

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2023

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Grace Catanese

Semester: Fall

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

Final Grade: Satisfactory

Date of Completion: 12/4/2023

Faculty eSignature: Fran Brennan MSN, RN

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

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:								NA		NA	S	NA	S	NA			NA	S
a. Identify spiritual needs of patient (Noticing).								NA		NA	S	NA	S	NA			NA	S
b. Identify cultural factors that influence healthcare (Noticing).								NA		NA	S	NA	S	NA			NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						S	NA	S		S	S	NA	S	NA			NA	S
Clinical Location: Patient age**						FB	CB	CB		FB	FB	FB	FB	FB			FB	FB
						3T 78	NA	NA		3T 91	3T 61	NA	3T 65	NA				

Comments

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

Week 6 (1c,d)- Great job showing respect for your patient's needs, being compassionate and kind while delivering care. You also demonstrated the appropriate use of Maslow's hierarchy of needs during the head to toe assessment performed on your patient during this clinical experience. FB

Week 9 (1a,b)- Grace, these competencies were changed to a satisfactory rating because you were able to identify the needs of this patient during her hospital admission. You recognized how her prognosis was affecting her in a spiritual and cultural manner, and provided support in a manner that was appropriate for the time and situation. Great job! FB

Week 10 (1c)- Nice job considering your patient's preferences while coordinating appropriate care to ensure positive patient outcomes. FB

Week 12 (1c)- Great job being respectful of patient's values and wishes while coordinating care for your patient during this clinical rotation. FB

*** 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:						S	NA	S		S	S	NA	S	NA			NA	S
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).																		
b. Use correct technique for vital sign measurement (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						S NA	NA	S		S	S	NA	S	NA			NA	S
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).								NA		NA S	S	NA	S	NA			NA	S
e. Collect the nutritional data of assigned patient (Noticing).								NA		S	S	NA	S	NA			NA	S
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).								NA		NA	NA	NA	NA	NA			NA	NA
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).								NA		NA S	S	NA	S	NA			NA	S
						FB	CB	CB		FB	FB	FB	FB	FB			FB	FB

Comments

Week 6 (2a,b)- Grace, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. (2c)- This competency was changed because you did not have to conduct a fall assessment or institute any precautions. Make sure you are rating on the competencies completed for the week. FB

Week 9 (2a,c)- Great job with patient assessments during this clinical rotation. You provided very thorough and structured assessments. You were able to identify the appropriate focused assessment based on information gathered during the initial assessment. Great job identifying the fall risk for your assigned patient and ensuring all precautions were in place. Make sure to identify a priority problem instead of using a medical diagnosis. For your assigned patient that presented with a UTI, an appropriate priority problem would have been impaired urinary elimination. (2d,g) These competencies were changed to a satisfactory because you assisted with hygiene care, assessing the skin as you performed this care. You discussed testing and patient status for your assigned patient providing nursing interventions and care needed on clinical and in your CDG. FB

Week 10 (2a,c,d)- You did a great job performing all assessments. You also demonstrated the ability to gather information from assessments performed to determine a priority problem for your assigned patient. After determining the priority problem, you implemented all necessary interventions. FB

Week 12 (2a,c,d)- You did a great job performing appropriate assessments. You provided pertinent information from assessments, labs, and diagnostic testing to determine a priority problem for your assigned patient. Associated interventions were implemented that were relevant to the priority problem based off of information gathered. (2g) Great job interpreting the lab data and diagnostic procedures that provides substantial information for the priority problem. Keep up the good work! FB

*** 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:						S NA	NA	NA		S	S	NA	S	NA			NA	S
a. Receive report at beginning of shift from assigned nurse (Noticing).						S NA	NA	NA		S	S	NA	S	NA			NA	S
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						S NA	NA	NA		S	S	NA	S	NA			NA	S
c. Use appropriate medical terminology in verbal and written communication (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
d. Report promptly and accurately any change in the status of the patient (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
e. Communicate effectively with patients and families (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
						FB	CB	CB		FB	FB	FB	FB	FB			FB	FB

