of the patient (Responding).						NA	NA	N/A		S	S	NA	S	NA				
e. Communicate effectively with patients and families (Responding).						NA	S	S		S	S	NA	S	NA				
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						NA	S	S		S	S	NA	S	NA				
						FB	NS	NS		AR	HS	AR	HS	HS				

Comments

Week 9 (3 e,f)- The communication with your patient was excellent, and you received rave reviews from her. You helped others by answering call lights and assisting another patient with their hygiene needs. Keep up the great work! AR

Week 10 (3d,e,f)- You identified that the patient should be a high fall risk, you then followed through by documenting the fall risk, then you educated the patient on the fall risk precautions and implemented the high fall risk precautions and lastly you communicated that with the primary nurse caring for the patient. HS

Week 12 (3d,e,f)- Nice job identifying that the Stat lock on your patients Foley was not positioned properly and that it needed to be removed and a new one placed. You were able to communicate this with the patient, and the nurse and correct the situation which made your patient very happy. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																		
3. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:						NA	S	S		S	S	NA	S	NA				
a. Document vital signs and head to toe assessment according to policy (Responding).						NA	S	S		S	S	NA	S	NA				
b. Document the patient response to nursing care provided (Responding).						NA	S	S		S	S	NA	S	NA				
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				NA	S	S		S	S	NA	S	NA				
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S						N/A		S	S	NA	S	NA				
e. Provide basic patient education with accurate electronic documentation (Responding).								N/A		S	S	NA	S	NA				
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						NA	S NI	NI		S	S NI	NA	S	NA				
*Week 2 – Meditech		FB				FB	NS	NS		AR	HS	AR	HS	HS				

Comments

* End-of-Program Student Learning Outcomes
 Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting
 Week 6 (4c,d)-Satisfactory for listening attentively and actively participating in the Meditech orientation. You showed beginning competence in the ability to access the patient EHR, document care in an intervention, and locate patient data. You were able to access Lexicomp to locate patient education materials. Additionally, nursing policies and procedures were located on the health systems intranet. Great Job! NS/CB/FB

Week 7 4(a) – You did a nice job documenting a full physical assessment on a patient for the first time this semester. You utilized your practice in lab in the meditech system to accurately portray assessment details in the medical record. You will continue to improve in this area with each experience. NS

Week 7 4(f) – This competency was changed to “NI” due to your original post not having a reference listed. You did include an in-text citation; however, a reference was not included. When doing APA format, you would include the author(s) or authoring organization and publishing year for the in-text citation, and a full reference to demonstrate where that information was obtained. You did a great job in your response post to Nikki including both aspects. Purdue OWL for APA formatting is a great resource to refer to. Let me know if you have any questions! Your responses were well thought out, nice work. NS

Week 9 (4a,b)- Overall your Meditech documentation was thorough and accurate. There were only a few minor revisions that needed to be made. Keep up the great work with documentation. (4f)- Your clinical discussion post was satisfactory according to the CDG grading rubric. The information you provided was a good summary of the patient you cared for. Please refer to the provided APA resources (OWL Purdue) for assistance with how to accurately cite the reference you used. The reply to your peer provided new information and insight. Great job! AR

Week 10 (4a,b)- You had to make only a couple changes on the documentation on the first day, this then improved by the second clinical day. (4f)-This competency was changed to “NI” because you did not answer all of the last questions components. You did include an in-text citation on your post as well as your peer response; however, you did not cite in APA format on the in-text or the actual reference listed, you only added the website. Please refer to Purdue OWL for APA formatting. HS

Week 11: I will try better to look at purdue owl for further intext citation. I thought I did it right I guess I need more improvement on it. Thank you Heather. AR

Week 12 (4a,b)- For documentation this week, on the first day you had missed some areas and needed to correct a couple things, but on the second day this week you did a great job documenting. Nice job on the improvement! (4f)-Nice job on your CDG this week, you provided a lot of information on your patient’s priority problem, interventions provided and the medications that were administered. HS

