EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Grace Catanese

Final Grade: **Satisfactory/Unsatisfactory**

Semester: **Spring**

Date of Completion:

Faculty: **Dawn Wikel,** MSN, RN, CNE**; Rachel Haynes,** MSN, RN**; Kelly Ammanniti,** MSN, RN, CHSE**; Monica Dunbar,** DNP, RN; **Heather Schwerer,** MSN, RN; **Nick Simonovich,** MSN, RN

Faculty eSignature:

Teaching Assistant: **None**

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 on 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". 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 Competency Tool & Skills Checklists

Simulation, Prebriefing, & Reflection Journals

Nursing Care Map Rubric

Meditech Documentation

Clinical Debriefing

Clinical Discussion Group Grading Rubric

Evaluation of Clinical Performance Tool

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make-up (/Date/Time)

Lasater's Clinical Judgment Rubric & Scoring Sheet

Virtual Simulation Scenarios

Faculty's Name	Initials
Kelly Ammanniti	**KA**
Monica Dunbar	**MD**
Rachel Haynes	**RH**
Heather Schwerer	**HS**
Nick Simonovich	**NS**
Dawn Wikel	**DW**

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 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, 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 boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
1/25/24	Excess fluid volume	S/RH	NA	NA

Note: Students are required to submit two satisfactory care maps over the course of the semester. If the care map is not evaluated as satisfactory upon initial submission, the student must revise the care map based on instructor feedback/remediation and resubmit. A maximum of two remediation attempts will be provided for a single care map and if still unsatisfactory, the student will be required to start fresh and initiate a care map on a new patient. At least one care map must be submitted prior to midterm.

Objective

1. Illustrate correlations to demonstrate the pathophysiological alterations in adult patients with medical-surgical problems. (2,3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies: a. Analyze the involved patho-physiology of the patient's disease process. (Interpreting)			S	NA	S												
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	NA	S												
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	NA	S												
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	NA	S												
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	NA	S												
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	NA	S												
g. Assess developmental stages of assigned patients. (Interpreting)			S	NA	S												
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S												
Indicate your clinical site as well as your patient's age and primary medical diagnosis in this box weekly.	Meditech, FSBS, IV		Rehab, 62, cirrhosis & ascites	Infection control & digestive health	3T, 8L, Fall with nasal fracture.												

	Instructors Initials	RH	RH	RH	DW													

Comments:

Week 1 (1h)- During week 1, the Meditech, FSBS and IV pump sessions were all considered clinical hours. You came prepared to each of them and demonstrated competency accordingly. For this reason, you have earned an S for this competency. HS, DW, NS

Week 3: (1 c, d, e, f)- This week you did a great job discussing your patient's pathophysiology of their illness as well as had a great discussion of their medications and why they were relevant to their care. You did a good job noticing and keeping track of their strict I&Os throughout your clinical days. RH.

Objective																	
2. Perform physical assessments as a method for determining deviations from normal. (3,4,5)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
Competencies: a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	NA	S												
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	NA	S												
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	NA	S												
d. Communicate physical assessment. (Responding)			S	NA	S												
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	NA	S												
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	S												
	RH	RH	RH	DW													

Comments:

Week 1 (2f)- By attending the Meditech clinical update & providing your full, undivided attention during the demonstration of documenting insulin, IV solutions, and the Meditech 2.2 upgrades, you are satisfactory for this competency. NS

Week 3: (2 a-f)- This week you did a good job of performing your head to toe when time was available to you due to the therapy scheduling. You also were able to document and find other assessment pieces in the electronic health record. RH.

*End-of-Program Student Learning Outcomes
Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Objective																	
3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
Competencies: a. Perform standard precautions. (Responding)	S		S	NA	S												
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	NA	S												
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	NA	S												
d. Appropriately prioritizes nursing care. (Responding)			S	NA	S												
e. Recognize the need for assistance. (Reflecting)			S	NA	S												
f. Apply the principles of asepsis where indicated. (Responding)	S		S	NA	S												
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA	NA												
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			NA	NA	NA												
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	NA	S												
j. Identify recommendations for change through team			S	NA	S												

*End-of-Program Student Learning Outcomes
Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

collaboration. (Reflecting)																	
	RH	RH	RH	DW													

Comments:
Week 3: (3 c, d, e) This week you demonstrated good organization and time management when it was time for medication administration. This was difficult due to the varying therapy schedules we had to work around. You did a good job looking up your medications, administering medications, completing your head to toe, and charting your findings while also participating in therapy with your patient throughout both days. You were not afraid to ask for assistance when needed! RH.

