EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Davondre Harper

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
Lasater's Clinical Judgment Rubric & Scoring Sheet
Virtual Simulation Scenarios

ABSENCE (Refer to Attendance Policy)

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

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
2/2/24	Impaired Gas Exchange	S/KA	NA	NA
2/9/2024	Impaired Urinary Elimination	S/NS	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)			na	s	s	s	na	na	S	na	s						
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			na	s	s	s	na	na	S	na	s						
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			na	s	s	s	na	na	S	na	s						
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			na	s	s	s	na	na	S	na	s						
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			na	s	s	s	na	na	S	na	s						
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			na	s	na	~~na~~ S	na	na	S	na	s						
g. Assess developmental stages of assigned patients. (Interpreting)			na	s	s	s	na	na	S	na	s						
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		na	s	s	s	s	na	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 Pump Sessions		No Clinical	3T – 71 y/o male Altered Mental Status	4N – 71 y/o male UR/AKI	5T – 79 y/o male Multi/High Fall Risk	Digestive Health	Simulation Scenario #1		Infection Control ECSC	3T – 82 y/o male Stroke						
Instructors Initials	**HS**		**HS**	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

Comments:

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

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. I added the S in for this competency as you did not self-evaluate for this competency. Please be sure to self-evaluate all competencies that are not grayed out. HS

Week 3-Be sure to indicate the clinical site in the last box each week including for off-site and no clinical weeks. HS

Week 4 – 1a, b, c, e– You did a nice job discussing on clinical your patient's disease process and what nursing was doing to help the patient. You were able to discuss symptoms we were monitoring and managing in your patient as well as pertinent labs for your patient diagnosis. You also set a goal for your patient and were able to discuss your patient's work towards meeting that goal. KA
Week 4 – 1d – You did a nice job reviewing all your medications before you administered them to the patient. You were able to discuss the reason why the patient was taking the medication as well as what we were monitoring the patient for. You also were able to discuss what information was needed to determine if the medication should be administered (i.e. blood pressure, pulse). KA

Week 5 1(a-h) – Davondre, nice job this week discussing your patient's alternations in health and the pathophysiology involved his urinary retention and acute kidney injury. You identified his symptoms of retention and lack of urinary output for greater than 24 hours, excessive output on initiation of the foley catheter, and hematuria. You discussed his elevated BUN/Creat levels as being related to the hydronephrosis identified on the CT scan. You correlated the medical management and need to place a 3-way catheter for continuous bladder irrigation as a result of his continued hematuria. Great work discussing your patient and using clinical judgement in decision making throughout the week. NS

Week 6: (1 c, d, e)- 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. RH.
Week 6: (1f)- I changed this to "S" due to you sitting with the patient during therapeutic dining group and also assisting/reminding him to tuck his chin while drinking during medication administration. You were monitoring him during eating to ensure he was preventing risk of aspiration, which is due to his health history, as well as making sure he was tucking his chin to allow for easier swallowing thin liquids. 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)			na	s	s	s	na	na	S	na	s						
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			na	s	s	s	na	na	S	na	s						
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			na	s	s	s	na	na	S	na	s						
d. Communicate physical assessment. (Responding)			na	s	s	s	na	na	S	na	s						
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			na	s	s	s	na	na	S	na	s						
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	s		na	s	s	s	na	na	S	na	s						
	HS		**HS**	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

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 4 – 2a, d – You did a nice job thoroughly assessing your patient and notifying your nurse of any pertinent information. You were able to identify the focused assessment needing to be completed for your patient related to their diagnosis and monitored abnormal assessment findings. KA
Week 4 – 2f – You utilized the EMR to research your patient and determine what care needed to be provided to your patient throughout the day. You also utilized the EMR to research your patient's health history and information related to the patient's current hospital visit. KA

Week 5 2(a,e) – Good work with your assessments this week, noticing deviations from normal. You did well to discuss your priority assessments related to your patient's disease process, monitoring the urine output and focusing on the GU assessment priority. You closely monitored the continuous bladder irrigation after initiating the three-way catheter and discussed the importance of monitoring for clots, urine output, and signs/symptoms of urinary retention as a result of the hematuria. NS

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

Week 6 (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 worked around therapy schedules to get your head to toe as well as your reassessment done. You also were able to document and find other assessment pieces in the electronic health record. RH

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		na	s	s	s	na	na	**S**	s	s						
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		na	s	s	s	na	na	**S**	na	s						
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			na	s	s	s	na	na	**S**	na	s						
d. Appropriately prioritizes nursing care. (Responding)			na	s	s	s	na	na	**S**	na	s						
e. Recognize the need for assistance. (Reflecting)			na	s	s	s	na	na	**S**	na	s						
f. Apply the principles of asepsis where indicated. (Responding)	S		na	s	s	s	na	na	**S**	s	s						
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			na	na	s	na	na	na	**S**	na	na						
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			na	s	na	s	na	na	**S**	na	s						
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		na	s	s	s	na	na	**S**	na	s						
j. Identify recommendations for change through team collaboration. (Reflecting)			na	s	s	s	na	na	**S**	s	s						
	HS		**HS**	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