Objective

4. Exemplify psychomotor skills and nursing care safely using evidence-based practice. (3,4,5,7,8)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week S8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:						NA	S	S		S	S	NA	S	NA				
a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).						NA	S	S		S	S	NA	S	NA				
b. Apply the principles of asepsis and standard/infection control precautions (Responding).						NA	S	S		S	S	NA	S	NA				
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).								N/A		S NA	NA	NA	S	NA				
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).						NA	S	S		S	S	NA	S	NA				
e. Organize time providing patient care efficiently and safely (Responding).						NA	S	S		S	S	NA	S	NA				
f. Manages hygiene needs of assigned patient (Responding).								N/A		S	S	NA	S	NA				
g. Demonstrate appropriate skill with wound care (Responding).								N/A			NA	NA	NA	NA				
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).						NA	S	S						NA				
						FB	NS	NS		AR	HS	AR	HS	HS				

Comments

**** You must document the location of the pull station and extinguisher here for your first clinical experience.**

Week 7 – Fire extinguishers and pull stations are located near room 3027 3010 between 3018-3019. NS

Week 9 (5c)- NA for this competency as your patient did not have a foley catheter this week. Be sure to carefully read each competency in the future and give yourself a “NA” as appropriate. (5e)- Good job with organizing your time; you completed all care and documentation timely and were then available to assist others. (5f)- Assisted a patient with hygiene needs even though you were not caring for them directly. Great job! AR

Week 10 (5e)-Nice job this week prioritizing patient care and getting everything completed in a timely manner! You were able to complete all of the care for your assigned patient as well as helping other patients at times, such as changing a patient or answering a call light. HS

Week 12 (5c,f)- You were able to empty the Foley and provide peri-care to your patient this week, as well as identifying that his Stat Lock was not placed in the proper location on the patients thigh. (5e)-The first day this week you were faced with a challenge when you had to change patients after you had already looked up information and began your plan of care. You did a nice job in prioritizing care and managing your time after getting a late start because of the change that had occurred. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																		
5. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:																		
a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).								N/A		S	S	NA	S	NA				
								NS		AR	HS	AR	HS	HS				

Comments

Week 9 (6a)- You did a good job “putting the pieces together” which demonstrated appropriate clinical judgment for this stage in your education. Keep up the good work. AR
 Week 10 (6a)- Nice job this week gathering the necessary information on your patient and identifying the key information necessary to develop the patient specific plan of care. HS
 Week 12 (6a)-Nice job utilizing your clinical judgment this week and providing patient care around your assessment findings. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective																		
6. Convert basic pharmacology principles into safe medication administration. (3,5,6,7)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:								N/A					S	NA				
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).								N/A					S	NA				
b. Recognize patient drug allergies (Interpreting).								N/A					S	NA				
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).								N/A					S	NA				
d. Administer oral, intramuscular, subcutaneous, and intradermal medications using correct techniques (Responding).								N/A					S	NA				
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).								N/A					S	NA				
f. Assess the patient response to PRN medications (Responding).								N/A					NA	NA				
g. Demonstrate medication administration documentation appropriately using BMV (Responding).								N/A				U	S	NA				
*Week 11: BMV								NS				AR	HS	HS				

Comments

Week 11/12 My mistake on missing my my self evaluations. I felt like I participated and understood what was going on for BMV orientation.

