

**EVALUATION OF CLINICAL PERFORMANCE TOOL  
Medical Surgical Nursing – 2024**

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

**Student:**

**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:**

**ABSENCE (Refer to Attendance Policy)**

- 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

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

Lasater's Clinical Judgment Rubric & Scoring Sheet

Virtual Simulation Scenarios

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

## 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.

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**\*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
3/23/24	Ineffective Tissue Perfusion	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.

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## 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
<b>Competencies:</b>			S	NA	S	NA	S	NA	S	NA	S	S	S				
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
g. Assess developmental stages of assigned patients. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S	NA S	S	NA	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	Rehab, 62, cirrhosis & ascites	Infection control & digestive health	3T, 81, Fall with nasal fracture.	Erie County Senior Center	Rehab, 70, sprained ankle	NA	MIDTERM	NA	4N, 66, TIA	3T, 82, acute respiratory failure	5T, 76, Left hemispheric CVA				

	Instructors Initials	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					
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**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.

Week 5 (1a-e)-Nice job this week identifying the symptoms that were associated with your patient’s disease process. You were also able to identify potential side effects that could have been caused by some of the medications prescribed to your patient. HS

Week 6: 1h was changed to “S” because you should have prepared for clinical this week by gathering materials for your activity as well as bringing your clinical paperwork that was necessary for the clinical experience. RH

Rehab Clinical Objective 1 B-E-This week you were able to identify symptoms, medical treatments, pharmacotherapy, and diagnostic tests that were a part of the patient’s stay on the Rehab unit. You did a great job in correlating all of these with the patient’s diagnosis. Great job! MD

Week 10 1(a-h) – Grace, you did a nice job this week discussing and making correlations between your patient’s alteration in health, pathophysiology involved, and assessment findings for a patient admitted with stroke like symptoms and TIA. I prompted you with numerous questions throughout the week aimed at enhancing your clinical judgment and connecting the information learned in class. You discussed her symptoms of numbness/tingling unilaterally on admission as well as other signs of stroke to monitor for. You correlated her past medical history of TIA, HTN, obesity, HLD, and age as risk factors for neurological alterations related to stroke. You reviewed and discussed the diagnostic tests that were performed, including head CT, neck CTA, MRI, metabolic panel. and echocardiogram, including nursing implications for each. You correlated her medications to both her current and past medical history, including her aspirin therapy and anti-hypertensives. You discussed s/s to monitor for related to stroke and the importance of performing focused neurological assessments. Good job putting the pieces together on your patient this week. NS

Week 11 – 1a, b, c, e– You did a nice job discussing on clinical your patient’s disease process related to acute respiratory failure and fall 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 11 – 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

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
<b>Competencies:</b> a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	NA	S	NA	S	NA	S	NA	S	S	S				
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	NA	S	NA	S	NA	S	NA	S	S	S				
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	NA	S	NA	S	NA	S	NA	S	S	S				
d. Communicate physical assessment. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	S	NA	S	NA	S	NA	S	S	S				
	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					

**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.

Week 5 (2a-f)-Your assessment this week was a bit more challenging due to the fact that your patient preferred to sleep however you were still able to get your assessment completed and relay the necessary information to your team leader and the primary nurse. You were able to individualize your assessment based on the patient's priority problem and utilize the electronic health record to obtain additional information assisting you in providing care. HS

\*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Rehab Clinical Objective 2 A-This week you were able to perform a great head to toe assessment! You were able to translate all of your findings in documentation and while discussing your patient with me. You really did a great job putting the pieces together with the patient's assessment and what you would see with the diagnosis! MD

Week 10 2(a,e) – Good job with your assessments this week. You identified priority assessments to be performed, specifically frequent neuro assessments, to determine possible changes in your patient's condition. You conducted and documented a thorough neurological assessment to ensure her symptoms were described accurately. NS

Week 11 – 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 11 – 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

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
<b>Competencies:</b>	S		S	NA	S	NA	S	NA	S	NA	S	S	S				
a. Perform standard precautions. (Responding)	S		S	NA	S	NA	S	NA	S	NA	S	S	S				
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	NA	S	NA	S	NA	S	NA	S	S	S				
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
d. Appropriately prioritizes nursing care. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
e. Recognize the need for assistance. (Reflecting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
f. Apply the principles of asepsis where indicated. (Responding)	S		S	NA	S	NA	S	NA	S	NA	S	S	S				
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA	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	NA	S	NA	S	NA	NA	S	NA				
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	NA	S	NA	S	NA	S	NA	S	S	S				

