

**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)
<b>Faculty’s Name</b>			<b>Initials</b>
Chandra Barnes			CB
Frances Brennan			FB
Amy Rockwell			AR
Nicholas Simonovich			NS
Heather Schwerer			HS
Brittany Lombardi			BL

Stacia Atkins

SA

## 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.**

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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
<b>Competencies:</b>									NA							
a. Identify spiritual needs of patient (Noticing).									NA	S	NA	S	NA			
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	NA	S	NA			
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						NA	S	NA	S	S	NA	S	NA			
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						NA	S	NA	S	S	NA	S	NA			
						CB	CB	CB	CB	HS	HS	HS				
						NA	3T 88	NA	NA	3T 70	NA	3T 79	NA			

Clinical Location:  
Patient age\*\*

**Comments**

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

Week 7(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

Week 9(1c,d)- Your patient had an extended stay at the hospital, and you did a nice job providing her care based on her needs and preferences. You also utilized Maslow's Hierarchy of needs to determine the care needed. Nice job! HS

Week 11(1a,c,d) You spent a lot of time listening to your patient which was very important for him. You were able to incorporate his preferences and needs into the plan of care. You allowed him to have a say in the way that the care was provided while also educating him on the why certain interventions were being performed. HS

\* End-of-Program Student Learning Outcomes

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

**Objective**

1. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)\*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
<b>Competencies:</b>																
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).						NA	NI	NA	NI	S	NA	S	NA			
b. Use correct technique for vital sign measurement (Responding).						NA	S	NA	S	S	NA	S	NA			
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						NA	S NA	NA	NA	S	NA	S	NA			
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	NA S	NA	S	NA			
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	NA	S	NA			
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	NA	NA	NA			
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).									NA	S	NA	S	NA			
						CB	CB	CB	CB	HS	HS	HS				

**Comments**

**Week 7:** I put “Needs Improvement” for 2.a. because I forgot to assess the capillary refill of all four extremities during my head-to-toe assessment. Thank you for explaining why you rated yourself this way. The more clinical experience you get, the easier it will be to remember all components of a head-to-toe assessment. CB

Week 7(2a,b): Izzy, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. Competency 2c was changed to a “NA” due to not conducting a fall assessment this clinical. CB

Week 9(2a-d) You did a nice job this week completing your vital signs, head to toe assessment, fall/safety, and skin assessment. You were able to identify abnormal lung sounds of rhonchi while auscultating your patients’ lungs. You also identified that the patient had been refusing the bed alarm and provided education and maintained fall precautions during your shift. You also did an excellent job on your pain assessment and made sure to document it thoroughly. HS

Week 11(2a-d) You did a great job with your assessment this week. Your patient had a lot of abnormal assessment findings and you were able to identify them. You did a nice job completing his fall/safety and skin assessment and implementing the appropriate interventions for the plan of care based on your findings. HS

\* End-of-Program Student Learning Outcomes

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

**Objective**

2. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)\*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
<b>Competencies:</b>																
a. Receive report at beginning of shift from assigned nurse (Noticing).						NA	S	NA	S	S	NA	S	NA			
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	NA	NA	NA	S	NA	S	NA			
c. Use appropriate medical terminology in verbal and written communication (Responding).						NA	S	NA	S	S	NA	S	NA			
d. Report promptly and accurately any change in the status of the patient (Responding).						NA	S	NA	S	S	NA	S	NA			
e. Communicate effectively with patients and families (Responding).						NA	S	NA	S	S	NA	S	NA			
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						NA	S	NA	S	S	NA	S	NA			
						CB	CB	CB	CB	HS	HS	HS				

**Comments**

Week 7(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. CB

Week 9 (3a-f) You did a nice job receiving report from the previous shift and updating the nurse at the end of your shift. You notified the nurse regarding your patient being in pain, and you informed her of all of the associated information and documented accordingly. HS

Week 11(3a-f) You were able to receive a report from the nurse at the beginning of the shift. You communicated with her throughout the shift informing her of any concerns you had, such as the patient not wearing his SCD's and the stat lock not fitting the Foley correctly. You were able to discuss the plan of care for the patient. You also used appropriate medical terminology with the patient when speaking to him about his edema. You asked him if he understood what it meant, and he did and then you explained what he could do to help decrease it. Great job! HS

\* End-of-Program Student Learning Outcomes

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

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

**Comments**

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

Week 7(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

Week 9(4a,b,c) You did a good job this week documenting all of the care and interventions you provided to your patient.