Week 11 (7g)- Technically you were satisfactory in your BMV orientation to documentation, however you have received an Unsatisfactory due to not self-evaluating yourself for Week 11. Please refer to pages 1-2 of this tool for instructions on how to correctly address this U. If you do not correctly address the U, or you don't self-evaluate yourself for this competency, you will continue to receive an unsatisfactory. Here is the statement about how you performed in the BMV orientation: AR Week 11 (7g) - You are satisfactory for this competency by attending the Bedside Medication Verification (BMV) clinical orientation, actively listening, observing, and discussing accurate medication documentation and safe administration with the use of the BMV scanner. NS/CB

Week 12 (a,b,c,d,g)- Nice job this week in administering medications! You followed all of the proper safety checks and were able to identify the rationale for why the patient was receiving the medications and you were able to state the necessary information that needed to be obtained prior administered the medication. We definitely faced a challenge this week while having computer issues when scanning the medications and the computer freezing, however that did not stop you from following the correct procedure for safe medication administration. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Objective

2. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
Competencies:						NA	S	S		S	S	U	S	NA				
a. Reflect on areas of strength** (Reflecting)						NA	S	S		S	S	U	S	NA				
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)						NA	S	S		S	S	U	S	NA				
c. Incorporate instructor feedback for improvement and growth (Reflecting).						NA	S	S		S	S	U	S	NA				
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).			S			NA	S	S		S	S	U	S	NA				
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						NA	S	S		S	S	U	S	NA				
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						NA	S	S		S	S	U	S	NA				
g. Comply with patient's Bill of Rights (Responding).						NA	S	S		S	S	U	S	NA				
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						NA	S	S		S	S	U	S	NA				
i. Actively engage in self-reflection. (Reflecting)						NA	S	S		S	S	U	S	NA				
*						FB	NS	NS		AR	HS	AR	HS	HS				

**** Strength/weakness reflection (a,b): Must have different written example each week of clinical/lab. You must explain your plan for how you will improve. Example, "I am having a difficult time with obtaining a manual BP. I will get a BP cuff from Amy and practice manual BP's with at least three members of my family this week." Please ensure that you answer this section in-depth with your plan of action. Each week must be different.**

Week 6- Jenny, The instructor initials go into the bottom square each week for each objective after your evaluation tool is reviewed and feedback given. FB

Week 7 one strength that I had was observing the lung sounds and catching some wheezes from my patient. I could hear them much better when he rolled over on side so I could listen to them from back. I thought I could hear them better when he did that. Great observation, Jenny! You were able to utilize your assessment skills and knowledge of adventitious lung sounds during your assessment. This is a great strength to note for your first clinical experience! NS

One weakness was my communication with my patient. I couldn't really get him to talk much about his personal life such as his family and other things. Next time I will practice with my classmates on communication and getting to know someone better. This will help with my future communications with patients. This can be challenging if your patient isn't willing to communicate. I appreciate your attempts to engage in conversation to the best of your ability. Sometimes patient's are just not feeling up to talking much. I think you have a great plan for improvement in the future! NS

Week 9 One strength that I noticed was that I was able to communicate well with my patient on her needs and about her diagnoses. She told me she was an retired RN and all the pathways being an RN can take you. She stated that she thought I did a great job on my clinical and hoped I would get my RN in the coming years. AR

One weakness was that I needed to separate my PCT role from my Nursing role. My focus is supposed to be my patient. I was answering call lights while caring for her which I needed to focus more on her. I agree with your area of weakness for this week. You did discuss this with me during the clinical day and it is important that you recognized this. For your next clinical experience, be sure to provide more of a "plan" for improvement as you discuss your weakness. AR

Week 9- Overall you did a great job this week while in the clinical setting. I look forward to your continued growth throughout the semester. AR

Week 10 one strength that I noticed that is getting more confident with using the computer system and looking up the history of my patient and watching her labs get better. I feel like it all comes together in nursing and I did initially have some issue with documentation but I worked on it and communicated well with my patient and my clinical instructor on that. I agree I am able to see the improvement in your ability to navigate the EHR as well as your documentation within the patient chart. HS

Week 10 one weakness is that time management wasn't my strongest. I feel like as much as I tried to pull away from my PCT role other factors where weighing heavily on me. I need to stop and focus on who I was there for if I have time I will help but my main priority is my patient and I felt I was being pulled everywhere. I agree I can see the challenges that you are facing with the transition between work and student role. However, you did a nice job this week when you determined that you were not caught up with obtaining your patient information and told the PCT that you were not able to bathe the patient that they asked you to bathe which was not your assigned patient. I did change this competency to "NI" because you did not specifically address how you plan to improve on this process. HS