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

j. Identify recommendations for change through team collaboration. (Reflecting)			S	NA	S	NA	S	NA	S	NA	S	S	S				
	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					

**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.

Week 5 (3c, d, e)- You did a nice job this week as team leader. You were able to prioritize the patients and assist the other students when needed. You had effective discussions regarding priority problems for each patient. Great job! HS

Rehab Clinical Objective 3 D-You were able to identify the priority assessments with your patient and prioritize interventions that needed to be completed! MD

Week 10 2(b) – You were able to gain experience this week with several new skills, including wound care, saline flush, FSBS, IV pump maintenance, and priming IV tubing. While many of these experiences were new to you this semester, you approached them with confidence and discussed each step accurately. Nursing measures were implemented safely and competently. NS

Week 10 2(c,d) – As team leader, you were challenged with prioritizing multiple complex patient situations. In our discussions, you did well to identify priority patient problems, focused assessments, and time management. As team leader you prioritized patient care appropriately and ensured all medications were administered in a timely manner according to priority setting frameworks. Nice job! NS

Week 11 – 3b – You did a great job managing your patient’s care and ensuring his needs were being met. You helped focus on helping him regain his independence again after his fall. You also helped monitor his output and bladder scan him to determine if he was having urinary retention. Terrific job! KA

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
<b>Competencies:</b> k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
m. Calculate medication doses accurately. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			NA	NA	S	S	NA										
o. Regulate IV flow rate. (Responding)	S		NA	NA	S	S	NA										
p. Flush saline lock. (Responding)			NA	NA	S	S	NA										
q. D/C an IV. (Responding)			NA	NA	S	NA	NA										
r. Monitor an IV. (Noticing)	S		NA	NA	NA	NA	NA	NA	S	NA	S	S	S				
s. Perform FSBS with appropriate interventions. (Responding)	S		NA	NA	S	S	NA										
	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					

**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

Week 5 (3 k, l, m ,r)- You did a nice job this week with your medication administration. You were prepared and knowledgeable on each medication. You were able to assess the IV site on the patient and document accordingly. HS

Rehab Clinical Objective 3 K-M-This week you were able to identify the rights of medication administration and you were able to accurately administer medications to your patient. You identified safe practice and performed really well with administering your patient's medications! MD

Week 10 3(k-s) – Wow, you were able to fill up this entire section this week with new experience! That is great to see. I appreciate you discussing your areas in which you had not gained experience yet so that we could identify learning opportunities. You did well this week in medication administration both for your assigned patient and for the patients under your care as team leader. You identified the six rights, performed three safety checks, and utilized the BMV scanner for patient safety. Accurate dosage calculations were performed. You gained experience with administering several PO medications, preparing IV tubing for continuous infusion, programming an IV pump, monitor IV sites for complications, performed a saline flush, and obtained a FSBS using proper technique. You and your peer identified two non-functioning IV sites when assessing for patency with an IV flush and demonstrated competence in removing the IVs safely. Overall great job with new skills this week! NS

Week 11 – 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 practiced dexterity. KA

Week 11 – 3n & o –You did a nice job priming your piggy back and connecting your patient to the IV medication. You performed all IV skills with practiced dexterity. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

Week 11 – 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 11 – 3r – You did a nice job monitoring your patient's IV site this week and documenting your assessment in the EMR. KA

Week 11 – 3s – You demonstrated proper technique when completing FSBS on your patient. You utilized the information received from the monitor to determine the need for insulin utilizing the patient's prescribed coverage scale. You documented all information correctly in the EMR. KA

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
<b>Competencies:</b>																	
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S	S	S	NA	S	NA	S	S	S				
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S	NA	S	NA	S	NA	S	S	S				
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	S	S	S	NA	S	NA	S	S	S				
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	NA	S	NA	S	NA	S	NA	S	S	S				
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			S	NA	S	NA	S	NA	S	NA	S	S	S				
	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					