Comments:

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

Week 4 – 3b – You did a terrific job managing the care of a patient who had altered mental status. I know this was out of your comfort zone and you handled the situation so well. You should be proud of yourself. KA
Week 5 3(c,d) – You did a nice job this week as team leader. You discussed your priority for each patient and organized your day well. You started the day by receiving report on 4 different patients and discussed which patient would be your priority to assess first. You identified the patient with hematuria and a continuous bladder irrigation as your top priority related to the blood loss and need to manage the CBI to prevent complications. You then shifted your priority to the patient with altered mental status from a UTI with a focus on safety. You discussed your third priority as the patient 2 days post-op following a bowel colectomy procedure that had been progressing towards intended outcomes and pending discharge that day. Lastly, you prioritized the patient admitted with a fall and acute kidney injury with stable labs and vital signs. You also prioritized your medication administration well, noting the importance of administering insulin close to meal times then focusing on scheduled PO medications that were prescribed for each patient. Overall you did well in discussing your clinical judgment decisions, prioritizing your day, and assisting your peers as team leader. NS

Week 5 3(b,g) – You gained experience this week with inserting a three-way urinary catheter. You demonstrated accurate technique, maintained sterility, and did your best to maintain patient comfort throughout. Due to the patient experiencing urethral trauma from the initial foley insertion in the ER, you met some resistence during insertion. You managed this appropriately by encouraging the patient to take deep breaths, and slowly rotating the catheter for insertion into the bladder. You also gained experience in setting up, monitoring and managing the continuous bladder irrigation that was prescribed for your patient. Overall nice work with demonstrating safety in performing various nursing measures this week. NS

Week 6: (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

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)			na	s	s	s	na	na	**S**	na	s						
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			na	s	s	s	na	na	**S**	na	s						
m. Calculate medication doses accurately. (Responding)			na	s	s	s	na	na	**S**	na	s						
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			na	s	s	na	na	na	**S**	na	s						
o. Regulate IV flow rate. (Responding)	S		na	s	s	na	na	na	**S**	na	s						
p. Flush saline lock. (Responding)			na	s	na	na	na	na	**S**	na	s						
q. D/C an IV. (Responding)			na	na	s	na	na	na	**S**	na	na						
r. Monitor an IV. (Noticing)	S		na	s	s	na	na	na	**S**	na	s						
s. Perform FSBS with appropriate interventions. (Responding)	S		na	na	s	na	na	na	**S**	na	s						
	HS		**HS**	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

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

(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

*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Week 4 – 3k – You did a nice job administering your medications this week. You observed the rights of medication administration and was able to answer all questions about your medications. You had the opportunity to pass PO, SQ, and IV medications this week. You performed the medication administration process with beginning dexterity. KA
Week 4 – 3p – You did a nice job flushing your patient's IV this week and ensuring patency of the IV line. You were able to document this appropriately in the EMR. KA
Week 4 – 3r – You did a nice job monitoring your patient's IV site this week and documenting your assessment in the EMR. KA

Week 5 3(k-s) – You demonstrated confidence and competence in medication administration this week. You identified the six rights of medication administration and performed the three safety checks, using the BMV scanner for patient safety. You gained experience in administering various PO medications, accurately performing all dosage calculations. As team leader you gained experience with administering IV infusions, monitoring IV sites closely and identifying infiltration – great job with your assessment skills! You followed appropriate procedure by stopping the infusion and discontinuing the IV to prevent worsening complications. Job well done! NS

Week 6: (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! You were very patient with your medication administration as your patient was asking some questions and he had to take one or two pills at a time in applesauce. You also were able to administer a subcutaneous injection after drawing it up from a vial. Be mindful when drawing up medications not to touch the blunt tip as it could cause contamination. Great job! 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)			na	s	s	s	na	na	S	s	s						
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			na	s	s	ni	na	na	S	na	s						
c. Report promptly and accurately any change in the status of the patient. (Responding)			na	s	s	s	na	na	S	na	s						
d. Maintain confidentiality of patient health and medical information. (Responding)			na	s	s	s	na	na	S	s	s						
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			na	~~S~~ NI	s	s	na	na	S	~~Na~~ S	s						
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			na	s	s	s	na	na	S	na	s						
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			na	s	s	s	na	na	S	na	s						
			HS	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

Comments:

Week 4 – 4b – You completed the SBAR worksheet and provided your RN with handoff communication related to your patient utilizing the SBAR you developed. You made sure all pertinent information and changes in patient status were communicated to your nurse during hand-off report. KA