Week 11- You have received an Unsatisfactory for all competencies under Objective 8 due to not self-evaluating yourself for Week 11. Please refer to pages 1-2 of this tool for instructions on how to correctly address these U's. If you do not correctly address the U's, or you don't self-evaluate yourself for this competency, you will continue to receive an unsatisfactory. Please let me know if you have any questions. AR

Week 11/12 One weakness I had with BMV and med lab was not administering my shot correctly. I have been used to giving my shots the last 25 years being a diabetic. I need to learn outside my own habits and learn a different way of doing things. It helped that Amy took time with me to take my time and not stress out so much about the little things.

Week 11/12 One Strength was being sure of my competency on the six right for patients. Right patient, Right medication, Right dose, Right time, Right Route, and Right documentation. There is a lot of factors that goes into administering meds with patients.

Week 12 One weakness was not having all my information correctly for my med administration, when we were reviewing my patient's medications. Next time I will take my time and not rush so fast to get things done. I agree you did struggle in gaining the correct information prior to reviewing the medications with the instructor, however after we discussed this you were able to obtain the needed information. HS

Week 12 One strength was the following day was communicating with the doctor about PRN medication for my patient and telling a nurse about the med. Although it wasn't the bedside nurse we did get the word out to someone about this medication being helpful to my patient for his bladder spasms. Nice job in communicating with the other providers in order to advocate for you patient. HS

Week 12- Overall you did a nice job this week, you were faced with many challenges on the first day and you kept pushing through in order to provide care for your patient. HS

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Skills Lab Competency Evaluation	Lab Skills										
	Week 1 (4)*	Week 2 (2,3,5,8)*	Week 3 (2,3,4,5,8)*	Week 4 (2,3,4,5,8)*	Week 5 (2,3,4,5,8)*	Week 6 (1,2,3,4,5,8)*	Week 7 (2,3,4,5,8)*	Week 8 (2,3,4,5,8)*	Week 9 (2,3,4,5,8)*	Week 10 (2,3,4,5,6,8)*	Week 11 (2,5,7)*
	Date: 8/21/2023	Date: 8/31/2023	Date: 9/7/2023	Date: 9/14/2023	Date: 9/21/2023	Date: 9/28/2023	Date: 10/3/2023	Date: 10/12/2023	Date: 10/19/2023	Date: 10/24/2023	Date: 10/31/2023
Performance Codes: S: Satisfactory U:Unsatisfactory											
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	AR	AR	NS	AR	NS	NS	NS	NS	AR	NS/AR	AR
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Course Objectives

Firelands Regional Medical Center School of Nursing
Nursing Foundations 2023
Skills Lab Competency Tool

Student Name: Jennifer Bilbrey

Comments:

Week 1 (Technology Lab):

During this lab you were able to satisfactorily navigate:

- Edvance360 Learning Management System.
- Skyscape Resource System.

- Assessment Technologies Institute (ATI) / Virtual Simulation (vSim) Systems.
- Guided tour of library and computer lab. AR

Week 2 (Hand Hygiene; Vital Signs; PPE):

During lab this week you were able to satisfactorily demonstrate:

- Appropriate hand hygiene utilizing hand sanitizer and soap/water.
- Accurate verbalization of procedure for donning & doffing PPE.
- Appropriate level of skill during guided practice with measurement of radial and brachial pulses, along with manual blood pressure. Vital signs skills will be observed 1:1 with faculty during Week 3. Keep up the good work! AR

Week 3 (Vital Signs):

Awesome work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two consecutive blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 126/70, and you identified it as 128/68, great job. The second measurement was set at 154/84 and you interpreted it as 158/84, well within the desired range. You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You only required one prompt throughout the whole checkoff related to asking the patient about smoking, chewing gum, eating/drinking prior to obtaining the oral temperature. You provided accurate detail in your communication with the “patient”. Keep up the great work!! NS