\*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! DWNA

Week 5 (a, b, c, e)- You communicated effectively as team leader with the other students in order to prioritize care for each patient. Nice job on your CDG this week! As you identified some of the nursing care is based around a discussion with other members from the healthcare team. HS

Week 6 (4e)- According to the CDG Grading Rubric, you have earned an S for your participation in the Erie County Senior Center discussion this week. Your discussion was thoughtful and supported by evidence. RH

Rehab Clinical Objective 4 E-You had a wonderful CDG this week with response! You were able to turn in your CDG on time, have the adequate word count for both posts, and you were able to provide to the conversation with the information you gave! You also provided a reference and in text citation for both the initial post and peer response. Great job! MD

Week 10 4(e) –I appreciated the thoughts provided in your reflection and discussing the results for the implicit bias CDG prompt. NS

Week 11 – 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 11 – 4e – Grace, you did a great job responding to the CDG questions this week on your patients adding diagnosis and potential complications we were monitoring for while he was there. You thoughtfully responded to your classmates post and add to the discussion on their patient. You included a reference and in-text citation in both of your posts. Remember to include a page number or a paragraph number if there are no page numbers when in-text citing a direct quotation. Keep up all the hard work! KA

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
<b>Competencies:</b>																	
<b>a. Describe a teaching need of your patient.** (Reflecting)</b>			S	NA	S	NA	S	NA	S	NA	S	S	S				
<b>b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)</b>			S	NA	S	NA	S NI	NA	NI	NA	S	S	S				
	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					

**\*\*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. **Great job! Yes, your patient was definitely at risk for falls as she had recently fallen prior to coming into the hospital. HS**

WEEK 6 a & b. This week I had clinical at the ECSC, so I did not have any teaching for anyone since I did not have a patient.

WEEK 7 a & b. Education related to my patient this week was informing her how to keep track of her carb count. She was on a carb restricted diet and wanted to follow this same regimen once she got discharged. She did not know how to read the nutrition labels on the back of food and drinks, so I showed her how to do it. This was all taught

\*End-of-Program Student Learning Outcomes

through discussion with her. I utilized meditech to look up her diet before I spoke with her as well as how much carbs she was allowed to consume a day. I knew she understood when she read the back of her granola bar label to me. **I am glad you were able to utilize meditech, however, you need to provide another resource that would give you the information on how to count carbs. MD**

WEEK 8 a & b. NA did not have clinical. **DW**

WEEK 9 a & b. Did not have clinical this week. **DW**

WEEK 10 a & b. Education related to my patient this week was informing her how to look for certain signs and symptoms for a stroke. She was in there for a TIA to rule out stroke. I utilized skyscape and my knowledge of what we learned this week in lecture to ensure I gave her the proper things to look for in a stroke. **Great job connecting theory to practice in the care for a patient with stroke like symptoms. These will be important symptoms to monitor for at home to prevent worsening health outcomes. She has numerous risk factors for stroke, and could benefit from education related to stroke prevention. Nice job! NS**

WEEK 11 a & b. Education related to my patient this week was informing him to let me know when he felt like he needed to use the restroom. He had bladder scans ordered q8h due to retention, so it was important for him to let me know immediately if he needed to go. I used skyscape to inform him of the different risk factors and symptoms associated with urinary retention. **Nice job! KA**

WEEK 12 a & b. Education related to my patient this week was informing her that even though she did not want to eat, nutrition is a very important part of healing and getting back to feeling better. My patient did not want to eat breakfast or lunch the second day of clinical, so I utilized skyscape to inform her of the different risks associated with not receiving proper nutrition, in hopes that it would make her realize just how important it is to eat, even when we don't want to.