Week 4 – 4e – Davondre, you did a nice job responding to your CDG questions related to your EBP article on delirium in patients and a sleep program this week. It was very relevant to your patient this week from the second day. I would have liked to see you explain and summarize the article a little more. You included a reference in

*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

APA format, but no internal in-text citation. You must include both in your CDG posts to receive a satisfactory. I found an in-text citation in your post to your peer, but not in your EBP article summary. In your reference only the first letter of the first word of the article needs to be capitalized. Also, for the in-text citation in your post to your peer the in-text citation would look like this (Farasat, et.al, 2020, pg#). You only need to include a page number if it is a direct quote. You were thoughtful with your response to your peer and added to the discussion of their EBP article. Overall you did a nice job. KA

Week 5 4(a,b) – You did well communicating with your patient(s), peers, and health care team members throughout the week. You noted the inappropriate humor that your patient used and did well in your CDG discussing how this potentially could impact the care received. As team leader, you managed the team well using good communication to ensure all patient care needs were met. NS

Week 5 4(e) – Nice work with your CDG requirements this week. You responded to the team leader CDG prompt with good detail, describing your prioritization and management of care during the experience. You identified an important TeamSTEPPS concept that related to your role. An in-text citation was provided, be sure to include the publishing year after stating.. “described by the American Hospital Association (2024)…”. Your response to Cameron provided additional insight to the conversation and included the use of a reputable source to support your discussion. All criteria were met for a satisfactory evaluation according to the CDG grading rubric. NS

Week 6 (4a, b, e, f, g) You did a well communicating with your patient and peers this week. You were able to complete your SBAR sheet and give a good SBAR report during debriefing this week. As we discussed at the end of the clinical week that there is a time for fun and a time to be serious, so I do agree and respect your self-reflection of the NI for 4b. Keep up the good work! RH

Week 9 4(e) – All criteria were met for a satisfactory evaluation related to CDG prompts for ECSC and IC. See my comments on your posts for more details. NS

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)			na	s	s	s	na	na	**S**	na	s						
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			na	~~S~~ NI	s	s	na	na	**S**	na	s						
			HS	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

****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 4- 5A & B: Education related to Edema (making sure that she implemented ankle rolls and ambulated q1-2hrs to increase the circulation in her lower extremities and potentially reduce some of the swelling/neurological pain) was provided to my patient through discussion and demonstration with my hands. This was necessary so she would be prepared when PT came to work with her. There unfortunately was no education sheet provided to the patient when I educated her. Despite her saying "I do that at home", she did begin rotating her ankles and massage them after I explained this to her, validating that she understood what was taught via teach back method. Where did your information come from? 5b is related to documenting where the information came from like Skyscape. Please make sure to include this in the future to receive a satisfactory for this competency. KA

Week 5- 5A & B: I would say that I provided education related to 3-Way Catheter insertion/maintenance. I provided my patient with what the procedure included removal of his current Foley Catheter and replacing it with a 3-Way Catheter to monitor, locate, irrigate, and remove the hematuria/blood present in his urine. There was no educational sheet provided to the patient but the information came from the Essentials for Nursing Practice Book. Very good! NS

Week 6- 5A & B: I provided education related to Fall Precautions. I provided the patient with common physical hazards that should be removed/avoided prior to ambulation (i.e., inadequate lighting, barriers along normal walking paths/stairs, and a lack of safety devices (e.g., walkers or handrails). There was no educational sheet provided to the patient, but the "common physical hazards" information came from the Falls paragraph on page 787 in the Essentials for Nursing Practice Book. This is a great educational topic for your patient because he is planning to return home and he will need to make some modifications in his home to ensure he lowers his risk for falls due to environmental factors. RH

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

Week 10- 5A & B: I provided education related to Stroke Precautions. Being that he had diabetes, I let him know that it is a significant risk factor for stroke. Stroke risk in people with diabetes is 5 times higher than in those without diabetes. He also was a smoker, so I educated him that smoking nearly doubles the risk for ischemic stroke, which was what he had experienced. Smokers are 4 times as likely to have a hemorrhagic stroke than nonsmokers. The risk from smoking decreases substantially over time after the smoker quits. After 5 to 10 years of no tobacco use, former smokers have the same risk for stroke as nonsmokers. This information came from the Modifiable Risk Factors related to Stroke on page 1517 in the Lewis's Medical-Surgical Nursing Book.