Week 4 (Assessment):

Satisfactory with head to toe assessment guided practice, hand-off report activity, and Lexicomp/Intranet navigation activity. You will be observed 1:1 for Head to Toe Assessment competency during Week 5. AR

Week 5 (Assessment; Mobility):

Great job in lab this week! You have satisfactorily demonstrated a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall well done. You required two prompts throughout your check-off. One prompt was related to assessing the sclera and conjunctiva. The second prompt was related to identifying the correct heart valves (aortic and pulmonic). You identified lung sounds as wheezes instead of crackles. This is just for practice, but you could consider reviewing YouTube videos on various lung sounds to help in that area. You demonstrated friendly, professional, and informative communication. Great work! NS

Feedback on documentation this week: With this being the first time that you fully documented these interventions, there are some areas for improvement. You did a good job, overall, with your Meditech documentation. You documented on the interventions listed below; however, some areas were inaccurate or omitted. Please review each area of documentation so you can examine areas that were omitted. I want you to feel comfortable and confident with Meditech documentation.

- Vital signs – accurate and complete.
- Pain – omitted “physician already aware” comment related to pain. Otherwise, accurate and complete.
- Safety - omitted “Pneumonia” comment as reason for isolation. Omitted comment “education completed” for fall precautions.
- Physical assessment – omitted “nystagmus – none” under HEENT assessment. Omitted left ear documentation. Omitted “gum condition” as WNL. Omitted “sputum production method” as spontaneous under respiratory assessment. Omitted left upper extremity edema documentation under cardiovascular. Omitted use of laxatives under gastrointestinal assessment. Omitted documentation of symptoms of nausea and vomiting.

Mobility Lab 9/21/2023: Satisfactory completion of mobility lab through demonstration of the following: Logrolling/turning a patient, lifting a patient in bed, repositioning from lying to sitting, repositioning from sitting to standing, stand/pivot transfer from a bed to a chair, ambulating with a walker, ambulating with crutches, ambulating with a cane, use of a gait belt, and safe use of a wheelchair. Proper body mechanics were utilized to promote safety for the health care worker and the patient. Great job with active participation throughout the duration of the lab. NS

Week 6 (Personal Hygiene Skills):

Satisfactory with patient hygiene, making an occupied bed, shaving, oral care, hearing aid care, application of ace wraps, TED Hose/SCD's, and clinical readiness scenario during guided practice. Completed Meditech documentation for Hygiene and Ted Hose. Keep up the great work! NS

Week 7 (NG Skills: Insertion, Irrigation, and Removal; Feedings):

Nice job this week in the skills lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. For the Insertion checklist, you only required one prompt related to appropriate steps for measurement according to the checklist. We discussed the difference between ATI and the textbook following your observation. For irrigation, one prompt was required related to labeling the equipment appropriately. For removal, you did not require any prompts. You did a great job verifying placement before each skill was performed. You were able to verbalize understanding of the difference between irrigation and flushing and aspiration precautions. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! NS

Week 8 (Foley Skills: Insertion, Removal; Sterile Gloves; I&O, Documentation Lab):

You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. You recognized the potential contamination of sterile field when you thought your glove may have come into contact with your sleeve and appropriately discussed how that would be resolved, nice recognition. You reminded yourself to assess the patient for allergies to iodine or shellfish before inserting the catheter or cleaning with the iodine swab. One prompt was required related to remembering to hold the catheter in place at the labia while instilling the balloon fluid to prevent accidental dislodgement. A second prompt was required related to holding onto the catheter at the labia while the balloon fluid was being drained during removal. Otherwise, job well done! You maintained the sterile field throughout the Foley insertion, and did not contaminate the catheter or your gloves at any point. You correctly verbalized the differences in catheter insertion for a male patient. Actively participated in the Intake and Output stations, and completed Meditech documentation related to Urinary Catheter Management and Intake & Output. You independently completed the Meditech documentation for Urinary Catheter Management. Keep up the great work! NS

