

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student:

Final Grade: Satisfactory/Unsatisfactory

Semester: Fall

Date of Completion:

Faculty: Frances Brennan, MSN, RN; Amy Rockwell, MSN, RN;
Chandra Barnes, MSN, RN; Nick Simonovich, MSN, RN
Heather Schwerer, MSN, RN; Brittany Lombardi, MSN, RN, CNE

Faculty eSignature:

Teaching Assistant: Stacia Atkins, BSN, RN

DIRECTIONS FOR USE:

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S)**, **Needs Improvement (NI)**, **Unsatisfactory (U)**, and **Not Available (NA)**. The faculty member will initial if in agreement with the student's evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, U, or NA". If the student does not self-rate, then it is an automatic "U". A student who submits the clinical evaluation tool late will be rated as "U" in the appropriate competency(s) for that clinical week. Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

Skills Lab Checklists	Faculty Feedback
Care Map Grading Rubric	Documentation
Administration of Medications	Clinical Reflection
Simulation Scenarios	
Skills Demonstration	
Evaluation of Clinical Performance Tool	
Clinical Discussion Group Grading Rubric	
Lasater Clinical Judgment Rubric	

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
Faculty's Name			Initials
Chandra Barnes			CB
Frances Brennan			FB
Amy Rockwell			AR
Nicholas Simonovich			NS
Heather Schwerer			HS
Brittany Lombardi			BL

Stacia Atkins	SA
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PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

Satisfactory (S): Safe, accurate each time, efficient, coordinated, confident, focuses on the patient, some expenditure of excess energy, within a reasonable time period, appropriate affective behavior, occasional supporting cues, minimal faculty feedback needed related to written clinical work.

UNSATISFACTORY CLINICAL PERFORMANCE

Needs Improvement (NI): Safe, accurate each time, skillful in parts of behavior, focuses more on the skill and self rather than the patient, inefficient, uncoordinated, anxious, worried, and flustered at times, expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues, faculty feedback required in several areas of clinical written work.

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U", the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

***Grey shaded weekly competency boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Objective																
1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Identify spiritual needs of patient (Noticing).																
b. Identify cultural factors that influence healthcare (Noticing).																
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						S	NA									
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						S	NA									
Clinical Location: Patient age**						CB										
						3T 83 years old	NA									

Comments

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

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

* End-of-Program Student Learning Outcomes

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

Objective																
3. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*																
2. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment thru use of clinical judgment skills. (3,4,5)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Midterm	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Final
Competencies:						S	NA									
a. Receive report at beginning of shift from assigned nurse (Noticing).																
a. Perform head to toe assessment, utilizing hand off (report) pertinent, techniques of inspection, palpation and auscultation, current information to the next provider of care (Responding).						S NA	NA									
c. Use appropriate medical terminology in verbal and written communication (Responding).						S	NA									
b. Use correct technique for vital sign measurement (Responding).						S	NA									
d. Conduct a fall/safety assessment and institute appropriate precautions in the status of the patient (Responding).						S	NA NA									
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).						S	NA									
e. Collect the nutritional data of assigned patient (Noticing).						S	NA									
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).						CB										
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).																
						CB										

Comments

Week 6(2a,b): Abby, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. I changed competency "2c" to a "NA" because you did not perform a safety assessment during this clinical. CB

* End-of-Program Student Learning Outcomes

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

Comments

Objective																
4. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Document vital signs and head to toe assessment according to policy (Responding).						S	NA									
b. Document the patient response to nursing care provided (Responding).						S	NA									
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				S	NA									
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S														
e. Provide basic patient education with accurate electronic documentation (Responding).																
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						S	NA									
*Week 2 –Meditech		CB				CB										

Week 6(3a,c,d,e): Great job receiving hand off report on your patient. Good job using medical terminology while communicating with your patient, reporting abnormal findings, and communicating effectively with your staff RN. I changed competency “3b” to a “NA” because you did not give a hand off report on your patient at the end of clinical. CB

* End-of-Program Student Learning Outcomes

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

Comments

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

Week 6(4a,b,c,f): Satisfactory job with documentation of the head to toe assessment and vital signs of your patient. Make sure to note any areas you may have forgot to assess, so that assessments and documentation are thorough and accurate. You did a good job utilizing Meditech for documentation and to look up patient information. You completed your first cdg, meeting all requirements per the grading rubric, excellent job! CB