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)			na	s	s	na	na	na	S	na	na						
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)			na	s	~~S~~ NI	~~na~~ U	s	na	S	s	s						
			HS	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

****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:

6B: Some social determinates that influenced my patient care would be that my Thursday patient's mental status was deteriorating. So, with that I had to make sure that I spoke loud and clear so he could hear me and was somewhat aware of what was going on, so he wasn't startled or frightened. I also had to alter how I did my head-to-toe assessment since my patient couldn't give subjective data by assessing his facial expressions/FLACC. Reflecting on this experience, I think I did very good with my patient and even got him to smile at me a couple times, so I think he was content with the care he was receiving. I also believe your patient live in an extended care facility which is another SDOH that cn impact his ability to mange his overall health besides his AMS changes and chronic illnesses. Great job. KA

See Care Map Grading Rubrics below.
Week 4 – 6a – You satisfactorily completed your care map on your patient this week. Please see comments on the rubric at the end of the tool for details. KA

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

6B: A social determinates that influenced my patient care would be that he was 71-year-old man who was administered with Urinary Retention and an Acute Kidney Infection. This required him to have his current indwelling catheter removed and replaced due to the severity/unimprovement of his conditions/symptoms. This procedure is preformed sterile; however, I was extra cautious on sterility due to his age, the removal/replacement of the catheter, and his bladder/kidneys having an "active bleed" according to the assessments performed. Reflecting on this experience, I think I did everything that was required of me sterility and supportively wise. Sterility is very important to help prevent potential complications related to catheter insertion. However, this isn't necessarily a social determinant of health, though. When reflecting on this competency, you want to review your patient's social environment and how it could impact his care. SDOH include economic stability, education access and quality, health care access and quality, neighborhood and build environment, and social and community context. As nurses we want to explore how these social concepts can impact their overall health. Do patients have the economic means to manage their health conditions, do they have the education level to understand the discharge instructions, do they have social support at home to help with managing their health, means for transportation to attend follow-up visits, etc. Be sure to utilize the provided link when reflecting on SDOH that could impact patient care in the future. NS
https://health.gov/healthypeople/priority-areas/social-determinants-health

week 6: (6b)- This was changed to a "U" because it is a requirement for ALL clinicals, including off site clinicals. Your patient had some type of social determinate of health that could impact their care. Please address this "U" and explain how you will prevent getting another "U" in the future. You will continue to get a "U" until this is addressed. RH I will prevent this in the future by making sure to identify factors associated with Social Determinants of Health with every patient moving forward. I also will make sure to fill out the Clinical Tool according to the care that was provided that week. DW

Week 7: (6B)- One patient didn't have cellular service due to AT&T's Service Outage, so we made sure that we had his wife's number prior to the procedure so we could arrange for her to be present during the education and to escort him out. I think I did a good job with being an extra pair of helping hands to the nurse I was shadowing by offering to help/helping with whatever task was asked of me. DW

Week 9: (6B)- One social determinate of health that I noticed with the ECSC is that the elderly relied on a specific mode of transportation in order to come to the Senior Center. This caused some of the seniors to miss the activities that we had planned due to them not being present when their mode of transportation was scheduled to leave and other determinates such as feeling under the weather. There wasn't much I could do to respond to these social determinates being that it's not in my credentials to pick seniors up due to not having the "correct" mode of transportation. However, I would suggest ensuring that the seniors who wanted to attend but couldn't due to missing the transportation be woken up earlier to have enough time to prepare and to be on time with their schedules. NS

Week 10: (6B)- One social determinate of health that I noticed with my patient would be the lack of social support. He lived at home by himself due to his marriages ending in divorces and his children being older and either moving away, having families of their own, or both. There wasn't much that I could do to respond to this social determinate being that he didn't want his family to be contacted because according to him "they all have their own lives" and him not wanting to interrupt them from that. However, I did make sure to interact/conversate with him and allow him time to speak/express how he felt, despite his speech being very gargled and difficult to understand. The only thing I would suggest is to keep reassuring the patient that he is loved and him being admitted to hospital for a stroke is substantial enough to "interrupt" his children's lives to update them on his prognosis/progression.

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		na	s	s	s	s	na	**S**	s	s						
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		na	s	s	s	s	na	**S**	s	s						
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		na	s	s	s	na	na	**S**	S	s						
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		na	s	s	s	na	na	**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		na	s	s	s	na	na	**S**	S	s						
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	~~S~~ U		na	s	~~U~~ NI	ni	na	na	**NI**	S	s						
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		na	s	s	s	na	na	**S**	S	s						
h. Actively engage in self-reflection. (Reflecting)	S		na	s	s	s	na	na	**S**	S	s						
	HS		**HS**	**KA**	**NS**	**RH**	**DW**	**HS**	**HS**	**NS**							

****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 (7f)-You received a U for this competency because you did not hand in the tool by the due date of Saturday at 2200, you submitted it after being reminded to do so. Please be mindful of deadlines on assignments moving forward. HS

Moving forward, I will make sure to review the syllabus for upcoming assignments to ensure that I submit them in a timely manner. HS