Documentation Lab – You have satisfactorily completed the documentation lab by actively participating in Meditech documentation related to vital signs, physical re-assessment, safety and falls, pain assessment, patient rounds, TED hose/SCD/Ace wrap, feeding method, Intake and Output, urinary catheter management, and writing a nurse note. You utilized your time wisely, asked appropriate questions, and gained experience with each intervention listed in preparation for clinical. Feedback and remediation were provided as needed during the documentation review. Great job! CB

Week 9 (Dressing Change: Dry Sterile, Damp to Dry Packed, Stoma Skills):

You have demonstrated competence in the skill of wound assessment and wound care through guided observation of Dry Sterile Dressing and 1:1 observation of Damp to Dry Packed Wound Dressing Change. During the Damp to Dry Packed Wound Dressing Change, you did require two prompts related to the following: remember to assess for tunneling and undermining; when opening the sterile supplies, you touched the edges of the gauze and caused contamination. You were able to recognize that you contaminated the ABD with the edge of another package. When placing the sterile 4X4's over the packing remember to only touch the edges and not the portion of the gauze that will be on the packing. Your communication with the patient was great. Documentation was completed related to wound care and patient rounds in the Meditech system. Additionally, you participated in the stoma care station to gain additional knowledge and skills. Great job this week! AR

Week 10 (Safety; Infection Control; Prioritization; Weight; Pressure Ulcer Prevention; Soft Restraints; Doppler BP):

Satisfactory participation with the following stations: Prioritization, Patient Weight, Restraints, Doppler BP, Meditech documentation, and Patient Scenario involving Safety, Infection Control, and Pressure Ulcer Prevention. Keep up the hard work! AR

Week 11 (Medication Lab):

Satisfactory participation and performance of the following skills in the medication lab: Oral, IM, SQ, and ID medication administration; performance of IM injection on fellow student; performance of SQ & ID injection on practice sponge; use of and drawing medication out of ampule and vial; communication/accountability activity with awareness of allergies & dosage calculation. AR

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
		*	*

Note: Students are required to submit one satisfactory care map by 11/20/2023 at 0800. If the care map is not evaluated as satisfactory upon initial submission, the student may revise the care map based on instructor feedback/remediation and resubmit one time to receive a satisfactory evaluation. ***See Attached Nursing Care Map Grading Rubric.**

Firelands Regional Medical Center School of Nursing
Care Map Grading Rubric

Student Name: Jennifer Bilbrey		Course Objective: Develop patient-centered plans of care utilizing the nursing process (3,4,5,6,7)*					
Date or Clinical Week: 10/26/2023							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	2	You did not list 7 patient specific abnormal assessment findings from your patient. You included normal findings within this, and you also stated abnormal GI/GU assessment but did not elaborate other than slow hypoactive bowel sounds. You did list 6 lab/diagnostic findings specific to the patient, you may consider using abnormal values from the uranalysis such as bacteria. The risk factors you listed were not patient specific, you need to include exact patient values in this category. Consider adding patient specific history within this area the patient had an extensive health history that would be important to consider when providing care.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	1	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	5. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	
	6. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	2	
	7. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	0	

