

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

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

Student: Joshua Hernandez

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/4/2023

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

Faculty eSignature: Chandra Barnes, 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	N/A	S	N/A			NA	S
a. Identify spiritual needs of patient (Noticing).								NA		NA	S	N/A	S	N/A			NA	S
b. Identify cultural factors that influence healthcare (Noticing).								NA		NA	S	N/A	S	N/A			NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						N/A	S	S		S	S	N/A	S	NA			NA	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						N/A	S	S		S	S	N/A	S	N/A			NA	S
						CB	CB	CB		CB	CB	CB	CB	CB			CB	CB
Clinical Location: Patient age**						N/A	3T/ 61 yrs old.	NA		4N/ 74 Yrs old.	4N/ 76 Yrs. old.	N/A	4N/ 80 Yrs. old.	N/A			NA	

Comments

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

Week 7(1c,d) – Nice job this week interacting with a patient for the first time in the clinical setting. You were able to respect your patient's preferences, values, and needs when entering the room to obtain vital signs and a head to toe assessment. You used Maslow's to determine the importance of assessing vital signs and an assessment to meet the physiological needs of your patient first, great job! CB

Week 9(1d): Josh, great job this week determining your patient's needs and using Maslow's to prioritize those needs. I also changed competency 1a,b to a "S" because you although you may not verbally voice these to your patient you, if something were to arise you would identify these factors. CB

Week 10 1(c,d) – Josh, nice job this week interacting with your patient, and respecting your patient's preferences, values, and needs. You used Maslow's to determine the importance of meeting the physiological needs of your patient first. CB

Week 12 (1a,b): Great job this week ensuring that all spiritual and cultural factors were taken into account when caring for your patient. CB

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

Comments

Week 7(2a,b): This week you were able to use skills learned in the lab and take content learned in theory and combine them to apply your knowledge in the clinical setting. You were successful in obtaining vital signs and a head to toe assessment on a live patient for the first time. You were able to notice your patient had edema to their bilateral lower extremities, and you were able to use your clinical judgement to further assess the situation by reviewing their previous assessment findings. Great job!. CB

Week 9(2a,c,g): Great job this week performing your head to toe assessment and fall assessment on your patient. You were able to calculate your patient's John Hopkins Fall Risk score and ensure that the environment was clean and free of clutter, therefore reducing the risk of falls and injuries. You were also able to tie together your patient's priority problem and lab/diagnostic testing that would correlate. I changed competency 2d to a "S" because although you don't calculate a score, you do assess your patient's risk of skin breakdown during your head to toe assessment. CB

Week 10(2a,e,g): Great job performing your head to toe assessment using different techniques to help you collect data on your patient. You were able to use findings from your assessment and look at diagnostic studies in the EMR to understand your patient's priority problem. You were able to look at your patient's nutritional status (BMI, meal intake, modified diets) and see how that tied in with your priority problem as well. CB

Week 12(2d,g): Josh, great job implementing appropriate interventions related to skin risk. Also, great job describing diagnostic findings related to your patient's priority problem. CB

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

Comments

Week 7(3e): Josh, you did a great job communicating effectively with your patient this week! I know this can be challenging for the first time in the clinical setting, however you were able to use appropriate communication skills to learn more about your patient. CB

Week 9(3e): Great job this week communicating with your patient, bedside RN, and peers. I changed competency 3b to a “S” due to the fact that you did an SBAR report with the bedside RN before leaving the unit for the day. CB

Week 10(3e): Josh, great job this week communicating with your patient. You explained everything that was being done to your patient and you were able to relay important information to the bedside RN. CB

Week 12(3a,b): Good job this week receiving report from the off going shift and giving appropriate information to the bedside nurse when leaving clinical for the day. CB

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

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 Lexicomp to locate patient education materials. Additionally, nursing policies and procedures were located on the health system intranet. Great job! NS/CB