*End-of-Program Student Learning Outcomes

WEEK 1: My strength this week would be that I prepared prior to the labs we participated in by watching the videos and reviewing all of the required information on ATI. I also remained pretty positive and uplifting throughout the week, despite being exhausted, I tried to keep the energy and vibrations positive. Also, I managed to manually set the drop rate to 56 gtt/min! HS
WEEK 1: A weakness of mine this week would be that I haven't fully got back into the routine of school. I had a game plan to come in how I left last semester, but I haven't fully got off to a running start. I know it has only been a week, and the weather isn't beneficial, but after being back for a week I feel that now I am prepared for this semester! How I plan to get into the routine is by reviewing my materials and staying ahead of the materials/requirements so that I don't feel as if I am not prepared! That is a great plan! Be sure to review the material, and don't procrastinate. HS

WEEK 2: My strength this week would be that I demonstrated resiliency by learning how to suction/maintenance of a tracheostomy and managed to receive a Satisfactory rating with 0 prompts all within a day of receiving/learning the material/procedure! I am very proud of myself for pulling it off. HS
WEEK 2: Personally, I don't think I had a weakness this week. Despite, I can always use improvement in a particular area, I don't think there was anything that stuck out to me during this week. HS

WEEK 3: NA
WEEK 3: NA

WEEK 4: My strength this week would be that I correctly administered all the medication that was required of me! Not only did I administer them orally, but I also got to do a subcut injection which went pretty smooth (besides the needle being stubborn and not retracting) and getting to administer Furosemide and Hydromorphone intravenously!!! This and my Thursday's patient were the highlight of my clinical week. You did a great job administering your medications this! KA
WEEK 4: My weakness this week would be that I started off Thursday with a little self-doubt after receiving the handoff report and hearing that the patient was experiencing alterations in his mental status. I was nervous after hearing him screaming from the hallway and then being offered a different patient if it would be too much for me. I appreciated the words of affirmations, but I think mentally I was preparing myself for the worst scenario but to my surprise, he was the cutest/sweetest old man! Also, I almost got emotional a couple times watching him struggling to function/talk/eat and I had to pull it together so that was another thing but overall, it was a beautiful experience! You did wonderful caring for him. I am glad you were able to overcome your nervousness because you did an excellent job providing holistic care to him and ensuring all of his needs were met. Remember to include a goal on how you can work on improving this area in the future. Such as having an affirmation you can say to yourself when you are doubting your abilities to remind yourself that you are cable, knowledgeable, and enough in all situations you come across. KA

WEEK 5: My strength this week would be that I performed a catheter insertion. Being that this was a last-minute physician order, I was completely unprepared mentally and material wise. Despite the nerves, I was ready for the challenge and did my best at not letting the patient know that I was nervous and that he was my first ever catheter insertion. Overall, I think this was a great learning experience and a reality check when it comes to clinicals and how orders and patient's plan of care can change. Davondre, this was a nice reflection on your strengths this week. You made some important points related to how quickly a plan of care can change. As nurses, we have to be resilient when our plan changes abruptly. This was a good experience in noting how we must be flexible with our care while maintaining composure. While I am sure you were nervous, you demonstrated competence and confidence in your ability to insert the catheter. Unfortunately, this was a difficult insertion for your first experience; however, it was a good learning experience as there will be many times that your nursing measures may not be successful on first attempt. You were able to experience the importance of teamwork in health care as the assigned RN came in to assist with a difficult insertion. I thought you did a great job with this learning experience! NS
WEEK 5: My weakness this week would also be that I performed a catheter insertion and that I was a team leader. Personally, I think that the catheter insertion could've went better being that it took 3 people to successfully insert it. Also, with me being a team leader, it was actually draining and despite me being told that I did a good job, I would never willingly volunteer to do that job. I feel that it depleted my social battery, and I felt spread thin and way behind schedule being that I had to juggle 4 people's patients and prioritize them which made me unable to be there for all of the patients I was "in charge" of. A goal I will set moving forward is to be more efficient with time management and make sure to do what is required of me in a quick yet efficient way. (I put a U for professionalism because I didn't adhere to the appearance standard) Don't be overly critical of yourself regarding the catheter insertion. Your assigned patient had already experienced trauma from difficult foley insertion in the ER, making the insertion of a much larger catheter more difficult. There will be many times in your career that a procedure takes multiple people and multiple attempts. As for the team leading experience, this is the reason we include this learning opportunity. It's important to identify how much different it can be to manage multiple patients. You are very new in your nursing career and it takes time to develop the ability to manage and prioritize your time with numerous patients. You provided strong support to your peers and we accomplished everything we needed to for the day to promote positive outcomes. I think you have a plan to learn from the experience and improve in the future. I changed this competency to "NI" because overall I thought you did well. I respect your self-evaluation and desire to improve; however, I feel the "U" is being too critical of yourself. Overall this was a great reflection on your experience! NS