Responding	8. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	0	The nursing interventions that you have listed are not patient specific. The interventions should be based around the care that you provided to the patient after you identified that the priority nursing problem was impaired urinary retention. It appears you have selected generic interventions. Each intervention needs to be individualized for the patient. Each intervention should include a frequency (q4h, daily), you must also include the rationale as to why each intervention is to be performed for this specific patient.
	9. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	0	
	10. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	0	
	11. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	0	
	12. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	0	
Reflecting	13. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	0	The evaluation of the top priority should be a reassessment of the abnormal assessment findings that you identified at the start of the care map. There should be specific assessment findings listed. You then need to determine if the plan of care needs to be continued, modified or terminated based on the finding from the reassessment. Refer to the care map rubric and guidelines for specific details.
	14. Evaluation includes one of the following statements: <ul style="list-style-type: none"> • Continue plan of care • Modify plan of care • Terminate plan of care 	Complete			Not complete	0	
<p>Total Possible Points= 42 points 42-33 points = Satisfactory 32-21 points = Needs Improvement* < 21 points = Unsatisfactory*</p> <p>*Total points adding up to less than or equal to 32 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.</p> <p>Faculty/Teaching Assistant Comments: Jenny, please review the comments within the care map rubric. The care map should be specific to this patient, all information listed should directly pertain to the care that should or was provided to the patient. The complications should be directly linked to the signs and symptoms that you were monitoring and assessing the patient for. Review the examples of care maps that you have. Please let me know if you have any additional questions prior to re-submitting this. You did receive an unsatisfactory and will need to remediate this assignment. The remediation is due 11/19/2023 at 0800. Please refer to my comments, the rubric and the care map guidelines as you revise the care map. HS</p>							<p>Total Points: 13</p> <p>Faculty/Teaching Assistant Initials: HS</p>

Firelands Regional Medical Center School of Nursing
Nursing Foundations 2023
Simulation Evaluations

<u>Simulation Evaluation</u>	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Performance Codes: S: Satisfactory U: Unsatisfactory	Date: 11/7/2023 or 11/14/2023
Evaluation (See Simulation Rubric)	S	
Faculty Initials	HS	
Remediation: Date/Evaluation/Initials	NA	

* Course Objectives

- A. Reflect on an area of strength after observing/participating in each simulation scenario.
- B. Recognize one area for improvement and set a goal to meet this need.

The goal must include what you will do to improve, how often you will do this, and when you will complete the goal (example- "I forgot to raise the head of the bed when the patient began having trouble breathing. I will review the proper nursing interventions for dyspnea in the textbook and on skyscape twice before the next simulation scenario").

Simulation #1:

A. One area of strength was noticing my patient need for oxygen during the head to toe assessment. I also tried to make sure my patient was comfortable during that time. I communicated with Essence about getting the oxygen started and actually jumped in to help her. **HS**

B. One are of improvement is to not leave the pills on the patients counter. I went to look up information on a pill that my patient to know what the affect of it was. Next time I will take the pills with me so the patient doesn't try to take them without me witnessing it, **I agree it is important to not leave medications sit unattended to. Another area would be to review the medications and write down all necessary information prior to going to the bedside. HS**

Faculty comments:

Simulation #2:

A.

B.

Faculty comments:

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse; O=Observer

STUDENT NAME(S) AND ROLE(S): Jenny Bilbrey(M), Nikki Papenfuss(O), Seannita Byrd(A)

GROUP #: 5

SCENARIO: NF Simulation #1

OBSERVATION DATE/TIME(S): November 7, 2023 1300-1400

CLINICAL JUDGMENT COMPONENTS						<u>OBSERVATION NOTES</u>
NOTICING: (1,2,4,6,7) *						<p>Assessment nurse introduced self and role. Identified patient with name and date of birth when entering the room for patient safety.</p> <p>Noticed temp 99.2, SpO2 of 91% RA, HR 78, RR 20, B/P 130/74.</p> <p>Noticed temp 99.2 as slightly elevated.</p> <p>Noticed Spo2 at 91% on RA. Did not seek further information on patient's cough.</p> <p>Pain assessment performed.</p> <p>Noticed crackles upon auscultation.</p> <p>Noticed tissues in patient's bed. Did not notice yellow sputum (remediated in debriefing).</p> <p>Medication nurse introduced self and role when entering the room. Performed 6 rights of medication administration by using the BMV scanning system for patient safety. Accurately identified patient name and date of birth. Information obtain from patient about how medications are taken at home. Asked patient about allergies.</p>
INTERPRETING: (1,2,4,6,7) *						<p>Prioritized respiratory status, seeking information related to breathing.</p> <p>Interpreted temp 99.2 as related to pneumonia diagnosis.</p> <p>Interpreted low SpO2 of 91% as requiring oxygen per physician's order.</p> <p>Interpreted crackles as related to diagnosis of pneumonia (fluid in lungs).</p> <p>Prioritized safety precautions related to recent fall.</p>
<ul style="list-style-type: none"> • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B 						
<ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 						