*End-of-Program Student Learning Outcomes
Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Objective																	
3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
Competencies: k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	NA	S												
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	NA	S												
m. Calculate medication doses accurately. (Responding)			S	NA	S												
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			NA	NA	NA												
o. Regulate IV flow rate. (Responding)	S		NA	NA	NA												
p. Flush saline lock. (Responding)			NA	NA	NA												
q. D/C an IV. (Responding)			NA	NA	NA												
r. Monitor an IV. (Noticing)	S		NA	NA	NA												
s. Perform FSBS with appropriate interventions. (Responding)	S		NA	NA	NA												
	RH	RH	RH	DW													

Comments:

Week 1 (3o,r)- During the IV pump session, you actively participated in the programming and maintenance of the Alaris IV pump. Additionally, you accurately identified abnormal IV site assessment data with an IV site monitoring activity. HS

*End-of-Program Student Learning Outcomes
Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Week 1 (3s)- The student was able to satisfactorily perform a Quality Control check of the glucometer as well as demonstrate skills and knowledge required for proper fingerstick blood glucose measurement with the ACCU-CHEK Inform II glucometer. DW

Week 3: (3 k, l, m)- You were well prepared for medication administration this week and you performed all checks well! You used the EMAR to look up medications that were due then used skyscape to further investigate each medication. You answered all my questions well and your medication pass went smoothly! RH

Objective																	
4. Use therapeutic communication techniques to establish a baseline for nursing decisions. (1,5,7)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
Competencies: a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S												
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			S	NA	S												
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	NA	S												
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S												
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	S												
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	NA	S												
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			S	NA	S												
	RH	RH	RH	DW													

*End-of-Program Student Learning Outcomes
Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Comments:
Week 3: (4 b, e, f, g) you upheld the professionalism standard while on the floor and interacting with staff and patients. You also did great with your discussion post and reply this week. You gave a good SBAR report prior to leaving for the day. RH

Week 4 (4e)- According to the CDG Grading Rubric, you have earned an S for your participation in the Infection Control discussion this week. Your discussion was thoughtful and supported by evidence. Nice job with APA formatting. Keep up the good work! DW

Objective																	
5. Implement patient education based on teaching needs of patients and/or significant others. (1,6)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
Competencies: **a. Describe a teaching need of your patient.**** (Reflecting)			S	NA	S												
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			S	NA	S												
	RH	RH	RH	DW													

****5a & b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab- describe the patient education you provided; be specific- include the topic, method of delivery, reason for teaching need, materials to support learning through above resources (if applicable), and method used to validate learning.**
Example: Education related to orthostatic hypotension (changing positions slowly by sitting at the side of the bed or chair for a few minutes before moving to another position, utilizing the walker when ambulating) was provided to my patient through discussion and demonstration. This was necessary to maintain patient safety as he/she was experiencing a drop-in blood pressure and dizziness when getting out of bed. A patient education sheet was printed from Lexicomp and given to the patient. The teach back method was used to validate learning.

Comments:

WEEK 3 a & b. Education related to my patient's different medications side effects was provided by looking different things up on Skyscape as well as through discussion. This was necessary to the patient before giving the medications because a lot of them had side effects such as headaches and dizziness. If he didn't know that those were the side effects, he could have tried getting up after taking them and fallen. To validate the learning, he asked for assistance when ambulating after he took the medications, rather than just getting out of bed himself like he had been before. This was a great educational point for your patient! Some patients are unaware of some medication side effects, even if they have been taking them medication for a long time. RH

WEEK 4 a &b. This week I had clinicals for infection control and digestive health, so I did not have any teaching for anyone since I did not have a patient. DW

WEEK 5 a & b. Education related to my patient that was needed was informing her not to try and move suddenly, since she was dizzy and had orthostatic hypotension. She has a history of frequent falls, the reason she was in the hospital in the first place, so I also turned her bed alarm on and ensured I had someone with me to assist when moving her around. I informed her to let me know if she was feeling dizzy or like she may pass out anytime while I was obtaining her orthostatic BPs. I used Skyscape to look up orthostatic hypotension and the symptoms it causes, so I was able to tell her through a discussion that is what may be causing the dizziness and feeling faint. It was very easy for her not to move though since she slept most of the time. I validated this learning when she was able to tell me when she was feeling dizzy or faint as I was taking her orthostatic blood pressures.