WEEK 6: My strength this week would be that I got to pass medications with applesauce. It was a new medication passing technique that I haven't got the opportunity to try. 10/10 experience! You did so well with this and you were so patient while doing your med pass. Great job! RH
WEEK 6: My weakness this week would be that I didn't write my medications the day prior to passing them. This could've given me more time for my head-to-toe assessment. Moving forward, I will make sure that I write my medications the day prior if applicable. This could have saved you time, you're right, but you still managed your time well this week while looking them up and completing your head to toe. Having an extra day to look them up is also nice. RH

WEEK 7: My strength this week would be that I tolerated experiencing EDG/Colonoscopy procedures firsthand. It was a pretty cool thing to witness and getting to see the Colon from the camera made me realize that it was not what I expected to look like based on the anatomical figures I've seen before. Glad to hear you've learned something from this experience. We find it beneficial in giving you a realistic view of anatomy, as well as having knowledge of exactly what the diagnostic procedures entail so you can better educate your patients in the future. DW
WEEK 7: My weakness would be that I didn't really get to communicate with the physician being that he was performing the colonoscopies and then went straight to charting afterwards. I did however get to ask the nurse all the questions I had. Despite thanking them for allowing me to sit in and watch them operate, I would definitely try to find some time to pick their brains if I had more time and if the schedule permitted it. Moving forward, I will make sure that I am able to communicate with the health care team more efficiently if time permits it. Great reflection, Davondre! DW
Week 7 (objective 7)- Whenever you have clinical, please be sure to evaluate yourself on all competencies in this objective. You had Digestive Health observation this week; therefore, competencies c-h should have been evaluated. Please keep this in mind for all future clinicals. DW

Midterm-Davondre, you have done a great job this semester in increasing your clinical judgement skills. You communicate very well not only with your patient but also with their family members. You do a nice job of explaining the care that you are providing to the patient as you are doing it which allows the patient to gain trust in you and the care that you are providing. (7f)-You did receive an NI in this competency for midterm. You self-evaluated yourself with an NI for a couple of the weeks based on first time experiences one was for a Foley insertion and the other was as team leader. I appreciate that you have acknowledged that these are areas for improvement. Moving forward into the future you should have an additional layer of confidence when being exposed to these situations again, therefore getting to the satisfactory rating. HS

WEEK 9: My strength this week would be that I went to the ECSC and got to help with creating a happy/lighter atmosphere for the seniors. Despite them not partaking in the activities that we provided, when we played the card game Jackpot, it created a more social setting and got their cognitive skills up and running. I am happy to hear that you were a positive aspect of their day! NS

WEEK 9: My weakness this week would be that we as a collective didn't get the Seniors more involved with the activities we brought for them. We did however, create examples and tried to make them more interested but they just didn't seem into it. In the future, I would be more encouraging by getting up and asking them if they would like to participate in said activates, and invest in easier/more accessible tools such as jumbo markers, colored pencils, crayons, paint brushes, etc. Good thoughts! NS

WEEK 10: My strength this week would be that I made my patient feel heard by actually taking the time to listen and decipher what he was trying to communicate through his speech impairment (i.e., slurring, gargling, aphasia).

WEEK 10: My weakness this week would be that I thought my patient's BP of 76/50 was due to an error with the machine or the cuff not being applied correctly by the therapist. This can and most definitely will be improved in the future by not only assessing the machine and the cuff but the patient as well. I will make sure if the situation were to present itself again that I would assess the patient's neuro status and make sure that they aren't experiencing any lethargy and are alert and oriented x4! This was a scary situation to experience because I've never had something like this happen before and it is not a machine/cuff error. Also, I want to thank you Heather and also apologize if I kind of just stood there while everyone came to the room to assist, I genuinely blacked out and thought the situation wasn't going to result how it did.

Student Name: Davondre Harper				**Course Objective:**			
Date or Clinical Week: Week 4							
	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	Davondre, you did a nice job including the relevant information about your patient for the assessment findings, lab/diagnostics, and risk factors section. KA
	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	You did a nice job listing the important nursing priorities for your patient. You should only highlight one priority as your focus. Would you like to focus on the impaired gas exchange or the ineffective airway clearance? When you look at the complications section it should be 3 complications related to your chosen nursing priority and then 3 S&S to assess for with each complication. So you have 3 complications listed under Impaired gas exchange (confusion, hypoxemia, respiratory failure) but no S&S for each. So for hypoxemia you could have listed cyanosis, decreased SpO2, and increased respiratory rate. You would want to do this for your other 2 complications of confusion and respiratory failure. You did a nice job highlighting the majority of the pertinent information. You would want to high the patient's respiratory rate and lung sounds in the assessment section as well. KA
	5. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	
	6. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	7. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	0	
Responding	8. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	You did a nice job writing interventions related to your designated nursing priority. You made sure your interventions were prioritized, realistic, and had rationale. Qwo of your interventions did not have frequencies. For lab/diagnostics you could make it prn or when available. For the fall
	9. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	10. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	