<p>RESPONDING: (1,2,3,4,5,6,7) *</p> <ul style="list-style-type: none"> • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D <li style="padding-left: 20px;">B 	<p>Practiced standard precautions with hand hygiene before entering the room.</p> <p>Promptly performed a head-to-toe assessment.</p> <p>Collaborative communication between assessment and medication nurse.</p> <p>Communicated with patient about interventions being performed, with questions answered appropriately.</p> <p>Good therapeutic communication utilized by the assessment and medication nurse while with the patient.</p> <p>Responded to low SpO2 of 91% by raising the head of the bed and applying oxygen at 2L per nasal cannula as per physician's orders.</p> <p>Responded to redness of the bilateral heels by initiating a pillow to offload pressure.</p> <p>Encouraged patient to cough and deep breath.</p> <p>Appropriately used the BMV scanning system for medication safety. Communicated medications to be administered.</p> <p>Difficulty answering questions related to reason medications are taken prompted by patient. Consider writing information about medications down and bringing it with you to the bedside. Remember to never leave medication unattended at the bedside.</p>
<p>REFLECTING: (1,2,4,5,6,8) *</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>Observers provided good insight during debriefing. Noticed the good infection control measures. Discussed initiating O2 via nasal cannula for low Spo2 per orders. Discussed strengths of both the assessment nurse and medication nurse. Constructive feedback was provided. Observers discussed potential educational needs related to the scenario. Noticed the implementation of the six medication rights. Identified positive communication between team members and with the patient.</p> <p>Participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement and discussed ways to make improvements in the future. Good discussions amongst all members of the team. Nice job!</p>

<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of “Beginning” or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p> <p>Scenario Objectives:</p> <ul style="list-style-type: none"> • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Differentiate between need for complete head to toe versus focused assessment and execute accordingly (1,5,6,8) * • Select and administer prescribed oral and intramuscular medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) * • Recognize patient oxygenation and pain control needs and provide appropriate interventions (2,4,5,6,7) * 	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing:</p> <p>Attempts to monitor a variety of subjective and objective data but is overwhelmed by the array of data; focuses on the most obvious data, missing some important information.</p> <p>Identifies obvious patterns and deviations, missing some important information; unsure how to continue the assessment.</p> <p>Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads.</p> <p>Interpreting:</p> <p>Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data.</p> <p>In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse.</p> <p>Responding:</p> <p>Is tentative in the leader role; reassures patients and families in routine and relatively simple situations, but becomes stressed and disorganized easily.</p> <p>Generally, communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport.</p> <p>Develops interventions on the basis of the most obvious data; monitors progress but is unable to make adjustments as indicated by the patient’s response.</p> <p>Is hesitant or ineffective in using nursing skills.</p> <p>Reflecting:</p> <p>Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered.</p> <p>Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.</p>
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EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2023

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

I was given the opportunity to review my final clinical ratings in each course competency. I was given the opportunity to ask questions about my clinical performance. I have the following comments to make about my clinical performance/final clinical evaluation:

Some comments that I have are that I think I have grown from this whole experience. I am hopeful that I will get better with communication when it comes to my medication experience of dosage and finding out more about what I should and shouldn't do. This was a big learning experience for me because I am confident in my care as a STNA and caring for my patients but stepping out of my comfort zone was a big one for me. To realize becoming a nurse involves so much more than what I initially thought.

Student eSignature & Date: _____