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	NA	NA	NA	NA	S	NA	S	NA	NA				
b. <b>Identify factors associated with Social Determinants of Health (SDOH) &amp;/or cultural elements that have the potential to influence patient care.**</b> (Noticing, Interpreting, Responding, Reflecting)			S	NA U	S	S	S	NA	S	NA	S	S	S				
	RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA					

**\*\*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. HS

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. **As an older adult she needs a strong support system to make sure she can obtain her medications and make it to her follow up appointments.** HS

WEEK 6: A common SDOH I saw that related to almost all the elders at the ECSC was a lack transportation. Most of them rely on public transportation since they cannot drive themselves. This could affect their health because if something were to happen to them or they needed to drive themselves to the hospital in case of an emergency, they would have to rely on others or call 911. RH

WEEK 7: A SDOH for my patient this week was that she has stairs to climb to get upstairs as well as living alone. She had a sprained ankle and very weak knees, which made it difficult for her to get up the steps in PT. If it was difficult to get up those two steps in PT, I can only imagine what it'll be like to get up the many steps in her house. She is 70 years old so living alone is not ideal for her since she could get hurt and no one would know. **Great SDOH! MD**

WEEK 8: NA did not have clinical this week, had sim lab. DW

WEEK 9: Did not have clinical this week. DW

WEEK 10: A SDOH for my patient this week was that she is unable to get around very well due to a TIA that caused weakness, numbness, and tingling on the left side of her body. This could impair her ability to do things by herself such as go up the stairs in her home, get around without an assistive device, and even simple tasks such as getting up from a chair or toilet. **Safety is certainly a concern in the home environment as a result of her numbness and tingling that she was experiencing. What could we as the bedside nurse do to advocate for her home needs? Who can we consult or collaborate with to ensure discharge planning addresses these needs?** NS

WEEK 11: A SDOH for my patient this week was that his insurance denied him to be transferred to the rehabilitation floor in the hospital. My patient came to the hospital after 3 falls in one day which led to him hurting his wrist as well as fracturing his ribs on his left side. Without the proper care and being able to attend some sort of rehab facility, he will not be able to get his mobility levels back to normal as fast. After caring for him this week, I learned that he is not even able to get out of a chair on his own without the assistance of two people. **This is definitely a concern needing addressed. I know the healthcare provider was trying to appeal the decision.** KA

WEEK 12: A SDOH for my patient this week is that she suffers with severe depression. My patient seemed to be fine on the first day of clinical, but on the second day she expressed to me that her depression was so bad that she didn't even want to eat. Throughout that day I noticed she didn't eat breakfast at all and didn't want to eat lunch either. Without the proper nutrition, it can worsen her health and make her decline even more and become weaker.

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

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RH	RH	RH	DW	HS	RH	MD	RH	RH	DW	NS	KA				
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**\*\*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. **You did a nice job! HS**

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. **This does get a little easier the more times you have to wake them up. HS**

WEEK 6: One area of strength for me this week was communicating with all the staff at the ECSC. My group and I asked the lunch staff if they needed any help with anything and ended up helping them out for the first hour of the clinical to prepare for all the older adults to arrive. **RH**

WEEK 6: One area for improvement is remembering that I need to speak a little louder when communicating with older adults, since a lot of them having hearing problems. I can improve on this by reminding myself of it each time I have an older adult patient and simply by practicing at clinicals. **RH**

WEEK 7: One area of strength for me this week was the relationship I developed with my patient. I felt like it was very easy to communicate with her and bond over different things. **You had a wonderful patient this week! MD**

WEEK 7: One area for improvement is that I need to learn how to manage a wheelchair better. I struggled with figuring out how to take the foot pedals off the chair for my patient and needed to ask someone for help. I can improve on this by watching a video on YouTube before my next clinical. **Great goal! MD**

WEEK 8: NA not clinical this week, sim lab.

**Midterm comment: good job throughout the first half of the medical-surgical course! It appears you have had the opportunity to perform various skills, enhance your clinical judgment, provide patient care, and reflect of your experiences. You are satisfactory in most competencies at this point of the semester, great job! You have some skills that are an "NA." It appears you have not had the opportunity to demonstrate foley care (competency 3g) or done much with IV care (competency 3n-s). Please seek out opportunities to meet these competencies during the second half**

of the semester. Let your clinical faculty know at the beginning of clinical of this need so they can help you find opportunities to meet these competencies. You have an “NI” in competency 5b, please seek out ways to improve to avoid getting further “NI”s on your tool. You have satisfactorily completed one care map required for this semester, make sure you continue to manage time well to complete the second one prior to the end of clinical! Continue to work hard as we enter the second half of the semester, you’re doing great! RH

WEEK 9: Did not have clinical this week. DW

WEEK 10: One area of strength for me this week was being open to new opportunities and performing skills such as wound care, IV skills, and FSBS. Very good! You actively sought out these opportunities and demonstrated a desire to learn and improve. I appreciated your willingness to jump into these experiences. Great job! NS