Week 7(4 a,c,f): Good job with your documentation of vital signs and a head to toe assessment, you were very thorough and detailed. My only advice for documentation of the head to toe assessment is to make sure you click on the + sign in the top left corner every time so you don’t miss anything and always have the meditech guidelines with you to ensure you are documenting on the correct areas. Great job on your first CDG, you met all requirements of the grading rubric. Your intext citation for your original

post should be, (Potter et al., 2019, p.354). If you have additional questions regarding in-text citations or references, there is a APA list under clinical resources on Edvance360. I changed competency 4b to a “S” because documenting vitals and an assessment is documenting information related to the patient’s response to care. CB
Week 9(4c,f): You did a good job accessing medical information on your patient in Meditech. Great job meeting all the requirements for your cdg this week. CB
Week 10(4c,f): You did a good job of accessing your patient’s EMR to look up information related to your patient’s hospitalization. You did a great job on your cdg this week, meeting all requirements. CB
Week 12(4c,e,f): You did a great job this week accessing your patient’s information on the electronic medical record. You were able to verify medication and provide education related to medication taking. CB

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

Comments

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

The Location of the pull station is across from 3037 and the fire extinguisher is across from 3035 CB

Week 9(5a,b,f): Josh, you did a great job demonstrating correct body mechanics while completing your assessment and while assisting your patient to the bathroom. You did a great job ensuring that you were foaming in/out when entering a patient's room, good job! CB

Week 10(5a,d): You were able to maintain correct body mechanics this week while managing basic patient care such as bathing your patient, transferring your patient to the chair, and while your patient was in bed, great job! CB

Week 12(5e): Great job with time management this week with your medication administration. You were able to organize your time and prioritize your patient's needs. Also, great job with the removal of a foley catheter, reviewing the policy and following the correct technique. CB

* 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:								NA		S	S	N/A	S	N/A			NA	S
a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).								CB		CB	CB	CB	CB	CB			CB	CB

Comments

Week 9(6a): Great job this week realizing what your patient’s priority problem would be in order to develop a plan of care. CB

Week 10(6a): Good job this week assessing your patient and gathering information from the electronic medical record to help you identify your patient’s priority problem, and centering patient care around that. CB

Week 12(6a): You were able to develop a plan of care for your patient related to their priority problem, good job! CB

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

Comments

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(7a-d, g): Josh, you did a great job with medication administration. You were able to identify why your patient was receiving the medication, potential side effects, and appropriate patient education. You followed the 6 right s of medication administration with 3 medication checks, verifying the correct patient and their allergies. You were able to utilize the BMV for medication administration documentation. CB

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

**** 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(8f): Josh, you are receiving this “U” due to your clinical tool being submitted late. Your clinical tool is due on Saturdays at 2200. 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. CB

Week 6: I understand that my score was a “U” due to my clinical tool assignment being submitted late. My competency will be met at a satisfactory level because I have placed my clinical evaluation tool due dates on my planner and will assure that I have submitted my clinical evaluation tool on time. I will submit my clinical evaluation tool before Saturday at 2200. I will give myself enough time to be able to turn in my clinical evaluation tool if in case I run in to some trouble with my computer or wifi issues. Josh, this is a great plan to ensure that your clinical tool is on time. CB

Week 7: I believe that a strength that I had during clinical was effective communication with my patient. I was able to communicate with my patient what I was going to be performing on them and receiving teach back which helped me know if the patient needed any further clarification. A weakness that I displayed was missing on some steps for a head-to-toe assessment. I plan on performing a head-to-toe assessment on five of my family members and go over my skills checklist 5 times as I am doing it on my family members this week. Josh, great job communicating with your patient this week. You also have a great plan in place to help you practice and feel more confident when completing a head to toe assessment. CB