Comments

Week 6 (3a,b)- These competencies were changed to a "NA" because you did not receive a shift report and did not perform a hand of report. Make sure you are rating yourself on competencies actually completed the corresponding week. (3 c,d,e) Great job with the use of medical terminology use while communicating with your patient, reporting abnormal findings, and communicating effectively with your assigned patient. FB

Week 9 (3a,b)- Great job receiving and providing pertinent information during shift report, and hand off report. Appropriate medical terminology was used during all communications provided. Good job communicating appropriately to staff RN and other health care disciplines when necessary. FB

Week 10 (3e)- Great job communicating with your patient this week. Communication comes in many forms and building a trusting relationship is very important to a successful plan of care. FB

Week 12 (3d,e)- You have demonstrated the ability to respond appropriately to any changes that may occur with your assigned patient. Reporting changes from assessments, vital signs, or symptoms has been prompt and to appropriate reporting structure. You have also displayed the ability to communicate appropriately with patients and their families. Great Job! FB

*** 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:						S	NA	S		S	S	NA	S	NA			NA	S
a. Document vital signs and head to toe assessment according to policy (Responding).																		
b. Document the patient response to nursing care provided (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				S	NA	S		S	S	NA	S	NA			NA	S
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S						S		S	S	NA	S	NA			NA	S
e. Provide basic patient education with accurate electronic documentation (Responding).								NA		S	S	NA	S	NA			NA	S
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						S	NA	S		S	S NI	NA	S	NA			NA	S
*Week 2 –Meditech		FB				FB	CB	CB		FB	FB	FB	FB	FB			FB	FB

Comments

Week 2 (4c,d)- Satisfactory for listening attentively and actively participating in the Meditech orientation clinical. You showed beginning competence in the ability to access a patient's EHR, document care in an intervention, and locate patient data. You were able to access Lexicom to locate patient education materials. Additionally, nursing policies and procedures were located on the health system intranet. Great job! NS/CB/FB

Week 6 (4 a,b,c) Satisfactory job with documentation of head to toe assessment and vital signs. Make note of areas you may have forgot to chart on during this clinical experience, so you can improve on for future clinicals. (4f) Your initial discussion post and response was completed on time and was substantial. An area of improvement would be the in-text citation and reference.

Examples: Reference- Potter, P., Perry, A., Stockert, P., & Hall, A. (2019). *Essentials for nursing practice* (9th ed.). Mosby. **Or** Venes, D. (2021). *Taber's cyclopedic medical dictionary* (24th ed). F. A. Davis Company: Skyscape Medpresso, Inc.

In-text citations- According to Jones (1998), "students often had difficulty using APA style, especially when it was their first time" (p. 199). **or** She stated, "Students often had difficulty using APA style" (Jones, 1998, p. 199), but she did not offer an explanation as to why. **Or** APA style is a difficult citation format for first-time learners (Jones, 1998, p. 199).

If you still need some assistance reference Purdue OWL. FB

Week 9 (4 a,b,c) Great job with head to toe assessment, vital signs, and focused assessment. You documented thoroughly and in a timely manner. Nice job accessing pertinent information and additional information within the electronic medical record. You were able to identify and gather important information regarding your patient's problems and testing to provide an accurate plan of care, nice job! (4f)- CDG was appropriately posted following the CDG rubric, on time, and in a substantive manner. FB

Week 10 (4 a,b)- Great job with documentation this week with minimal editing needed. (4c)- You were able to access the medical record, gather pertinent information and interpret data. (4f)- Grace, there were two areas of concern this week one with the initial CDG post, the other area is with the peer post. Make sure you are following the CDG rubric to correct these areas for future posts. The initial post: the reference should be generated from the in-text citation, yours do not match. The peer post: You did not provide a reference for this post. FB

Week 12 (4a,b)- You are progressive showing improvement with documentation. Documentation has been thorough and accurate with minimal editing required. (4c) You have displayed the ability to access the electronic health record and gather all relevant information. (4f) CDG posts are within the guidelines provided within the CDG rubric, nice job! FB