*End-of-Program Student Learning Outcomes

Objective																	
6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
a. Develop and implement a priority care map utilizing the nursing process and clinical judgment. (Noticing, Interpreting, Responding, Reflecting)			S	NA	S												
b. **Identify factors associated with Social Determinants of Health (SDOH) &/or cultural elements that have the potential to influence patient care.**** (Noticing, Interpreting, Responding, Reflecting)			S	~~NA~~ U	S												
	RH	RH	RH	DW													

****6b- You must address this competency in the comments on a weekly basis. For all clinicals - provide an example of SDOH &/or cultural elements that influenced your patient's care; be specific.**

Comments:

See Care Map Grading Rubrics below.

WEEK 3: Some SDOH that influenced my patient's care was that he was a little bit older, being 62 years old, he needed quite a bit of help getting around. He was a male, and had some history of depression, which required medication that included side effects of homicidal behavior/ personality changes. How was his support system at home? I know at one point you said his wife was there visiting and he told her to go home and he did not want her there. Does this mean he will be like that upon discharge and not want her assistance? RH

WEEK 4: This week's clinicals were for infection control and digestive health, therefore I had no patient to identify SDOH for. Week 4 (6b)- Unfortunately, you are receiving a U for not commenting on an example of a SDOH that could have impacted a patient from your clinical experience this week. Please be sure to take your time and review the details of the clinical tool more closely each week. As you can see above, the directions tell you that a comment must be made for all clinicals. An example related to infection control may have been that

financial strain, which could impact ability to purchase medication and other treatment measures or ensuring that the correct disinfecting materials and solutions are available when they go home. Please be sure to address this U in the comments for next week. Failure to do so will result in a continued U until completed. DW

U on Week 4: I see that I received a U for last weeks SDOH question. I understand why and will be sure to read the directions more carefully next time. I did not realize that I could pick a SDOH for just anyone, as I thought I needed to have a patient to do so.

WEEK 5: A few SDOH that influenced my patient's care was that she was 81 years old, did not seem to have much of a support system while in the hospital, and has a long history of mental illnesses, such as depression, bipolar disorder, anxiety, and schizophrenia. This extensive history of mental illness made her not very talkative, so I was unable to figure out her living situation. Not having a very good support system with her age and all her different symptoms like dizziness and frequent falls could result in her getting severely injured and affect her health even more.

Objective																
7. Illustrate professional conduct including self-examination, responsibility for learning, and goal setting. (7)*																
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
a. Reflect on an area of strength. ** (Reflecting)	S		S	S	S												
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		S	S	S												
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		S	S	S												
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		S	S	S												
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S		S	S	S												
f. Exhibit professional behavior	S		S	S	S												

*End-of-Program Student Learning Outcomes

	i.e. appearance, responsibility, integrity, and respect. (Responding)																	
g.	Demonstrate the ability to give and receive constructive feedback. (Responding)	S		S	S	S												
h.	Actively engage in self-reflection. (Reflecting)	S		S	S	S												
		RH	RH	RH	DW													

****7a and 7b: You must address these competencies in the comments section on a weekly basis. Please write a different comment each week. Remember that a goal includes what you will do to improve, how often you will do it, and when you will do it by (example- "I had trouble remembering to do the three checks of the six medication rights prior to administering medications. I will review the six rights and medication administration content in the textbook twice before the next clinical. Additionally, I will request to meet with my clinical faculty member to practice preparing and administering at least three medications before the next clinical."**

Comments:

