

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).									NA	S	S	NA	S	NA	NA	
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	S	NA	S	NA	NA	
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						NA	Na	S	S	S	S	NA	S	NA	NA	
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						NA	NA	S	S	S	S	NA	S	NA	NA	
Clinical Location: Patient age**		NS				BL	CB	FB	FB	FB	FB	FB	FB	FB		
		Meditech Orientation				No Clinical	NA	80 3T		72 3T	71 89 3T		74 88 3T			

Comments

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

Week 8 (1c)-Great job with responding to the needs of your patient and coordinating her care respectfully. FB

Week 9 (1a,b)- Sydney, you were able to identify any specific needs for your patient and implement appropriately. You recognized how his prognosis was affecting him in a spiritual and cultural manner, and provided support in a manner that was appropriate for the time and situation. Great job! FB

Week 10 (1c)- Nice job considering your patient's preferences while coordinating appropriate care to ensure positive patient outcomes. FB

Week 12 (1c)- Great job being respectful of patient's values and wishes while coordinating care for your patient during this clinical rotation. FB

* 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
Competencies:																
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
b. Use correct technique for vital sign measurement (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						NA	NA	NA	NA	S	S	NA	S	NA	NA	
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	S	S	NA	S	NA	NA	
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	S	NA	S	NA	NA	
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	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	S	NA	S	NA	NA	
		NS				BL	CB	FB	FB	FB	FB	FB	FB	FB		

Comments

Week 8 (2a,b)- You did a great job with systematically performing your head to toe assessment. You also recognized an abnormality related to the patient's blood pressure, rechecked blood pressure, and reported appropriately. FB

Week 9 (2a,c)- Great job with patient assessments during this clinical rotation. You provided very thorough and structured assessments. You were able to identify the appropriate focused assessment based on information gathered during the initial assessment. Great job identifying the fall risk for your assigned patient and ensuring all precautions were in place. Make sure to access all lab values and identify their relevance to your patient's status. There were several abnormal lab values on your assigned patient this week. You did discuss diagnostic/lab testing and patient status for your assigned patient providing nursing interventions and care needed on clinical and in your CDG. FB

Week 10 (2a,c,d)- You did a great job performing all assessments. You also demonstrated the ability to gather information from assessments performed to determine a priority problem for your assigned patient. After determining the priority problem, you implemented all necessary interventions. FB

Week 12 (2a,c,d)- You did a great job performing appropriate assessments. You provided pertinent information from assessments, labs, and diagnostic testing to determine a priority problem for your assigned patient. Associated interventions were implemented that were relevant to the priority problem based off of information gathered. (2g) Great job interpreting the lab data and diagnostic procedures that provides substantial information for the priority problem. Keep up the good work! FB

*** 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
Competencies:						NA	NA	S	S	S	NA	S	NA	NA		
a. Receive report at beginning of shift from assigned nurse (Noticing).						NA	NA	S	S	S	NA	S	NA	NA		
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
c. Use appropriate medical terminology in verbal and written communication (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
d. Report promptly and accurately any change in the status of the patient (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
e. Communicate effectively with patients and families (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
		NS				BL	CB	FB	FB	FB	FB	FB	FB	FB		

Comments

Week 8 (3a-f)- Great job receiving report, providing important information related to assessment findings in a timely manner, and communicating with your assigned patient. You responded appropriately to an abnormal vital sign realizing the importance of the abnormality and reported promptly, great job! FB

Week 9 (3a,b)- Great job receiving and providing pertinent information during shift report, and hand off report. Appropriate medical terminology was used during all communications provided. Good job communicating appropriately to staff RN and other health care disciplines when necessary. FB

Week 10 (3e)- Great job communicating with your patient this week. Communication comes in many forms and building a trusting relationship is very important to a successful plan of care. FB