(4f)- Nice job on your initial CDG post and the peer response you met all of the rubric requirements and provided a thorough response to your peer. HS

Week 11(4a,b,c) Great job this week with your assessment this week! Your patient had a lot of abnormal assessment findings and you took your time in order to complete a thorough assessment. You identified his lower leg edema and that he was not wearing his SCD's, and that he did not have his Foley catheter secured. After identifying these concerns, you implemented the appropriate interventions. Great job! HS

(4f) Nice job on your initial CDG post and the peer response you met all of the rubric requirements and provided a thorough response to your peer. HS

\* End-of-Program Student Learning Outcomes

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

<b>Objective</b>																
4. Exemplify psychomotor skills and nursing care safely using evidence-based practice. (3,4,5,7,8)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
<b>Competencies:</b>																
a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).						NA	S	NA	S	S	NA	S	NA			
b. Apply the principles of asepsis and standard/infection control precautions (Responding).						NA	S	NA	S	S	NA	S	NA			
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).									NA	NA	NA	S	NA			
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).						NA	S	NA	S	S	NA	S	NA			
e. Organize time providing patient care efficiently and safely (Responding).						NA	S	NA	S	S	NA	S	NA			
f. Manages hygiene needs of assigned patient (Responding).									NA	S	NA	S	NA			
g. Demonstrate appropriate skill with wound care (Responding).									NA		NA	NA	NA			

h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).						NA	S	NA	S							
						CB	CB	CB	CB	HS	HS	HS				

Comments

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

One pull station on 3T is located at the front desk and a fire extinguisher is located by room 3010 by the stairs. Great job! CB

Week 7(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

Week 9(5d,e,f)- You did a nice job going right in the patients room and getting your assessment completed and assisting the patient with her meal tray and hygiene care. You planned your time efficiently in order to complete all tasks. You did all of these tasks in a timely manner and maintained safety and encouraged independence from the patient. HS

Week 11(5d,e,f) You did a nice job completing the necessary interventions and care for your patient. He had a lot going on and you were able to prioritize and organize the care effectively. You also did a nice job encouraging hygiene care even though he was not in favor of it, you managed to ensure that the Foley care was completed. HS

\* End-of-Program Student Learning Outcomes

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

Objective																
5. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
<b>Competencies:</b> a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).									NA	S	NA	S	NA			
									CB	HS	HS	HS				

**Comments**

Week 9 (6a)- You did a nice job utilizing clinical judgement skills based on your patient’s priority problem and then identifying interventions specific to the patient and developing the plan of care. HS

Week 11(6a) Excellent job utilizing your clinical judgment skills to care for your patient this week. You assured the plan of care fit your patient’s needs and preferences. You will continue to grow these skills as you progress through the semester and program. HS

\* End-of-Program Student Learning Outcomes

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

**Objective**

6. Convert basic pharmacology principles into safe medication administration. (3,5,6,7)\*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
<b>Competencies:</b>									NA				NA			
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).									NA				NA			
b. Recognize patient drug allergies (Interpreting).									NA				NA			
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				NA			
d. Administer oral, intramuscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				NA			
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				NA			
f. Assess the patient response to PRN medications (Responding).									NA				NA			
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			S	NA			
<b>*Week 11: BMV</b>									CB			HS				

## Comments

Week 11 (7g) - You are satisfactory for this competency by attending the Bedside Medication Verification (BMV) clinical orientation, actively listening, observing, and discussing accurate medication documentation and safe administration with the use of the BMV scanner. NS/CB