WEEK 1: One area of strength for me this week I believe was being able to fully demonstrate how to flush and administer a medication through an IV, I think I was able to easily grasp and understand how to do it for never doing it before.
WEEK 1: One area for improvement is trying to memorize the different equations for the IV. During the practice problems I missed a few because I mixed up the equations. I will improve on this by reading over the equations a few times before our quiz that Kelly sent as well as doing all the practice problems. Great goal! RH

WEEK 3: One area of strength for me this week was performing my head-to-toe assessment and vitals in a timely manner because my patient had to be to PT and OT at certain times. You did so great with this! It is hard to coordinate what we need to do as nurses as well as making sure the patient can also participate with PT and OT. RH
WEEK 3: One area for improvement is medication administration. I have only administered medications once in clinical so I couldn't quite remember all that needed to be done. I will improve on this by looking over the medication administration guidelines and process sheet that was given to me last semester before my next clinical. You will definitely get more practice this semester, but reviewing is always a great goal! RH

WEEK 4: One area of strength for me this week was being able to identify accurate documentation on isolation precautions for the infection control clinical. Well done! It's a good feeling when navigating the EHR starts to come together. DW
WEEK 4: One area for improvement is being able to remember which diseases are associated with which isolation precaution without having to look at my badge all the time. I could improve on this by looking my badge over before my next clinicals and trying to remember the different types of isolations. Great idea! The more you familiarize yourself with the content, the easier it will be to remember it in the future. With that said, the quick reference badge backer was created for a reason…so nurses don't have to go through the trouble of remembering every little detail. Instead, you know where to find the information when you need it and can use those few extra brain cells for something else 😊. DW

WEEK 5: One area of strength for me this week was being able to prioritize all four patients, being a team leader and getting medications looked up in a timely manner for all the patients that needed medications this morning.
WEEK 5: One area for improvement could be getting more comfortable with waking patients up in the morning. It can be an uncomfortable thing to do, and patients can be very cranky when being woken up so early. I can improve on this simply by being more confident in talking to and waking up patients in clinicals, I will try being more confident over the next week of clinicals to improve for the future.

Student Name: Grace Catanese	**Course Objective:**	MSN
Date or Clinical Week: 1/24-25/24		

	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	2. Were there any other abnormal electrolytes? (potassium, sodium, etc) 3. Does your patient have any other health history that could be relevant? Ex. Hypertension, cardiac history, high cholesterol, diabetes, 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**	3	4. This is a great list of priorities! 6/7. Good complications and symptoms listed. Edema can also cause weeping at the edematous site if it is significant enough.
	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	10. Intervention number 8 has a timeframe of "as ordered." For this care map I will say that is okay, but it will need to be more specific in the future. Intervention number 16 and 17 timeframe is "upon discharge." We want to educate our patients multiple times prior to discharge so I would change these to "daily and upon discharge."
	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	

							12. Intervention number 5, your rationale states confusion could be from electrolyte imbalance, which is correct, but due to his liver history, it could also be due to the ammonia build up in his body.
Reflecting	13. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	2	13. Make sure you are evaluating all highlighted items, even if they did not change. You did not re-evaluate the ultrasound, magnesium level, malnutrition, or sclera assessment.
	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:
Great job! You had a very thorough and thought out care map. Your interventions and rationales were individualized for your patient. My only suggestions would be to be more specific with some of your time frames and to evaluate all things you highlighted, as that is where points were missed.

Total Points: **41/42 Satisfactory**

Faculty/Teaching Assistant Initials: **RH**

Student Name:				**Course Objective:**			
Date or Clinical Week:							
Criteria		**3**	**2**	**1**	**0**	**Points Earned**	**Comments**
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	**(lists at least 7*) *provides explanation if < 7**	**(lists 5-6)**	**(lists 5-7 but no specific patient data included)**	**(lists < 5 or gives no explanation)**		
	2. 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. 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)**		
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**		
	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**		
	6. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**		
	7. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**		
Respondi	8. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**		
	9. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**		
	10. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**		
	11. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**		

ng	12. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**		
Reflecting	13. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**		
	14. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**		

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:**	**Total Points:** **Faculty/Teaching Assistant Initials:**

Firelands Regional Medical Center School of Nursing
Medical Surgical Nursing 2024
Skills Lab Competency Tool