Week 9: For my Clinical this week I believe that a strength that I had was being able to make my patient’s environment comfortable and safe for them. I was able to provide my patient an extra pillow and have natural light come in which they said they preferred than the room’s light. Since my patient was a fall risk, I made sure that they had on safety precautions such as yellow socks with grip at the bottom, yellow wrist band indicating they are a fall risk, fall precaution signs, and as well helping them to the bathroom and staying outside the door to prevent any accidents. A weakness that I feel I displayed was having trouble putting information in the right place during report and having to place the patient’s information on a blank sheet of paper and locate and place information in the correct spot when I had down time. I plan on looking over my report sheet twice a day before my next clinical on 10/25/2023 to get comfortable on where everything goes on the sheet. Josh, you did a great job this week ensuring that your patient’s environment was safe and that the appropriate precautions were in place to prevent injury. I understand that the report paper is difficult for you to use right now, but with time and experience, it will get easier, but you have a great plan in place to help you feel more comfortable. CB

Week 10: For my Clinical this week I believe that a strength that I had was being able to talk to my patient about his personal life. I believe that knowing what is going on with my patient’s home life and as well as let them talk about their feeling allowed me to coordinate care around that. I learned that my patient really loves his son and as well as grandson, so when my patient had received a call from his son, I knew how important those were for him so I allowed my patient privacy and time to talk to them. Josh, you did a great job communicating with your patient this week. Getting to know the patient as a “whole” is so important, especially when the patient lives with family members, so the dynamics of what is going on is important for a good outcome.

A weakness that I displayed was being hesitant about my patient’s lung sound. I am going to practice listening to lung sounds on four of my family members this week. I have also found a YouTube video on some examples of each different types of lung sounds I may come across. Josh, the more that you hear abnormal lung sounds, the more comfortable and confident you will be when documenting them. We want you to ask for our opinion, as you did this week, so that you are correctly documenting and your assessments are accurate. You have a great plan in place to help you with this weakness. CB

Week 11: For my Clinical this week I believe that a strength that I had was able to do perform a focused assessment in pain after administering a pain medication for my patient. It is important to know if the medication is affective for the patient because if it is not working, we can implement maybe a new medication into the patient’s plan. I was able to use the pain scale using 0-10 so I am able to understand where my patient pain level is. Great job re-evaluating your patient’s pain level after your patient was medicated. This is important to ensure that no other interventions need to be implemented for your patient’s comfort. CB

A weakness that I felt that I had was being forgetful on the steps of the foley removal and forgot that we have to hold the foley as we are draining the balloon by gravity. I will make sure to go over foley removal 2 times and watch the video presented by the FRMC school of nursing since this was the only step I missed but it is crucial that I get it down. Josh, Nick thought you did a great job, but it is always good to be aware of areas that you could improve in. CB

Final comment: Josh, you did an excellent job this semester! You came to each clinical prepared and ready to take on any patient assigned to you. You have grown over the weeks with your confidence and knowledge of not only the environment of the hospital and clinical setting, but also your patients and their needs. Every single one of your patient's were pleased with the care you provided and the time that you spent with them. You did not get the opportunity to perform wound or NG care, so please seek this opportunity out in your MSN semester. Great job, and I am excited to see your growth continue! CB

* 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
11/20/2023	Impaired Gas Exchange	*S/CB	*NA

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: Josh Hernandez		Course Objective: Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*					
Date or Clinical Week: 11/20/2023							
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)	3	Great job noticing all abnormal assessment findings, labs/diagnostic testing, and risk factors related to your patient. For all of your risk factors that are part of your patient's medical history, please be sure to include history to those. Example: History of lung cancer, history of COPD, etc.
	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	You did a great job listing nursing priorities, but I would have also included (risk for adult pressure injury, self-care deficit, decreased activity intolerance, imbalanced nutrition-less than body requirements, risk for impaired skin integrity). You did a great job highlighting abnormal findings that correlated with your top nursing priority of impaired gas exchange. Potential complications were listed and you were able to also list signs and symptoms related to each of them.
	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)	3	
	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	You did a great job listing realistic interventions that were related to your patient, that were prioritized. You provided a rationale for each intervention that was pertinent to your patient, and each intervention included a frequency.
	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	3	
	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	

Reflecting	13. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	You did a great job reflecting on your reassessment findings. Good job including to continue the plan of care.
	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	3	
<p>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.</p> <p>Faculty/Teaching Assistant Comments: Josh, great job overall on your first nursing care map. Please remember when completing any assignment that has guidelines and a rubric, have them both available to reference. CB</p>						<p>Total Points: 41/42</p> <p>Faculty/Teaching Assistant Initials: CB</p>	