WEEK 10: One area for improvement is that I need to work on time management. Being team leader this week taught me that it is hard having multiple patients to give meds to within a good time frame. To improve I will prioritize my tasks in a better way the next clinical. This was a challenging experience as you had numerous complex patient needs to manage. However, you did well in your discussions on prioritization and implementing the care in a timely manner. This is challenging for experienced nurses, let alone for you in your second semester of nursing school. This comes with time and experience. I hope this opportunity opened your eyes to the business that can occur day in and day out. I think you have a good plan to work on your prioritization. What can you do specifically to help prioritize your tasks moving forward? NS

WEEK 11: One area of strength for me this week was administering all the injections my patient needed. I was able to properly give insulin 3 times as well as a Lovenox injection. You did a nice job! KA

WEEK 11: One area for improvement is that I need to work on correct body mechanics when it comes to moving patients that have limited mobility. I realized a couple times that my body alignment when moving the patient was not completely right. I can improve on this by watching videos on YouTube of proper body mechanics before my next clinical since it is on the rehab floor. Great idea! Protect your back! You do not want to get an injury that can prevent you from working in the future. KA

WEEK 12: One area of strength for me this week was being able to take my patients blood pressure manually, rather than using the machine. This is the first time in clinical I have had to take a manual BP.

WEEK 12: One area for improvement is that I need to become more comfortable with communicating with other members of the team such as PT/OT/ST. I usually have questions when they come help my patient, but I always keep quiet instead of asking. I can improve on this simply by pushing myself to ask questions and realize that it is okay to ask questions, as I am a student trying to learn, and they know that. I will try to remember this by next semesters clinicals and can practice communicating with other team members in next week’s simulation.

Student Name: <b>Grace Catanese</b>		Course Objective: <b>MSN</b>					
Date or Clinical Week: <b>1/24-25/24</b>							
Criteria		3	2	1	0	Points Earned	Comments
<b>N</b> <b>o</b> <b>t</b> <b>i</b> <b>c</b> <b>i</b> <b>n</b> <b>g</b>	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	
<b>I</b> <b>n</b> <b>t</b> <b>e</b> <b>r</b> <b>p</b> <b>r</b> <b>e</b> <b>t</b> <b>i</b> <b>n</b> <b>g</b>	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	
<b>R</b> <b>e</b> <b>s</b> <b>p</b> <b>o</b> <b>n</b>	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
	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	

d i n g	11. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	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.” 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.
	12. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
R e f l e c t i n g	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: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	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.						<b>Total Points: 41/42 Satisfactory</b>	
<b>Faculty/Teaching Assistant Comments:</b> 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.						<b>Faculty/Teaching Assistant Initials: RH</b>	



Student Name: Grace Catanese		Course Objective: 6a					
Date or Clinical Week: Week 10							
Criteria	3	2	1	0	Points Earned	Comments	
<b>N</b> <b>o</b> <b>t</b> <b>i</b> <b>c</b> <b>i</b> <b>n</b> <b>g</b>	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	All abnormal assessment findings were listed with specific patient data, including subjective and objective findings. All abnormal diagnostics performed during the care provided were included. Risk factors were appropriately identified based on past medical and social history.
	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	
<b>I</b> <b>n</b> <b>t</b> <b>e</b> <b>r</b> <b>p</b> <b>r</b> <b>e</b> <b>t</b> <b>i</b> <b>n</b> <b>g</b>	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Pertinent nursing priorities were identified. The top priority problem of ineffective cerebral tissue perfusion was selected. Information from the noticing section were correctly highlighted as related to the top priority problem. Three potential complications were identified, with specific signs and symptoms to monitor for each.
	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	
<b>R</b> <b>e</b> <b>s</b> <b>p</b> <b>o</b> <b>n</b>	8. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	A thorough list of nursing interventions were listed. Interventions were prioritized appropriately with assessments taking highest priority. Each intervention included a specific
	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	