Student name: Grace Catanese								
Skills Lab Competency Evaluation Performance Codes: **S**: Satisfactory **U**:Unsatisfactory	**Lab Skills**							
	Week 1	**Week 1**	**Week 1**	**Week 1**	**Week 1**	**Week 2**	**Week 2**	**Week 9**
	Insulin (2,3,5,7)*	**Assessment** (2,3,4,5,7)*	**IV Math Application** (3,7)*	**Lab Day** (1,2,3,4,5,6,7)*	**IV Skills** (2,3,5,7)*	**Trach** (1,2,3,4,5,6,7)*	**EBP** (3,7)*	**Lab Day** (1,2,3,4,5,6,7)*
	Date: 1/9/24	**Date:** 1/9/24	**Date:** 1/10/24	**Date:** 1/10/24	**Date:** 1/12/24	**Date:** 1/17/24	**Date:** 1/18/24	**Date:** 3/11 or 3/12/24
Evaluation:	S	S	S	S	S	S	S	
Faculty/Teaching Assistant Initials	RH	RH	RH	RH	RH	RH	RH	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	

*Course Objectives

Comments:

Week 1

(Insulin)- You were able to correctly prepare an insulin pen and administer subcutaneous insulin. Insulin requirements were accurately identified and calculated through the corrective scale and carbohydrate coverage orders. MD

(Assessment)- You were able to satisfactorily demonstrate the Basic Head to Toe Assessment during lab. KA/RH

(IV Math)-You satisfactorily participated in the IV Math learning session on 1/9/24 as well as the assigned IV Math practice questions and the IV Math Application lab on 1/10/24. KA/DW

(Lab Day)- You satisfactorily completed the mandatory lab review of nursing foundational skills. This was achieved through simulating care for a patient in a scenario requiring competency in assessment, communication, medication administration (including PO and IM injection), nasogastric tube insertion and maintenance, patient mobility and hygiene, use of PPE for Contact Isolation, wound care, foley insertion, and development of nursing notes. NS/MD

(IV Skills)- You have satisfactorily completed IV lab including a saline flush, IV push medication administration, priming and hanging a primary and secondary IV solution, adjusting a flow rate to run by gravity, discontinuing IV solution, and monitoring the IV site for infiltration, phlebitis, and signs of complication. RH

Week 2
(Trach care and suctioning 1/17/24)- During this lab you satisfactorily demonstrated competence with tracheal airway suctioning and tracheostomy care. You were able to maintain sterile field when necessary and you did not need any prompts for either skill. You answered my questions regarding knowledge and competence of both procedures. Great job! RH
(EBP Lab)- You actively participated in the online searching process for evidence-based practice literature, as well as reviewing example articles to determine appropriate selection and information needed when summarizing a research article. KA/LK

Firelands Regional Medical Center School of Nursing
Medical Surgical Nursing 2024
Simulation Evaluations

Simulation Evaluation Performance Codes: **S**: Satisfactory **U**: Unsatisfactory	**Student Name:** Grace Catanese							
	vSim- Vincent Brody (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	**vSim**- Juan Carlos (Pharmacology) (*1, 2, 3, 4, 5, 6)	**vSim**- Marilyn Hughes (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Simulation #1 (Musculoskeletal & Resp) (*1, 2, 3, 4, 5, 6, 7)	Simulation #2 (GI & Endocrine) (*1, 2, 3, 4, 5, 6, 7)	**vSim**- Stan Checketts (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	**vSim**- Harry Hadley (Pharmacology) (*1, 2, 3, 4, 5, 6)	**vSim**- Yoa Li (Pharmacology) (*1, 2, 3, 4, 5, 6)
	Date: 1/29/24	**Date: 2/12/24**	**Date: 2/26/24**	**Date: 2/28 or 2/29/24**	**Date: 4/10 or 4/11/24**	**Date: 4/15/24**	**Date: 4/25/24**	**Date: 4/29/24**
Evaluation	S							
Faculty/Teaching Assistant Initials	DW							
Remediation: Date/Evaluation/Initials	NA							

* Course Objectives

Comments:

EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2024

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 and Date:
-

`12/27/2023