\* End-of-Program Student Learning Outcomes

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

**Objective**

2. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)\*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
<b>Competencies:</b>																
a. Reflect on areas of strength** (Reflecting)						NA	S	NA	S	S	NA	S	NA			
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)						NA	S	NA	S	S	NA	S NI	NA			
c. Incorporate instructor feedback for improvement and growth (Reflecting).						NA	S	NA	S	S	NA	S	NA			
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).						NA	S	NA	S	S	NA	S	NA			
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						NA	S	NA	S	S	NA	S	NA			
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						NA	S	NA	S	S	NA	S	NA			
g. Comply with patient's Bill of Rights (Responding).						NA	S	NA	S	S	NA	S	NA			
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						NA	S	NA	S	S	NA	S	NA			
i. Actively engage in self-reflection. (Reflecting)						NA	S	NA	S	S	NA	S	NA			
*						CB	CB	CB	CB	HS	HS	HS				

**\*\* 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 7:**

- a. My area of strength was staying calm and collected while ensuring good communication with my patient. I hope to continue good communication with my patients and staying calm even if I am overwhelmed. **Good communication is key in providing patient centered care, great job! CB**
- b. My area of weakness was not keeping up during the hand-off report of my patient. Next time I will be sure to know beforehand how the sheet is set up and will keep up when information is given to me, not missing any details. **Looking over the hand-off report sheet is a good plan to ensure that you know where to put patient information. CB**

**Week 7(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**

**Week 9:**

- a. My area of strength was utilizing different approaches to encourage my patient to get up to the chair for meals. Within the charting system I was able to see that my patient had been continuously refusing to get up to the chair at all during the day. The goal was to at least get up to the chair to eat meals, this would also help relieve some of the symptoms they were experiencing. They started off the morning by refusing right away, I continued to educate and pursue my patient each time I went in the room about the benefits of sitting in the chair for even if it was just a short thirty minutes. Once we started the hygiene care I was able to get them to the chair and they ended up feeling much better than before and ended up staying for a couple hours. This was the first time they had been out of the bed in days. Their symptoms were relieved greatly. I hope to be able to continue using different communication tactics to positively impact my patients. Using education, encouragement, and positivity. **Great job! HS**
- b. My area of weakness was making the time to utilize skyscape. It was harder than I thought to find an open computer or space that I would've been able to utilize using skyscape, along with knowing I had a good amount of time to do so. I was able to finish my assessments and other interventions in a timely manner, however there were other factors like my patient meal tray getting lost and having to reorder, that took up the extra time that I would've had. All my charting was done in the room, I made sure to take some notes on diagnoses that I wanted to look up on skyscape for my CDG. Next time I hope I can have the opportunity to have a little extra time to utilize skyscape. I think once I get use to the interventions and charting that I need to complete each clinical, it will make it easier to squeeze in time for these things. I hope to continue to improve my time management by being more aware and efficient when completing each intervention. **Each clinical experience will be different and some days you will have extra time and other days you may not have enough time. Becoming more comfortable and familiar with the documentation will allow for additional time in other areas. HS**

**Week 11:**

- a. This week my area of strength was utilizing skyscape. Last clinical it was hard for me to manage my time, making it hard to use skyscape. This made it difficult to understand and gather all the information regarding my patient. I included that within my area of weakness within the last clinical evaluation. This week I made sure to take time to utilize skyscape by researching my patient's history, diagnoses, and priority problems. I was able to learn extensive knowledge on diagnoses that connected the dots with what was going on with my patient. With each clinical it has become easier to manage my time when completing my assessments and obtaining information regarding my patient. I hope to continue managing my time efficiently especially during the busier clinical days. Making sure to utilize skyscape to see my all of my patients' problems as a whole and what details contribute to each other. **HS**
- b. This week my area of weakness was finding the appropriate way to communicate with my patient. My patient this week was depressed from being in the hospital setting for a long period of time, struggling with chronic illnesses. My patient expressed wanting to pass away, missing family/support system, losing loved ones, and having a hard time trusting the hospital staff. I made sure to take the time to sit and talk with my patient, providing any comfort they may have needed. Education, clearing up any confusion, and providing support. I struggled finding what to say when my patient brought up wanting to pass away and how messy their family life may be. I tried to provide support and uplifting communication, but it put me at a pause on how to respond. I did not know what to say regarding these specific topics. I asked if they could explain their feelings to me, provided my time and support, however I am not still sure on how to handle these types of situations. I hope to learn more on how to support these patients, and what I can say and do to make a positive impact. **This is a difficult situation that you will encounter many times during your clinicals and nursing career. I changed this competency to a NI because you did not specifically state how you plan to improve upon this weakness. In the future you must list a plan on how you will improve. HS**