* End-of-Program Student Learning Outcomes

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

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

Comments

****You must document the location of the pull station and extinguisher here for your first clinical experience.** Extinguisher across from room 3036, pull down across from room 3037. FB

Week 9 (5 d,e)- Nice job with the management of the care you provided to your assigned patient. You organize your time appropriately to provide safe, efficient care while making sure to provide care that contributes to positive patient outcomes. (5f)- Nice job encouraging and providing hygiene care for your assigned patient. FB

Week 10 (5e) Great job managing time effectively to provide all necessary care for your patient and getting the patient ready for surgery with the betasept bath.FB

Week 12 (5 c,d,e)-You have demonstrated great management of care for your assigned patient making sure all pertinent interventions were completed. You organize your time appropriately to provide safe, efficient care to ensure positive patient outcomes. (5f)- Try to always encourage hygiene care to patients, this is very important to not only make the patient feel better, but also for infection control. FB

*** 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).								NA		NA S	S	NA	S	NA			NA	S
								CB		FB	FB	FB	FB	FB			FB	FB

Comments

Week 9 (6a)- This competency was changed because you provided patient centered care to your assigned patient during this clinical rotation through the nursing interventions performed. FB

Week 10 (6a)- Great job utilizing clinical judgement while providing care to your patient during this clinical rotation. FB

* 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:								NA					S	NA			NA	S
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).								NA					S	NA			NA	S
b. Recognize patient drug allergies (Interpreting).								NA					S	NA			NA	S
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).								NA					S	NA			NA	S
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).								NA					S	NA			NA	S
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).								NA					S	NA			NA	S
f. Assess the patient response to PRN medications (Responding).								NA					S	NA			NA	S
g. Demonstrate medication administration documentation appropriately using BMV (Responding).								NA				NA	S	NA			NA	S
*Week 11: BMV								CB				FB	FB	FB			FB	FB

Comments

Week 12 (7a)-Great job identifying the action, classification, rationale, and side effects of each medication administered during this clinical rotation. (7c,d)-You demonstrated the use of the six rights of medication administration and correctly administered oral medications to your assigned patient. (7g) Appropriate use of the barcode medication verification system was displayed along with correct and thorough documentation of medications administered. FB

*** 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:						S	NA	S		S	S	NA	S	NA			NA	S
a. Reflect on areas of strength** (Reflecting)						S	NA	S		S	S	NA	S	NA			NA	S
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)						S	NA	S		S	S	NA	S	NA			NA	S
c. Incorporate instructor feedback for improvement and growth (Reflecting).						S	NA	S		S	S	NA	S	NA			NA	S
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
g. Comply with patient's Bill of Rights (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						S	NA	S		S	S	NA	S	NA			NA	S
i. Actively engage in self-reflection. (Reflecting)						S	NA	S		S	S	NA	S	NA			NA	S
*						FB	CB	CB		FB	FB	FB	FB	FB			FB	FB

**** 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 (8a)- One area of strength for me this clinical was communication with my patient. (8b)- An area I could improve on is ensuring all the steps to the head-to-toe assessment are completed. I could improve by reading over my checklist and practicing on family 2-3 times a week. GC **Grace I moved your strength and weakness statements under the rating grid. The rating grid is for S, NI, or U completed by yourself or instructor. Great idea, regarding a way to improve on the head to toe assessment, practice will make the assessment come to you more quickly another suggestion is to think about every system as you are moving down the body, check every part and function. Make a picture of the body and write down everything that needs to be checked in that area. Overall, great job during this first clinical experience. FB**

Week 9 – (8a) One area of strength for me this clinical was performing a head-to-toe assessment on my patient, since I covered all areas of it this week without forgetting certain steps, I missed last clinical. **Great job Grace, the more experience you get with all assessments the easier it will become. FB**
(8b) An area I could improve on for next clinical is ensuring all documentation is done without having to be reminded of anything. I can do this by familiarizing myself with meditech next time I am in lab, by clicking on different tabs and reading what they consist of. **Experience and practice are the best ways to ensure you are comfortable and familiar with the charting. I cannot express enough how important it is to be complete and accurate with documentation. FB**