d i n g	11. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	2	frequency to be performed. Most interventions were individualized and realistic for the assigned patient. In the future, be sure to include specific medication dosages to be more individualized to the patient in which the plan of care is being developed for. Instead of stating “as ordered” provide the specific dosage and route prescribed. Each intervention included an appropriate rationale.
	12. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
R e f l e c t i n g	13. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	All abnormal assessment findings were updated upon evaluation during last patient encounter. Based on the continued symptoms, it was appropriately determined to continue the plan of care.
	14. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	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.						<b>Total Points: 41/42 – Satisfactory</b>	
<b>Faculty/Teaching Assistant Comments:</b> Grace, nice job with your care map assignment related to ineffective cerebral tissue perfusion. I am glad that you were able to make correlations between what was learned in class and the patient situation that was presented. Be sure to review the comments provided for continued success. You have now completed both required care map submissions with a satisfactory evaluation, great job! Keep up the hard work. NS						<b>Faculty/Teaching Assistant Initials:</b> NS	



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

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

\*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

#### Week 9

(Lab Day- Skills Review)- You satisfactorily participated in lab on 3/11/2024 by practicing NG skills and navigating the IV pump. DW

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

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

\* Course Objectives

**Comments:**

Simulation 1: please review the comments placed on the simulation scoring sheet blow. In addition, review the individual faculty feedback placed within the Simulation #1 Prebrief and Reflection journal dropboxes. RH

**Lasater Clinical Judgment Rubric Scoring Sheet**

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

**STUDENT NAME(S) AND ROLE(S): Ava Lawson (A) Grace Catanese (M)**

**GROUP #: 1**

**SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory**

**OBSERVATION DATE/TIME(S): 2/28/2024 0800-1000**

<b>CLINICAL JUDGMENT COMPONENTS</b>	<b><u>OBSERVATION NOTES</u></b>
<p><b>NOTICING: (2) *</b></p> <ul style="list-style-type: none"> <li>• Focused Observation:            E        A        D        B</li> <li>• Recognizing Deviations from   Expected Patterns:            E        A        D        B</li> <li>• Information Seeking:            E        A        D        B</li> </ul>	<p><b><u>Focused Observation:</u></b> Pain assessment performed, sought information related to pain (numerical rating and location only). Be sure to complete a full pain assessment. Full set of vital signs obtained. (neurovascular assessment performed) Noticed pallor to the left foot, noticed cold to touch, noticed absent pulse, noticed delayed cap refill, noticed paralysis, noticed paresthesia (did not ask about pressure).</p> <p><b><u>Recognizing deviations:</u></b> Recognized 5/6 Ps during neurovascular assessment. Recognized abnormal vital signs (HR, RR, BP)</p> <p><b><u>Information seeking:</u></b> Did not ask additional subjective information related to pain (ex: is this pain new or different than on admission, associated symptoms, aggravating factors, etc.) Did not verify allergies prior to medication administration. Asked about last tetanus shot. Verified name and DOB. Did not seek patient’s understanding of complications occurring.</p>
<p><b>INTERPRETING: (1) *</b></p> <ul style="list-style-type: none"> <li>• Prioritizing Data:            E        A        D        B</li> <li>• Making Sense of Data:        E        A        D        B</li> </ul>	<p><b><u>Prioritizing data:</u></b> Focused pain assessment prioritized. Prioritized focused vital signs. Prioritized full head to toe assessment rather than focused assessment on fractured extremity after complaints of increased pain. Remediated during debriefing on prioritization of focused assessment to identify complications rather than head to toe assessment in this situation. Focused neurovascular assessment performed after head to toe assessment. Med nurse prioritized pain medication for pain relief. Prioritized fluids and antibiotics prior to surgery. Prioritized removing the sock for closer observation and removing the pillow from the affected extremity. Did not remove ice – discussed in debriefing.</p> <p><b><u>Making sense of data:</u></b></p>