\* 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
<b>Noticing</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)		
	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)		
<b>Interpreting</b>	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)		
<b>Responding</b>	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: <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		

**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

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

\* Course Objectives

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

Student Name: Isabella Riedy

<b>Skills Lab Competency Evaluation</b>	<b>Lab Skills</b>										
	<b>Week 1 (4)*</b>	<b>Week 2 (2,3,5,8)*</b>	<b>Week 3 (2,3,4,5,8)*</b>	<b>Week 4 (2,3,4,5,8)*</b>	<b>Week 5 (2,3,4,5,8)*</b>	<b>Week 6 (1,2,3,4,5,8)*</b>	<b>Week 7 (2,3,4,5,8)*</b>	<b>Week 8 (2,3,4,5,8)*</b>	<b>Week 9 (2,3,4,5,8)*</b>	<b>Week 10 (2,3,4,5,6,8)*</b>	<b>Week 11 (2,5,7)*</b>
	<b>Date:</b> 8/19/2024	<b>Date:</b> 8/28/2024	<b>Date:</b> 9/5/24	<b>Date:</b> 9/10/2024	<b>Date:</b> 9/17/2024 9/19/2024	<b>Date:</b> 9/24/2024	<b>Date:</b> 10/1/204	<b>Date:</b> 10/8,10/ 2024	<b>Date:</b> 10/15/2024	<b>Date:</b> 10/22/2024	<b>Date:</b> 10/29/2024
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	HS	HS	NS	AR	BL	AR	NS	AR	FB	AR	AR
<b>Remediation:</b> Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
<b>Remediation:</b> Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

**\*Course Objectives**

Comments:

**Week 1 (Technology Lab):** During this lab you were able to satisfactorily navigate:

- Edvance360 Learning Management System.
- Skyscape Resource System.
- Assessment Technologies Institute (ATI) / Virtual Simulation (vSim) Systems.
- Guided tour of library and computer lab. HS

**Week 2 (Hand Hygiene; Vital Signs; PPE):** During lab this week you were able to satisfactorily demonstrate:

- Appropriate hand hygiene utilizing hand sanitizer and soap/water.
- Accurate verbalization of procedure for donning & doffing PPE.

Appropriate level of skill during guided practice with measurement of radial and brachial pulses, along with manual blood pressure. Vital signs skills will be observed 1:1 with faculty during Week 3. Keep up the good work! HS

**Week 3 (Vital Signs):**

Awesome work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two consecutive blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 134/78, and you identified it as 132/74, which was within the range for a satisfactory result. The second measurement was set at 156/92 and you interpreted it as 152/92, well within the desired range. You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You did not require any prompts throughout the whole checkoff, great work! You provided accurate detail in your communication with the “patient”. Your documentation was 100% accurate. Keep up the great work!! NS

**Week 4 (Assessment):**

Satisfactory with head to toe assessment guided practice, hand-off report activity, Lexicomp/Intranet navigation activity, and the assessment/safety activity utilizing your clinical judgment skills. Great job! You will be observed 1:1 for Head to Toe Assessment competency during Week 5. AR

**Week 5 (Assessment; Mobility):**

Excellent job in lab this week! You have satisfactorily performed a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall very well done. You paid close attention to detail and were well-prepared. You did not require any prompts throughout your assessment, nice work! You demonstrated professional and informative communication.

Feedback on documentation this week: With this being the first time that you fully documented these interventions, you did a great job paying close attention to detail!