Week 10- (8a) One area of strength for me this week was documentation since I did not have to be corrected on anything this week. **Great job! FB**
(8b) One area I could improve on is being more of a nurse investigator and asking more questions. I could do this by researching communication styles and ask questions in a therapeutic matter. **Communication is very important, and you will find conversation and asking questions provides you with valuable information. It is your job to know as much about your patient as possible. You must build a trusting relationship through communication and you would be surprised what all they will tell you. FB**

Week 12 – (8a) One area of strength for me this clinical was gathering all the necessary information before giving my patient her medications.
(8b) One area I could improve on is being more willing to try new things, instead of being scared to do them on a patient. I can do this by studying up on some of the different skills like inserting a catheter or an NG tube so I can be more prepared and confident to try it out. **This is the time to perform skills, when you have an instructor there to assist and guide you through the skills. Use your skills check list to help refresh procedures for skills. You might want to put the checklist on your clip board for reference. FB**

*** End-of-Program Student Learning Outcomes**

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

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/22/2023	Impaired Gas Exchange	* S/FB	* NA/FB

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: Grace Catanese				Course Objective: 6. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*			
Date or Clinical Week: Week 12							
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)	3	Great job noticing all relevant data and identifying abnormal findings that are pertinent to your determination of priority problem for your assigned patient. Some areas for improvement would be make sure to include all abnormal findings. Some missing labs were chloride, calcium, AST, total protein, and albumin levels. A couple of risk factors not included were diabetes, and obstructive sleep apnea (OSA).
	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)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	Good job with list of priority problems. Some additional priority problems that could have been provided on the list were decreased activity level, fatigue, ineffective breathing pattern. Potential complications should be broken down with signs and symptoms provided. You provided a list of signs and symptoms but not complication. For example, Respiratory complications: decreased RR, decreased O2 sats, nasal flaring, increased CO2 levels. Anxiety might be another complication: nervousness, crying, altered attention, increased HR, increased BP. Impaired nutrition: food intake less than recommended daily allowance, decreased albumin, electrolyte imbalance, decreased total protein level.
	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	3	
	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)	3	
Responding	8. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Great job with interventions provided. Make sure interventions are individualized to your assigned patient and prioritized. Remember to assess first, then do or implement interventions based off of assessment, and educate last. Some additional interventions could have
	9. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	10. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	2	

Reflecting	11. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	13. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	included the administration of methylprednisone, and albuterol nebulizer especially since they were significant for the priority problem. There were a few Good job with evaluation of the highlighted assessment findings. These are the findings that are related to the priority problem.
	14. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete	3	
Total Possible Points= 42 points 42-33 points = Satisfactory 32-21 points = Needs Improvement* < 21 points = Unsatisfactory* *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. Faculty/Teaching Assistant Comments: Satisfactory completion, Great job with care map!							Total Points: 39
							Faculty/Teaching Assistant Initials: FB

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

<u>Simulation Evaluation</u> Performance Codes: S: Satisfactory U: Unsatisfactory	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Date: 11/7/2023 or 11/14/2023	Date: 11/27/2023 or 11/28/2023
Evaluation (See Simulation Rubric)	S	S
Faculty Initials	FB	FB
Remediation: Date/Evaluation/Initials	NA	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 after observing in this week's simulation, I would say was being able to multitask and watch both the assessment nurse and medication nurse and being able to give accurate feedback to both of my peers that I noticed.
- B. An area for improvement could be that I need to be able to accurately perform giving medications for the next simulation since that will be my role. I feel I could improve on this because I missed writing down a few things that the previous medication nurse forgot to do as well. I can do this by looking over my medication administration notes and memorizing the 6 rights a couple times a week before simulation #2.

Faculty comments: See rubric below.