	<p>Initially did not make sense of emergent situation for compartment syndrome. Eventually prioritized calling the provider with some prompting.</p> <p>When medical emergency was recognized after full assessment, provider was contacted.</p> <p>Made sense of antibiotic order prior to surgery.</p> <p>Made sense of dosage calculation related to morphine administration.</p>
<p><b>RESPONDING: (2,3,4,5,6) *</b></p> <ul style="list-style-type: none"> <li>• Calm, Confident Manner:     E     A     D     B</li> <li>• Clear Communication:       E     A     D     B</li> <li>• Well-Planned Intervention/ Flexibility:                   E     A     D     B</li> <li>• Being Skillful:               E     A     D     B</li> </ul>	<p><b><u>Calm, confident manner:</u></b></p> <p>Roles clearly defined between medication nurse and assessment nurse.</p> <p>Approach was calm during emergent situation. Communication with the patient regarding interventions to be performed.</p> <p>Calm communication with significant other to avoid distress. Confident demeanor in interactions with health care team members.</p> <p><b><u>Clear Communication:</u></b></p> <p>Communicated self and role when entering the room.</p> <p>Interventions communicated with the patient throughout. Communicated blood pressure results with the patient.</p> <p>Discussed appropriate conflict resolution and professionalism with off-going shift.</p> <p>Assessment findings communicated to team member.</p> <p>Used appropriate pronouns but did not address social diversity with the patient by asking preferred pronouns.</p> <p>Contacted provider with assessment findings. SBAR report attempted. Updated assessment findings provided (neurovascular assessment). Consider including vital sign update. Be sure to provide background information related to the patient and current situation. Review SBAR reporting to providers. Discussed in debriefing.</p> <p>SBAR report provided to OR nurse. Provided neurovascular assessment information. Provided update on medications that were administered and unresolved pain.</p> <p>Demonstrated caring approach. Be sure to continually communicate with the patient regarding changes to reduce fears and provide empathy.</p> <p>Contacted patient’s significant other with updates and need to move surgery up. Communicated complications were occurring. Followed up with patient that she was notified.</p> <p><b><u>Well-planned intervention/flexibility</u></b></p> <p>Compares bilateral extremities after noting abnormal findings.</p> <p>Removed pillow from affected extremity. Considered removing ice pack but did not actually remove.</p>

	<p>BMV scanner used for patient safety. Patient educated on morphine side effects of lethargy.</p> <p>Re-assessed pain after medication administration.</p> <p>Programmed IV pump accurately.</p> <p>Antibiotics and fluids initiated in a timely manner prior to surgery.</p> <p>Educated on complications of affected extremity.</p> <p>SBAR report provided to OR nurse. Provided neurovascular assessment information. Provided update on medications that were administered and unresolved pain. Review SBAR reporting.</p> <p><b><u>Being Skillful</u></b></p> <p>Wasted excess narcotic with witness. Dosage calculation performed accurately.</p> <p>Good infection control measures using aseptic technique. Saline flush performed to confirm patency.</p> <p>Selected appropriate needle size. Be sure to ask patient injection location preference. Good technique with IM injection. Good needle safety.</p>
<p><b>REFLECTING: (7) *</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis: E      A      D      B</li> <li>• Commitment to Improvement: E      A      D      B</li> </ul>	<p>Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. 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 held on gathering all pertinent data, providing full background and situation to the provider, and reading back orders.</p> <p>Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.</p>
<p><b>SUMMARY COMMENTS: * = Course Objectives</b></p> <p><b>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</b></p> <p><b>E= Exemplary</b></p> <p><b>A= Accomplished</b></p> <p><b>D= Developing</b></p> <p><b>B= Beginning</b></p> <p><b>Scenario Objectives:</b></p> <ol style="list-style-type: none"> <li>1. Select focused physical assessment priorities based on individual patient needs. (2)*</li> <li>2. Implement appropriate nursing interventions based on patient’s assessment. (1,3,6)*</li> <li>3. Communicate appropriately with the patient, family, team members, and healthcare providers incorporating elements of clinical judgment and conflict resolution. (4,7)*</li> </ol>	<p>Lasater Clinical Judgement Rubric Comments:</p> <p><b>Noticing:</b> 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. Makes limited efforts to seek additional information from the patient and family; often seems not to know what information to seek and/or pursues unrelated information.</p> <p><b>Interpreting:</b> Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse.</p> <p><b>Responding:</b> 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. Displays proficiency in the use of most nursing skills; could improve speed or accuracy.</p> <p><b>Reflecting:</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. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.</p>

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| <p>4. Provide patient-centered care with consideration to cultural, ethnic, and social diversity. (2,3,6)*</p> <p>5. Provide appropriate patient education based on diagnosis. (5)*</p> <p>* Course Objectives</p> |  |
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**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