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

Student Name: Joshua Hernandez

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: 9/6/2023	Date: 9/15/2023	Date: 9/21/2023	Date: 9/29/2023	Date: 10/3/2023	Date: 10/9/2023 10/12/2023	Date: 10/19/2023	Date: 10/24/2023	Date: 10/31/2023
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	AR	AR	NS	AR	NS	AR	NS	AR	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**

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 out of three blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 114/70, and you identified it as 110/64, great job. The second measurement was set at 136/88 and was incorrectly interpreted it as 158/80. You were able to accurately identify the third blood pressure that was set at 112/80 and interpreted at 110/80, nice job rebounding from the previous interpretation. Continue practicing to ensure you are able to remember the numbers. You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You did not require any prompts throughout the whole checkoff, nice work! You provided accurate detail in your communication with the “patient”. Your documentation was spot on. 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 only required one prompt throughout your whole check-off related to auscultating lateral breath sounds. You correctly identified lung sounds as crackles, nice job! 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.

- Pain – accurate and complete
- Vital signs - omitted “normal” for respiratory pattern. Otherwise, accurate and complete.
- Safety – Accurate and complete.
- Physical assessment – omitted eye discharge color as “clear” in the HEENT assessment. Omitted “hearing difficulty” for ear symptoms. Omitted left ear documentation. Omitted “history of chronic illness” under psychosocial assessment. Omitted “no previously passed” for dysphagia screen evaluation. Omitted “constipation” for bowel pattern.

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! AR

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 putting the tap on the clean irrigation tray rather than

the dirty bedside table. For irrigation, you did not require any prompts as you were able to remind yourself the two steps to verify placement prior to irrigation solution being inserted. For removal, you required one prompt related to injecting the 20 mL of air in the NG tube rather than the blue port when removing. This was discussed following your observation. 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. No prompts were needed throughout the entire process! Excellent job! You maintained the sterile field throughout the Foley insertion, did not contaminate the catheter or your gloves at any point, and had very good communication with your “patient”. Great job! You correctly verbalized the differences in catheter insertion for a male patient. You actively participated in the Intake and Output stations, and completed Meditech documentation related to Urinary Catheter Management and Intake & Output. Keep up the great work!!! AR

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 require two prompts related to the following: While opening the sterile supplies you contaminated the sterile cotton-tipped applicators, and when packing the wound you placed the saline dampened gauze directly on the patient’s skin and then began to pack the wound (this contaminated the packing). Your communication with the patient was excellent! 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

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) *
	Date: 11/7/2023 or 11/14/2023	Date: 11/27/2023 or 11/28/2023
Performance Codes:		
S: Satisfactory		
U: Unsatisfactory		
Evaluation (See Simulation Rubric)	S	S
Faculty Initials	CB	CB
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. I feel that a strength that I had during simulation this week was able to identify the protocols of what to do when a patient is having Dyspnea and understanding the rationale on why the doctor ordered the patient to have a certain percentage of oxygen and to reach 93%. I understood that a patient with a history of pulmonary problems this can be their baseline and why upping the oxygen volume won't necessarily help the patient and make it worse.

B. A area that I have for improvement would be that during simulation lab a medication was given for a patient which was a mucolytic if my patient was not having an effective cough but failed to recognize that the medication wasn't necessarily needed for the patient since their cough was effective and were able to bring sputum up. Although the medication would not have done harm to the patient it could have if another medication was ordered. Even if the medication was prescribed by the provider does not necessarily mean we give it. A plan to improve would be that I will go over my 6 rights of medications twice and go on skyscape and look over my medication and the need for it 3 times before I give it.