	11. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	precautions you would time it at all times. You would want to add interventions for assessing respiratory system (i.e. lung sounds) and for any respiratory specific medications we are administering to help your patient get better. KA
	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 reassessing all of your highlighted findings in the noticing section. The only factor that wasn't reassessed was the patient being a high fall risk. Even if unchanged you can state that it hasn't changed. KA
	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: **You satisfactorily completed your care map. Please see comments above on areas to improve on in the future. Nice job! KA**

Total Points: **36/42**

Faculty/Teaching Assistant Initials: KA

Student Name: Davondre Harper				**Course Objective:** 6a			
Date or Clinical Week: Week 5							
	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	A thorough list of abnormal assessment findings were provided. Consider including the abnormal HEENT assessment findings that were noted such as missing teeth without denture and the scars and nodules noted to the neck area as a result of his thyroid cancer and subsequent procedure. Numerous abnormal diagnostics were identified and listed based on information collected from the chart. Specific patient data was included for most. Be sure to include the specific BUN/Creat results in the future which are supportive of the AKI caused by the severe urinary retention. Risk factors were identified based on his past medical and social history. Consider his prescriptions for Plavix and Aspirin as risk factors for the hematuria.
	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	Four nursing priorities were identified based on the patient care required throughout the week. Consider additional priorities that resulted from the care needs, such as pain, decreased mobility as a result of the three way catheter and bladder irrigation, knowledge deficit related to the need for CBI, risk for skin breakdown due to his limited mobility, etc. You appropriately selected "impaired urinary elimination" as the top nursing priority. Based on the top priority, you identified potential complications that occurred and identified specific signs and symptoms to monitor for.
	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	Nice job with the intervention section of your care map for impaired urinary elimination. A thorough list of interventions were provided. Each intervention was prioritized appropriately with assessments taking highest priority. The listed interventions were
	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	individualized to the patient situation and an appropriate rationale was provided. Each listed intervention included a specific frequency to be performed.
	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**	0	When performing the evaluation section of the care map, you want to go back to your abnormal assessment findings and provide details on the most recent assessment of the patient to determine if they are progressing as intended. Based on the most recent assessment findings, we determine if the plan of care is helping to meet intended outcomes, or if we need to modify the plan of care to help improve the outcomes. It appears that you listed intended goals for the patient in the evaluation section. During the last day caring for him, he still had the 3-way catheter with continuous bladder irrigation, still had hematuria, BUN and Creat were still elevated, etc. Although the goal is to no longer need the indwelling catheter, absence of hematuria, etc. these were not the findings specific to your patient at this time. I agree with your statement to continue to plan of care until the assessment findings improve. In the future, be sure to re-list your assessment findings rather then stating goals.
	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.**

Total Points: 38/42 - Satisfactory

Faculty/Teaching Assistant Initials: NS

Faculty/Teaching Assistant Comments: Davondre, great work with your care map based on the priority problem of impaired urinary elimination related to your patient's diagnosis of urinary retention and hematuria. You used good clinical judgement in developing your care map and discussing the patient situation during the clinical week. You received 38/42 points for a satisfactory evaluation. Review the comments provided for continued success with care map assignments. You have now completed both required care map submissions with satisfactory evaluations for the semester. Kudos to you and your time management in completing both requirements prior to midterm. This will allow you to focus your attention on other aspects of the class. Job well done. Keep up the hard work! NS

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

Student name: Davondre Harper								
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 or 1/11/24	**Date:** 1/10 or 1/11/24	**Date:** 1/12/24	**Date:** 1/17 or 1/18/24	**Date:** 1/17 or 1/18/24	**Date:** 3/11/24
Evaluation:	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Faculty/Teaching Assistant Initials	HS	HS	HS	HS	HS	HS	HS	KA
Remediation: Date/Evaluation/Initials	NA	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 1/10/2024. 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. HS

Week 2
(Trach Care & Suctioning 1/17/2024) - During this lab, you satisfactorily demonstrated competence with tracheal airway suctioning and tracheostomy care. You provided comforting communication with your patient throughout the procedure. You did well to maintain your sterile field and applying sterile gloves. It was evident that you were

cognizant of the importance of maintaining sterility throughout both procedures. Just remember to appropriately discard used supplies away from the sterile drape to reduce the risk of contamination. You answered my questions appropriately demonstrating knowledge and competence of each procedure. No prompts were required for either skill. You were thorough in your approach and clearly well prepared. Keep up the hard work! NS
(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

Week 9
Lab day – Satisfactory demonstration in practicing NG tube and IV pump related skills. KA