Overall you did a great job! Please review the physical reassessment and safety interventions within the next two weeks so you can examine areas that were inaccurate.

- Vital Signs- Documentation was accurate and complete.
- Physical reassessment- For the cardiovascular assessment (edema), omitted comment “toes to knee bil. and the entire left upper extremity.”
- Safety- Omitted “pneumonia” as reason for isolation.
- Pain- Documentation was accurate and complete.

Mobility Lab 9/19/2024: Satisfactory completion of mobility lab through demonstration of the following: Logrolling/turning a patient, lifting a patient in bed, repositioning from lying to sitting, repositioning from sitting to standing, stand/pivot transfer from a bed to a chair, ambulating with a walker, ambulating with crutches, ambulating with a cane, use of a gait belt, and safe use of a wheelchair. Proper body mechanics were utilized to promote safety for the healthcare worker and the patient. Great job with active participation throughout the duration of the lab. BL

**Week 6 (Personal Hygiene Skills):**

Satisfactory with patient hygiene, making an occupied bed, shaving, oral care, hearing aid care, application of ace wraps, TED Hose/SCD’s, and clinical readiness scenario during guided practice. Completed Meditech documentation for Hygiene and Ted Hose. Keep up the great work! AR

**Week 7 (NG Skills: Insertion, Irrigation, and Removal; Feedings):**

Nice job this week in the skills lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. You did not require any prompts throughout the entire process. It was evident that you were very well-prepared and went the extra mile to ensure you understood the entire process. Very impressive! You were able to verbalize understanding of the difference between irrigation and flushing and aspiration precautions. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! NS

**Week 8 (Foley Skills: Insertion, Removal; Sterile Gloves; I&O, Documentation Lab):**

You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. One prompt was needed during removal as a reminder to hold onto the catheter at the labia while the balloon is draining via gravity. You did not require any prompts during the sterile glove application or the insertion of the catheter. The balloon did malfunction by not emptying completely prior to removal, however you maintained completion of the procedure and acted professionally! You were thorough and had very good communication with your “patient”. Great job! You correctly

verbalized the differences in catheter insertion for a male patient. You actively participated in the Intake and Output stations, and completed Meditech documentation related to Urinary Catheter Management and Intake & Output. Keep up the great work!!! AR

Documentation Lab – You have satisfactorily completed the documentation lab by actively participating in Meditech documentation related to vital signs, physical re-assessment, safety and falls, pain assessment, patient rounds, TED hose/SCD/Ace wrap, feeding method, Intake and Output, urinary catheter management, and writing a nurse note. You utilized your time wisely, asked appropriate questions, and gained experience with each intervention listed in preparation for clinical. Great job! CB

**Week 9 (Dressing Change: Dry Sterile, Damp to Dry Packed, Stoma Skills):**

You have demonstrated competence in the skill of wound assessment and wound care through guided observation of Dry Sterile Dressing and 1:1 observation of Damp to Dry Packed Wound Dressing Change. During the Damp to Dry Packed Wound Dressing Change, you did not require any prompts and initiated/maintained the “clean” field and followed aseptic technique throughout. Your communication with the patient was excellent. Documentation was completed related to wound care and patient rounds in the Meditech system. Additionally, you participated in the stoma care station to gain additional knowledge and skills. Great job this week! FB

**Week 10 (Safety; Infection Control; Prioritization; Weight; Pressure Ulcer Prevention; Soft Restraints; Doppler BP):**

Satisfactory participation with the following stations: Prioritization, Patient Weight, Restraints, Doppler BP, Meditech documentation, and Patient Scenario involving Safety, Infection Control, and Pressure Ulcer Prevention. Keep up the hard work! AR

**Week 11 (Medication Lab):**

Satisfactory participation and performance of the following skills in the medication lab: Oral, IM, SQ, and ID medication administration; performance of IM injection on fellow student; performance of SQ & ID injection on practice sponge; use of and drawing medication out of ampule and vial; communication/accountability activity with awareness of allergies & dosage calculation. AR

**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: \_\_\_\_\_