Week 12 (3d,e)- You have demonstrated the ability to respond appropriately to any changes that may occur with your assigned patient. Reporting changes from assessments, vital signs, or symptoms has been prompt and to the appropriate reporting structure. You have also displayed the ability to communicate appropriately with patients and their families. Great Job! FB

*** 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
Competencies:									S							
a. Document vital signs and head to toe assessment according to policy (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
b. Document the patient response to nursing care provided (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				NA	NA	S	S	S	NA	S	NA	NA		
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S							S	S	NA	S	NA	NA		
e. Provide basic patient education with accurate electronic documentation (Responding).									NA	NA	S	NA	S	NA	NA	
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						NA	NA	S	S	S	NA	S	NA	NA		
*Week 2 –Meditech		NS				BL	CB	FB	FB	FB	FB	FB	FB	FB		

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 8 (4a,c,f) Good job with head to toe and vital sign documentation this week. Documentation was completed with minimal corrections. You were able to access medical information on your assigned patient appropriately. Your clinical discussion followed all criteria within the rubric and was posted on time. FB

Week 9 (4 a,b,c) Great job with head to toe assessment, vital signs, and focused assessment. You documented thoroughly and in a timely manner. Nice job accessing pertinent information and additional information within the electronic medical record. You were able to identify and gather important information regarding your patient's problems and testing to provide an accurate plan of care, nice job! (4f)- CDG was appropriately posted following the CDG rubric, on time, and in a substantive manner. Your response to a peer also followed all the CDG rubric guidelines. Keep up the great work. FB

Week 10 (4 a,b)- Great job with documentation this week with minimal editing needed. (4c)- You were able to access the medical record, gather pertinent information and interpret data. (4f)- Your discussion post was complete and thorough providing supporting data for the priority problem. You also completed a substantial comment to one of your peers. FB

Week 12 (4a,b)- You are progressively showing improvement with documentation. Documentation has been thorough and accurate with minimal editing required. (4c) You have displayed the ability to access the electronic health record and gather all relevant information. (4f) Your initial CDG post and peer response was within the guidelines provided within the CDG rubric, nice job! FB

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

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

Objective																
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
Competencies:																
a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
b. Apply the principles of asepsis and standard/infection control precautions (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).									NA	NA	S	NA	NA	NA		
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
e. Organize time providing patient care efficiently and safely (Responding).						NA	NA	S	S	S	NA	S	NA	NA		
f. Manages hygiene needs of assigned patient (Responding).									NA	NA	S	NA	S	NA	NA	
g. Demonstrate appropriate skill with wound care (Responding).									NA		NA	NA	S	NA	NA	
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).						NA	NA	S	S							
		NS				BL	CB	FB	FB	FB	FB	FB	FB	FB		

Comments

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

Week 8 (5h) Fire extinguisher on the wall in front of nurses' station. Pull station behind nurses' station. SF

Week 8 (5e,h)- Great job providing safe and efficient care to your assigned patient. Satisfactory location of fire extinguisher. FB

Week 9 5.f- patient refused hygiene care, I documented correctly.

Week 9 (5 d,e)- Nice job with the management of the care you provided to your assigned patient. You organize your time appropriately to provide safe, efficient care while making sure to provide care that contributes to positive patient outcomes. FB

Week 10 (5e) Great job managing time effectively to provide all necessary care for your patient and getting the patient. (5f) Great job offering and encouraging hygiene care for your assigned patients. FB

Week 12 (5 c,d,e)-You have demonstrated great management of care for your assigned patient making sure all pertinent interventions were completed. You organize your time appropriately to provide safe, efficient care to ensure positive patient outcomes. (5f)- Try to encourage hygiene care to patients for each clinical experience, this is very important to not only make the patient feel better, but also for infection control. FB

* 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
Competencies: a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).									NA	U	S	NA	S	NA	S	
		NS							FB	FB	FB	FB	FB	FB		