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

Simulation Evaluation Performance Codes: **S**: Satisfactory **U**: Unsatisfactory	**Student Name:** Davondre Harper							
	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	S	S	S				
Faculty/Teaching Assistant Initials	KA	NS	HS	HS				
Remediation: Date/Evaluation/Initials	NS	NA	NA	NA				

* Course Objectives

Comments:

Simulation #1- Please review the comments placed on the Simulation scoring sheet below. In addition, review the individual faculty feedback placed within the Simulation #1 Prebrief and Reflection Journal dropboxes. HS

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Davondre Harper (M) Savannah Willis (A)
GROUP #: 1
SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory
OBSERVATION DATE/TIME(S): 2/29/2024 1230-1430

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (2) * • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	**Focused observation:** Focused pain assessment prioritized. Prioritized focused neurovascular assessment. Full set of vital obtained. **Recognizing deviations from expected patterns:** Noticed absent pulse. Noticed pallor, noticed cool to touch. Noticed delayed cap refill. Noticed paralysis. Did not or paresthesia. (5/6 Ps). Noticed hypertension. Noticed history of HTN and related to increased pain. Noticed tachycardia, tachypnea. **Information seeking:** Sought information related to patient allergies. Sought information related to preferred pronouns to address social diversity. Sought further information related to pain (numerical scale, consider asking additional questions related to pain). Confirmed name and DOB prior to med administration Asked preferred injection location Consider asking about last tetanus shot related to nature of the injury.
INTERPRETING: (1) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	**Prioritizing data:** Prioritized focused pain assessment. Looked at the extremity. Did not remove the sock with initial focused assessment. Prioritized pain medications. Prioritized focused neurovascular assessment. Prioritized fluids and antibiotics prior to surgery. Returned to full head to toe assessment after focused. Did not recognize emergent situation initially. (Discussed thought process in debriefing). Eventually prioritized contacting the health care provider. Prioritized removing pillow from the affected extremity but did not remove ice. **Making sense of data:** Made sense of dosage calculation for IM morphine. Made sense of compartment syndrome after performing full head to toe assessment. (Discussed thought process in debriefing).

	Made sense of need to initiate antibiotic prior to surgery. Made sense of information to be collected prior to contacting the provider.
RESPONDING: (2,3,4,5,6) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	**Calm, confident manner:** Roles clearly defined between medication nurse and assessment nurse. Approach was calm during emergent situation. Communication with the patient regarding interventions to be performed. Calm communication with significant other to avoid distress. Confident demeanor in interactions with health care team members. **Clear communication:** Great communication with the patient during assessment Communicated pain and assessment findings with the medication nurse. SBAR communication provided to the provider. Be sure to provide background information. Assessment information provided related to pain and additional symptoms. Communicated updated plan for surgery. Good education provided. Contacted significant other to update about patient's condition and need to move surgery up. Be careful with false reassurances. (Discussed during debriefing). Updated patient with communication to significant other. Report provided to OR nurse. Good details provided. Discussed conflict resolution with off-going shift in debriefing using professionalism. **Well-planned intervention/flexibility:** Medications administered in a timely manner. Removed the pillow from the affected extremity but not ice. Re-assessed pain after medication administration. Consider re-assessing vital signs. Contacted the provider with emergent findings. **Being skillful:** Correct needle size selected. Good needle safety. Good technique with IM injection. Remember to aspirate prior to injection. Good needle safety. Wasted excess narcotic with a witness. Dosage calculation performed accurately. Saline flush performed to confirm patency of the IV site. Remember to clamp the IV tubing before priming to avoid loss of medications. Keep the tubing clamped until it is loaded into the IV pump. IV pump programmed, but tubing was not loaded into the pump – medications were infused running wide open by gravity. (Remediated after the scenario and discussed in debriefing).

	Secondary tubing primed appropriately.
REFLECTING: (7) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Scenario discussed in regards to complications that occurred and interventions performed. Focused discussion on prioritizing focused assessment vs. full head to toe assessment based on situation. SBAR communication highlighted and discussed on gathering all pertinent data, providing full background and situation to the provider, and reading back orders. Discussion on medications and the use of the IV pump. All members agreed on understanding. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** 1. Select focused physical assessment priorities based on individual patient needs. (2)* 2. Implement appropriate nursing interventions based on patient's assessment. (1,3,6)* 3. Communicate appropriately with the patient, family, team members, and healthcare providers incorporating elements of clinical judgment and conflict resolution. (4,7)* 4. Provide patient-centered care with consideration to cultural, ethnic, and social diversity. (2,3,6)* 5. Provide appropriate patient education based on diagnosis. (5)* * Course Objectives	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes 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. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. 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 relevant patient data; monitors progress regularly but does not expect to have to change treatments. Is hesitant or ineffective in using nursing skills. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.

EVALUATION OF CLINICAL PERFORMANCE TOOL
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:
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`12/27/2023