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Cameron Beltran (A), Kaden Troike (M), Grace Catanese (O), Lindsey Steele (O)

GROUP #: 2

SCENARIO: NF #1

OBSERVATION DATE/TIME(S): 11/7/2023 0900-1000

CLINICAL JUDGMENT COMPONENTS						<u>OBSERVATION NOTES</u>
NOTICING: (1,2,4,6,7) *						Noticed alarm for low Spo2 of 91% on RA Recognized deviation from normal with oxygen status Asked name and DOB for patient safety when entering the room Medication nurse noticed orders in the MAR. Noticed BP 130/72, HR of 84, RR 18, temp 99.2 Sought information related to sputum production, color, etc. Medication nurse noticed order for guaifenesin Did not ask patient about allergies prior to medication. Did not look up medications prior to administration. Did not ask patient how she safely takes medication. Wristband scanned, but not confirmed with patient prior to administration. Noticed “whistling” or wheezing upon auscultation (set as crackles). Good teamwork and collaboration to confirm accurate lung sounds of crackles. Noticed tissues with yellow sputum in the bed. Noticed persistent, productive cough. Asked about last BM, normal characteristics, etc. Asked about urination and characteristics. For scheduled medication, allergies were assessed appropriately prior to administration. Did not notice reddened heels on assessment initially. When patient complained of pain performed focused assessment and noticed reddened heels. Asked patient about pain.
• Focused Observation:	E	A	D	B		
• Recognizing Deviations from Expected Patterns:	E	A	D	B		
• Information Seeking:	E	A	D	B		
INTERPRETING: (1,2,4,6,7) *						Interpreted low Spo2 appropriately. Prioritized low Spo2 initially. Prioritized vital signs after stabilizing Spo2. Prioritized PRN medication for persistent cough. Did not interpret abnormal lungs sounds accurately initially. After collaboration, correctly made sense of crackles.
• Prioritizing Data:	E	A	D	B		
• Making Sense of Data:	E	A	D	B		

RESPONDING: (1,2,3,4,5,6,7) *					Introduced self and role as student nurse. Elevated HOB for SOB Initiated oxygen at 2L per nasal cannula for low Spo2. Asked patient if her breathing improved after intervention to determine effectiveness Provided some education on nasal cannula Good hand hygiene for infection control. Educated patient to keep sputum next time she coughs up Checked PERRLA, accommodation, conjunctiva, did not assess oral mucosa Good skin assessment, checking temperature, moisture, edema Good teamwork by assessment nurse assisting with medication administration. Good collaboration to confirm lung sounds. Looked, listened, then palpated for abdomen assessment. Nice job. Good communication with the patient throughout assessment. ROM assessed in all extremities. Consider timing of medication administration for safety purposes. Educated on potential side effects for scheduled medications. BMV Scanner used for patient safety. Responded to reddened heels by placing a pillow under the legs.
• 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 B					REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B Observers did a great job actively paying attention to detail throughout scenario. Constructive feedback was provided during debriefing. Observers provided good insight on safe medication administration, including the six rights of medication administration. Observers also praised students for initiating O2 via nasal cannula for low Spo2 per orders while also discussing the need for prompt intervention. Constructive feedback was provided related to areas for improvement. Good discussion and support amongst those performing in the scenario and the observers. Everyone 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. The assessment nurse and medication nurse demonstrated collaborative communication between the team members and the patient.

SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Execute accurate and complete head to toe assessment (1,5,6,8) * • Select and administer prescribed oral medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) *	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. 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. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. 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. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses. Satisfactory completion of NF Scenario #1.
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Simulation #2:

- One area of strength for this simulation would be ensuring I followed the six rights of medication before giving anything to the mannequin/patient.
- An area for improvement could be to make sure I look over the objectives sheet each time before simulation to come better prepared for certain tasks. I will make sure that from now on I do this every time before coming to a simulation.