Comments

Week 9 (6a)- Great job providing patient centered care to your assigned patient during this clinical rotation. You received a “U” for this competency because you did not self-rate yourself. Make sure you are reading each objective with corresponding competencies and self-rate yourself appropriately. You will need to address the “U” rating on week 10 clinical tool per the directions located at the beginning of the clinical tool. **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. FB**

6a. I received a U for not self-rating myself for this competency. For further clinical tools I will triple check to make sure I have self-rated myself for all competencies. Thank you for addressing. It is a great habit to double and/or triple check all work to make sure work is complete and thorough. FB

Week 10 (6a)- Great job utilizing clinical judgement while providing care to your patient during this clinical rotation. FB

* 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
Competencies:																
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).									NA				S	NA	NA	
b. Recognize patient drug allergies (Interpreting).									NA				S	NA	NA	
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				S	NA	NA	
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				S	NA	NA	
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				S	NA	NA	
f. Assess the patient response to PRN medications (Responding).									NA				NA	NA	NA	
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			NA S	S	NA	NA	
*Week 11: BMV		NS							FB			FB	FB	FB		

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

7f. Patient did not receive any PRN medications.

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
Competencies:																
a. Reflect on areas of strength** (Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)						NA	NA	S	S	NI	S	NA	S	NA	NA	
c. Incorporate instructor feedback for improvement and growth (Reflecting).						NA	NA	S	S	S	S	NA	S	NA	NA	
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	
g. Comply with patient's Bill of Rights (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	
i. Actively engage in self-reflection. (Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	
*		NS				BL	CB	FB	FB	FB	FB	FB	FB	FB		

* 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 7(8f): Sydney, competency 8f was changed to an "U" because your clinical tool was submitted after the due date and time. From the directions above: 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. CB

For week 7 I was given a U for 8f due to turning in my clinical tool late. I will correct this by making sure my clinical tool is turned in on time. I will improve this by setting reminders on my phone. SF

(8f)- Make sure you are giving a specific information on how you will correct, ex. I will correct this by making sure to check the calendar for submission times and dates, as well as set an alarm on my phone at least 2 hours before assignments are due. FB

Week 8 (7a)- Strengths: I feel that my strengths were having good communication with the patient and gathering and documenting the vital signs.

(7b) Weakness: During my head-to-toe assessment I forgot to check strength in the patient's hands and feet. I will improve this skill by practicing strength test on family three times. Great idea, practice will make the process flow in a step by step manner. This will also make it effortless because repetition ingrains the content in your mind. FB

Week 9(8a)- Strengths: My strengths this week I thought were proper communication with my patients and also improving my head-to-toe assessment. Keep up the great work. FB

Week 9 (8b)- Weakness: A weakness I thought I had were difficulty resuming my assessment after many interruptions. I did manage to finish my assessment in a timely manner. I will improve my weakness by practicing my assessment on a family member and having someone interrupt the assessment three times. You must address how you plan to improve on the weakness you identified. This competency was changed to a NI because no plan for improvement was provided. FB

Week 10 (8a)- Strengths: This week I thought my strengths were improving on my head-to- toe assessment, being able to identify the wheezing and rhonchi in the lungs. Providing good communication and hygiene. Catching that my patient was a high fall risk and did not have the proper interventions in place, then placing the signs, and yellow socks and wristband on the patient. Great job, you are progressing well with each clinical rotation. You provide great care to your patients and are very thorough. FB

Week 10 (8b)- Weakness: This week I had trouble finding the dorsalis pedis pulse. I then used the doppler to help me hear the pulse. I will improve my skills on the pulse site by practicing it three times on my family members before my next clinical. Great idea, practice is very beneficial for the head to toe assessments or focused assessments. FB

Week 12 (8a)- Strengths: Throughout my clinical experiences and this being my last clinical experience I feel as if I have improved on having better time management on my head-to-toe assessment. Gathering the needed information to find my patient's priority problem. Sydney, you have progressed very well during the semester with assessments, clinical judgment, critical thinking and time management. Keep up the great work! FB

Week 12 (8b)- Weakness: I felt that my weakness this week would be my time management by looking up my medication and providing hygiene care. I did provide hygiene care to my patient, but I feel as if I could have been quicker with my time. I will improve this skill by creating flashcards and reviewing the medications three times to better my time management in the clinical setting. Medication administration can be challenging. The more experience you have with medications in the same classification will enhance your knowledge. Similar signs and symptoms are associated with medications in the same classification, making it easier to determine assessments and monitoring of patients. You will get better with experience.