Faculty comments: Josh, great job on your simulation #1 reflection. Knowing that just because a medication is ordered and understanding the reasoning is key for patient safety. CB

Simulation #2:

A.I believe that an area of strength that I had during my simulation #2 was being able to properly know where to give my patient their IM injection on their arm and was able to follow my 6 rights of medication administration for my patient. This is key to know when administering any kind of medication because if a mistake happens It could be as serious as causing harm to my patient. As the medication nurse I was able to educate my patient on the importance of the medication and the reason as to why I would be give the medication the IM route and the onset it will have which would be quick in relieving their pain if given this route.

B.I believe that a weakness that I presented during simulation as the medication nurse would be picking the wrong needle size and instead of using a 1 to 1 ½ inch needle I ended up grabbing the blunt needle. I realized this once the patient stated that they had pain during administrating their IM injection I had used the wrong needle size. Using the right needle is crucial when doing an IM injection because it minimizes discomfort and ensures the right amount of medication disperses in the site. I was able to discuss during debriefing and will make sure I go over needle sizes in my Potter and Perry textbook three times before my simulation lab.

Faculty comments: Josh, great job reflecting on your simulation #2 experience. You have a great plan in place to ensure that you are using the correct type and size needle for IM injections from here on out. CB

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Jennifer Collins (A), Destiny Houghtlen (M), Melisa Fahey (O), Joshua Hernandez (O)

GROUP #: 9

SCENARIO: NF #1

OBSERVATION DATE/TIME(S): 11/14/2023 1300-1400

CLINICAL JUDGMENT COMPONENTS					<u>OBSERVATION NOTES</u>
NOTICING: (1,2,4,6,7) *					Assessment nurse introduced self and role.
• Focused Observation:	E	A	D	B	Noticed cough and instructed patient to cough and deep breath after raising the head of the bed.
• Recognizing Deviations from Expected Patterns:	E	A	D	B	Information sought related to reason for hospitalization.
• Information Seeking:	E	A	D	B	Noticed temp 99.2, SpO2 87% on RA, HR 80, RR 18, B/P 130/82.
					Did not notice alarm for low Spo2.
					Pain assessment performed.
					Noticed abnormal lung sounds (wheezes- remediated in debriefing that lung sounds were crackles). Remember to listen to lung, heart, and bowel sounds on direct skin and not over the gown.
					Noticed the tissues in the patient's bed. Noticed the yellow sputum and asked

	<p>how long cough and sputum production have been going on.</p> <p>Information sought regarding smoking habits and interest in possible nicotine patch.</p> <p>Noticed medication orders in MAR.</p> <p>Medication nurse introduced self and role when entering the room. Accurately identified patient's name/date of birth and allergies. 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.</p> <p>Noticed indications for atorvastatin and multivitamin. Noticed potential adverse reactions and side effects (reminder to write medications down and bring sheet in room with you, remediated during debriefing).</p>
<p>INTERPRETING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p>Did not prioritize low SpO2. Completed head to toe assessment before applying oxygen as per physician's order.</p> <p>Promoted to assess bilateral heels after complaints of pain. No assessment performed, placed pillow under heels.</p> <p>Interpreted medication orders in MAR.</p> <p>Prioritized medication safety practicing 6 rights of medication administration.</p> <p>Interpreted some side effects of medications appropriately.</p>
<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 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>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 87% by raising the head of the bed and instructing patient to cough and deep breath.</p> <p>Appropriately used the BMV scanning system for medication safety. Communicated medications to be administered. Remember to never leave medication unattended at bedside.</p> <p>Great education provided on use of incentive spirometer and smoking cessation using the teach back method. Consider educating patient on fall precautions and home oxygen therapy.</p>
<p>REFLECTING: (1,2,4,5,6,8) *</p>	<p>Observers provided good insight during debriefing. Noticed the good</p>

<ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>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: 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. Identifies obvious patterns and deviations, missing some important information; unsure how to continue the assessment. 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: Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data. In simple, common, or familiar situations, is able to compare the patient’s data patterns with those known and to develop or explain intervention plans; has difficulty, however, with even moderately difficult data or situations that are within the expectations of students; inappropriately requires advice or assistance.</p> <p>Responding: Is tentative in the leader role; reassures patients and families in routine and relatively simple situations, but becomes stressed and disorganized easily. 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. Is hesitant or ineffective in using nursing skills.</p> <p>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.</p> <p>Satisfactory completion of NF Scenario #1.</p>