Faculty comments: See comments located on rubric below. FB

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Lindsey Steele (A), Grace Catanese (M), Cameron Beltran (O), Kaden Troike (O)

GROUP #: 2

SCENARIO: **NF #2**

OBSERVATION DATE/TIME(S): **11/27/2023 0900-1000**

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (1,2,4,6,7) * • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	Identified patient with name and DOB and compared to wristband for patient safety. Noticed SOB when entering the room. Noticed patient was not wearing oxygen when entering the room. Noticed Spo2 of 91%. Focused observation on patient's pain. Sought additional information related to patient's pain (precipitating factors, relief measures, rating, type, duration). Noticed patient's pain 7/10. Sought additional information by re-evaluating the patient's breathing status after oxygen administration. Noticed crackles on auscultation. Noticed sputum/tissues in the bed. Sought further information related to duration of cough and sputum. Noticed order for morphine and need to perform dosage calculation. Sought information related to allergies prior to medication administration. Consider asking patient preference for injection location. Sought additional information after medication administration related to relief and comfort.
INTERPRETING: (1,2,4,6,7) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritized oxygenation status, made sense of SOB and physician order for oxygen at 2L NC. Prioritized pain assessment when noticing patient in pain. Prioritized focused respiratory assessment related to pain on the right side and shortness of breath. Made sense of need to communicate with medication nurse to medicate for pain then prioritized returning to complete the head to toe assessment. Consider administering pain medications prior to continuing full assessment for patient comfort. Team members can collaborate to administer medications then return to complete full assessment. Made sense of the MAR for morphine administration related to pain 7/10. Did not make sense of MAR documentation related to morning PO medications already being administered initially, prompted by patient. Prioritized returning medications to the pyxis for medication safety.

RESPONDING: (1,2,3,4,5,6,7) *						Introduced self and role when entering the room for communication.
• Calm, Confident Manner:	E	A	D	B		Elevated HOB for shortness of breath
• Clear Communication:	E	A	D	B		Administered O2 via nasal cannula at 2L for Spo2 of 91%.
• Well-Planned Intervention/ Flexibility:	E	A	D	B		Focused pain assessment performed (full pain assessment performed). Lifted gown to look at the area related to pain.
• Being Skillful: B		E	A	D		Re-evaluated patient's breathing after applying oxygen.
						Educated on performing breathing exercises with incentive spirometry.
						Good communication with the patient regarding plan for pain relief. Good communication among team members.
						Considered collecting sputum for microbiology.
						Good communication with the patient during assessment for comfort.
						Dosage calculation performed accurately to determine need to waste 1ml (2mg) of morphine. Ordered 4mg (2ml), administered 4mg (2mL). Witnessed waste of excess narcotics.
						Good communication to determine medication orders. Returned unused medications after noticing they have already been administered.
						Selected appropriately sized needle for IM injection (22g, 1inch). Good aseptic technique with changing needles. Alcohol swab performed to clean injection site. Prematurely activated safety needle prior to injection. New needle obtained and applied.
						Educated on constipation and confusion side effects of morphine. Consider educating on drowsiness, risk for falls.
						Selected deltoid muscle for IM injection site. IM needle injected at 90-degree angle. Remember to aspirate prior to injecting medication to assess for presence of blood. Teamwork and collaboration noted to initiate safety appropriately for disposal.
						Re-evaluated Spo2 of 94% after oxygen administration and additional interventions, re-evaluated patient's breathing status after medication administration.
						Encouraged patient to utilize incentive spirometer. Education provided on appropriate use of incentive spirometer. Encouraged coughing and deep breathing after medication.
						Re-assessed vital signs to evaluate following narcotic administration. Re-assessed pain following medication. Great job evaluating effectiveness of interventions performed.
						Elevated heels on pillow for redness.

REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Each member actively participated in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement related to prioritization and IM injections and discussed ways to make improvements in the future. Observers provided good insight on med safety and communication amongst team members and with the patient. Identified educational opportunities that were presented in the scenario. Reflected on clinical judgement and critical thinking that required. Emotions, thoughts and feelings were explored. Each member demonstrated a desire to improve nursing performance.
SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: • 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) *	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. 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. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Communicates effectively; explains interventions; calms and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. Develops interventions on the basis of relevant patient data; monitors progress regularly. Displays proficiency in the use of most nursing skills. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.

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:

Student eSignature & Date: ____Grace Catanese 12/1/23____