Week 12 (8f)- Make sure to reach out to your clinical instructor if you do not receive the correct graded clinical evaluation tool uploaded into your dropbox. Reach out before the next clinical evaluation tool is due. This will prevent you from receiving an unsatisfactory for the professionalism competency. FB

* 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)	S	
Faculty Initials	FB	
Remediation: Date/Evaluation/Initials	NA	

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Morgan Allison (A), Mallory Jamison (O), Sydney Fox (M)

GROUP #: 8

SCENARIO: NF #1

OBSERVATION DATE/TIME(S): 11/12/2024 1000-1100

CLINICAL JUDGMENT COMPONENTS					OBSERVATION NOTES
NOTICING: (1,2,4,6,7) *					Assessment nurse introduced self and role. Identified patient with name and date of birth when entering the room for patient safety. Noticed temp 99.2, B/P 131/75. SpO2 of 90% RA. Did not notice low SpO2 (90%) as abnormal (discussed in debriefing). Pain assessment performed. Noticed cough. Asked patient about sputum, consistency, and color. Asked patient if it hurts when she coughs. Noticed tissues in patient's bed. Noticed yellow sputum in the tissues. Recognized lung sounds as crackles. Medication nurse introduced self and role when entering the room. Performed 7 rights of medication administration by using the BMV scanning system for patient safety. Accurately identified patient name and date of birth. Information obtain from patient about how medications are taken. Remember to ask about allergies. Noticed indications for atorvastatin and multivitamin. Noticed potential adverse reactions and side effects.
INTERPRETING: (1,2,4,6,7) *					Prioritized vital signs before completing a full head to toe assessment. Interpreted low SpO2 of 90% as requiring oxygen per physician's order. Prioritized medication safety practicing 7 rights of medication administration. Interpreted guaifenesin medication PRN for nonproductive/persistent cough. Interpreted side effects of medications appropriately.
RESPONDING: (1,2,3,4,5,6,7) *					Practiced standard precautions with hand hygiene before entering the room. Promptly performed pieces of a head-to-toe assessment. Did not palpate pulses, ask questions pertaining to LOC, or assess the integumentary system. (discussed in debriefing about reddened heels). Remember when auscultating lung sounds, to listen on the chest not over the gown. Elevated HOB when shortness of breath was noticed. Collaborative communication between assessment and medication nurse. Communicated with patient about interventions being performed, with questions answered appropriately. Responded to low SpO2 of 90% by raising the head of the bed and applying oxygen at 2L per nasal cannula as per physician's orders. Good body mechanics by raising the bed and lowering the side rails. Communicated am medications with patient. Education provided to patient on medication and side effects after prompted

	by the patient. Utilized BMV scanner for medication administration. Educated patient on use of incentive spirometer.
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Observers provided good insight during debriefing. Noticed the good infection control measures. Discussed initiating O2 via nasal cannula for low Spo2 per orders. Discussed strengths of both the assessment nurse and medication nurse. Constructive feedback was provided. Identified potentially having the patient sit up in bed to improve lung expansions to improve Spo2 levels. Observers discussed potential educational needs related to the scenario. Noticed the implementation of the six medication rights. Identified positive communication between team members and with the patient. Everyone participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement and discussed ways to make improvements in the future. Good discussions amongst all members of the team. Nice job!
SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Execute accurate and complete head to toe assessment (1,5,6,8) * • Select and administer prescribed oral medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) *	Lasater Clinical Judgement Rubric Comments: Noticing: Attempts to monitor a variety of subjective and objective data but is overwhelmed by the array of data; focuses on the most obvious data, missing some important information. Identifies obvious patterns and deviations, missing some important information; unsure how to continue the assessment. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data. In simple, common, or familiar situations, is able to compare the patient’s data patterns with those known and to develop or explain intervention plans; has difficulty, however, with even moderately difficult data or situations that are within the expectations of students; inappropriately requires advice or assistance. Responding: Is tentative in the leader role; reassures patients and families in routine and relatively simple situations, but becomes stressed and disorganized easily. 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. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision

	points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses. Satisfactory Completion of NF Scenario #1.
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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.

<u>Skills Lab</u> <u>Competency Evaluation</u> Performance Codes: S: Satisfactory U:Unsatisfactory		Lab Skills									
	Week 1 (4)*	Week 2 (2,3,5,8)*	Week 3 (2,3,4,5,8)*	Week 4 (2,3,4,5,8)*	Week 5 (2,3,4,5,8)*	Week 6 (1,2,3,4,5,8)*	Week 7 (2,3,4,5,8)*	Week 8 (2,3,4,5,8)*	Week 9 (2,3,4,5,8)*	Week 10 (2,3,4,5,6,8)*	Week 11 (2,5,7)*
Date: 8/19/2024	Date: 8/26/2024	Date: 9/4/24	Date: 9/4/2024	Date: 9/16/2024	Date: 9/23/2024	Date: 9/30/2024	Date: 10/7/2024	Date: 10/14/2024	Date: 10/21/2024	Date: 10/29/2024	
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	HS	HS	NS	AR	CB	AR	FB	FB	HS	AR	AR
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

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 out of three blood pressure results on the Vital Sim manikin for a satisfactory evaluation. The first blood pressure measurement was set at 108/66, and you identified it as 114/58, which was slightly out of the range for a satisfactory result. The second measurement was set at 126/88 and you interpreted it as 126/90, within the desired range. The third measurement was set at 146/80, and you interpreted it as 146/80 – spot on! You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You only required one prompt throughout the whole checkoff related to obtaining a heart rate in addition to blood pressure with orthostatic vitals, great work! You provided accurate detail in your communication with the “patient”. Overall your documentation looked very good. One area of note was omitting the linking of a

• Guided

nurses note to the vital sign intervention. The instructions stated to link a note stating “vital signs completed.” Be sure to pay close attention to all details when documenting. This will improve with continued practice in the lab. 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):

Great job in lab this week! You have satisfactorily demonstrated a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall well done. You did require 1 prompt related to asking patient orientation questions. You demonstrated friendly, professional, and informative communication. Great job!

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!

- **Pain-** omitted “relaxation techniques” from management technique to relieve pain
- **Vital signs-** Documentation was accurate and complete.
- **Safety-** Documentation was accurate and complete.
- **Physical reassessment-** Gastrointestinal (bowel movement aid)- omitted “daily”

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 health care worker and the patient. Great job with active participation throughout the duration of the lab. CB

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):

Great job this week in lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. You are satisfactory in all NG skills. Excellent patient education provided! You did not require any prompts during insertion, irrigation, or removal. Great job! You were able to verbalize understanding of the difference between irrigation and flushing. 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! FB

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. You did not require any prompts during the sterile glove application, Foley catheter insertion or the removal of the catheter. You had very good communication with your “patient”. Great job! You correctly verbalized the differences in catheter insertion for a male patient. 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!!! FB

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 require a prompt related to opening the package and keeping it open in keeping the gauze sterile, you touched the outside of the package prior to using the supplies. Your communication with the patient was excellent. You were able to discuss the importance of keeping the gauze sterile afterward the procedure. 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. Clinical scenario questions were presented to the group with active participation from all students. Great job this week! HS

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

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: _____