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): **Melisa Fahey (A), Joshua Hernandez (M), Jennifer Collins (O), Destiny Houghtlen (O)**

GROUP #: **8**

SCENARIO: **NF #2**

OBSERVATION DATE/TIME(S): **11/28/2023 1000-1100**

CLINICAL JUDGMENT COMPONENTS						<u>OBSERVATION NOTES</u>
<p>NOTICING: (1,2,4,6,7) *</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 						<p>Identified patient with name and DOB when entering the room and compared with wristband. Noticed patient was in pain when entering the room. Noticed Spo2 of 91% on RA. Sought information related to sputum production. Noticed tissues with sputum in the bed. Sought additional information on pain (duration, rating, location, radiating, alleviate/precipitating factors). Noticed pain 7/10. Noticed abnormal lung sounds upon auscultation. Noticed RR of 30. Medication nurse noticed PRN orders for pain medications. Noticed pain 7/10. Sought information from patient regarding pain medication preference Sought information on alcohol use with opioids. Noticed Spo2 dropped to 88% after removing oxygen. Medication nurse confirmed name and DOB with wristband. Sought information related to patient comfort.</p>
<p>INTERPRETING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 						<p>Prioritized pain assessment when entering the room Prioritized oxygenation status for Spo2 of 91% on RA. Made sense of provider order to maintain >93%. Prioritized focused pain assessment Consider administering pain medication prior to use of incentive spirometry due to patient discomfort. Prioritized focused respiratory assessment. Made sense of abnormal lung sounds. Did not interpret crackles. Prioritized vital signs assessment. Made sense of PRN pain medication orders for pain scale rating. Prioritized morphine administration over Percocet. Made sense of dosage calculation to be performed. Made sense of side effects of morphine and need to educate at a different time.</p>
<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 						<p>Good teamwork and collaboration to review the chart before entering the room. Identified self and role when entering the room. Administered oxygen at 2L via nasal cannula for Spo2 of 91% on RA.</p>

<ul style="list-style-type: none"> Well-Planned Intervention/ Flexibility: E A D B Being Skillful: E A D B 	<p>Encouraged patient to cough and deep breath. Encouraged use of incentive spirometer.</p> <p>Elevated HOB for shortness of breath.</p> <p>Focused respiratory and pain assessment completed.</p> <p>Medication nurse identified self and role when entering the room</p> <p>Educated patient on potential side effects related to opioids. Educated the patient on IM injection.</p> <p>Elevated heels on pillows to alleviate pressure.</p> <p>Removed oxygen after returned to 95%. Continually assessed Spo2. Re-applied oxygen when Spo2 dropped to 88%.</p> <p>Educated on splinting when coughing to relieve pain. Provided demonstration. Educated on coughing deep breathing to help with pneumonia.</p> <p>Educated on q4h order for morphine.</p> <p>Dosage calculation performed (2ml to be injected, 4mg). Wasted excess dose</p> <p>You must have a witness during wasting of narcotics. Cleaned site with alcohol swab, good aseptic technique. Used blunt tip needle, remember to use correct IM needle (20-23g, 1-1.5inch). Aspirated for presence of blood prior to injecting. Injected slowly. Never re-cap a needle after injected into a patient. BMV used for patient safety.</p> <p>Re-assessed pain after medication administration. Consider re-assessing vital signs after narcotic administration.</p> <p>Consider improved communication among team members when it comes to performing multiple interventions at once. The patient was receiving an injection while also having assessments performed which could be overwhelming to the patient.</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>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.</p>
<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p>	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. 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: 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.</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>Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Shows some communication ability (e.g., giving directions); communication with patients, families, and team members is only partly successful; displays caring. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Is hesitant or ineffective in using nursing skills.</p> <p>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.</p> <p>Satisfactory Completion of NF Simulation #2.</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:

Student eSignature & Date: Joshua Hernandez 12/04/2023