* End-of-Program Student Learning Outcomes

Objective

6. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Mid Term	Final
Competencies:																	
a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).																	
b. Apply the principles of asepsis and standard/infection control precautions (Responding).																	
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).																	
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).						S	NA										
e. Organize time providing patient care efficiently and safely (Responding).						S	NA										
f. Manages hygiene needs of assigned patient (Responding).																	
g. Demonstrate appropriate skill with wound care (Responding).																	
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).						S	NA										
						CB											

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

Comments

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

There is a fire extinguisher across from room 3036 and a fire pull station next to the exam room/conference room. CB

Week 6(5a,b): Great job utilizing correct body mechanics and raising the bed while performing an assessment. You did a great job ensuring that you foamed in/out when entering/exiting patients' rooms. CB

* End-of-Program Student Learning Outcomes

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

Comments

* End-of-Program Student Learning Outcomes

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

Objective																	
Objective																	
8. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*																	
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Make-Up	Final
Competencies:																	
a. Identify the action, rationale, and the strength** (Predicting).						S	NA										
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)						S	NA										
c. Incorporate instructor feedback for improvement and growth checks prior to medication (Responding).						S	NA										
d. Follow the standards outlined in the NMTCSN policy. Student must conduct (Responding).						S	NA										
e. Intraosseal medications using coining techniques (Responding).						S	NA										
e. Commitment and enthusiasm during all clinical interactions for time of last dose before giving PRN medication (Interpreting).						S	NA										
f. Exhibit professional behavior i.e. appearance, responsibility, PRN medications (Responding).						S	NA										
g. Demonstrate medical ethics of Rights (Responding)						S	NA										
h. Appropriately using patient health and medical information as required by federal HIPAA regulations (Responding).						S	NA										
i. Actively engage in self-reflection. (Reflecting)						S	NA										
*						CB											

Comments

* End-of-Program Student Learning Outcomes

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

**** Strength/weakness reflection (a,b): Must have different written example each week of clinical/lab. You must explain your plan for how you will improve. Example, “I am having a difficult time with obtaining a manual BP. I will get a BP cuff from Amy and practice manual BP’s with at least three members of my family this week.” Please ensure that you answer this section in-depth with your plan of action. Each week must be different.**

Week 6: Weakness: I had a hard time finding the dorsalis pedis pulse and posterior tibial pulse. I will practice palpating both pulses on at least 3 different people this week. Strength: Obtaining my patient's vital signs for the first time using the vital sign machine went well. I was not fumbling around with the vital sign machine like I thought I would be doing. Abby, you did a great job with obtaining vital signs and performing a head to toe assessment for the first time on an individual and not a manikin. You have a great plan in place to help build confidence and skill of finding and obtaining dorsalis pedis and posterior tibial pulses. CB

Week 6(8d,f,h): Excellent job following the student code of conduct, exhibiting professionalism while in the clinical setting, and ensuring that patient privacy was respected. CB

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

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

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
		*	*

Note: Students are required to submit one satisfactory care map by 11/18/2024 at 0800. If the care map is not evaluated as satisfactory upon initial submission, the student may revise the care map based on instructor feedback/remediation and resubmit one time by 11/25/2024 at 0800 to receive a satisfactory evaluation. ***See Attached Nursing Care Map Grading Rubric**

Firelands Regional Medical Center School of Nursing
Care Map Grading Rubric

Student Name:				Course Objective:			
Date or Clinical Week:							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)		
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)		
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)		
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	5. State the goal for the top nursing priority.	Complete			Not complete		
	6. 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		
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)		
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)		
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete		
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete		
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete		

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete		
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete		
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete		

Reference

An in-text citation and reference are required.

The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.

The care map will be graded “unsatisfactory” if no in-text citation AND reference is included.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

*****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *****

Faculty/Teaching Assistant Comments:

Total Points:

Faculty/Teaching Assistant Initials:

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

<u>Simulation Evaluation</u> Performance Codes: S: Satisfactory U: Unsatisfactory	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Date: 11/5/2024 or 11/12/2024	Date: 11/25/2024 or 11/26/2024
Evaluation (See Simulation Rubric)		
Faculty Initials		
Remediation: Date/Evaluation/Initials		

* Course Objectives

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 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 & Date: _____