EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Brooke Schafer

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/2/2024

Faculty eSignature: Heather Schwerer MSN, RN

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

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

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
11/2/2024	1 hour	CDG peer response	11/3/2024 1hr

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

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	NA	S	NA	S	NA	S
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	NA	S	NA	S	NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						S	NA	NA	S	S	NA	S	NA	S	NA	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						S	NA	NA	S	S	NA	S	NA	S	NA	S
						CB	CB	CB	CB	HS	HS	HS	SA	HS	HS	HS
Clinical Location; Patient age**						3T 90	NA	NA	NA	3T 69	NA	3T 74 54	NA	3T 77	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 you able to recognize physiological needs of your patient when performing head to toe assessment. CB

Week 9 (1c,d)- You did a nice job this week completing all of the care necessary for your patient. You incorporated his preferences and needs while planning the care. You also utilized Maslow's Hierarch of needs to determine what care needed to be completed. HS

Week 11 (1c,d) You performed care this week based n the patients preferences and needs. You allowed him to be part of the decision making while completing the interventions necessary. HS

Week 13 (1c,d) Nice job considering your patient's preferences while coordinating appropriate care to ensure positive patient outcomes. 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
Competencies: a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
b. Use correct technique for vital sign measurement (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						~~S~~ NA	NA	**NA**	NA	S	NA	S	NA	S	NA	**S**
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	S	NA	S	NA	S	NA	**S**
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	NA	S	NA	S	NA	**S**
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	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	NA	S	NA	S	NA	**S**
						CB	CB	**CB**	CB	HS	HS	HS	SA	HS	HS	**HS**

Comments

Week 6(2a,b): Brooke, 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

Week 9(a-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 that your patient had edema in his lower extremities and that you were having difficulty finding his pedal pulses. HS

Week 11 (a-d) You did a nice job on your assessment. Your patient on day 2 had a lot of abnormal assessment findings and you were able to successfully identify them, including his lower leg edema and weakness. You also completed the fall/safety and skin assessment for both of your patients. HS

Week 13 (2a,c,d)- You did a great job performing appropriate assessments especially with the abnormal findings in within the integumentary assessment. 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. 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
Competencies: a. Receive report at beginning of shift from assigned nurse (Noticing).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	NA	**NA**	NA	S	NA	S	NA	S	NA	**S**
c. Use appropriate medical terminology in verbal and written communication (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
d. Report promptly and accurately any change in the status of the patient (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
e. Communicate effectively with patients and families (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	S
						CB	CB	**CB**	CB	HS	HS	HS	SA	HS	HS	HS

Comments

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. 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. Once you identified that you were having a difficult time finding the pedal pulses you sought help in finding them, and were able to do so with minimal assistance. You notified the nurse after identifying the change in blood pressure during the shift. You communicated very well with your patient throughout the shift keeping him informed regarding his care. HS

Week 11 (3a-f)- You were able to receive report from the previous shift and then reported off at the end of your shift to the RN. You also reported the decrease in the SpO2 to the primary RN in a timely manner. You did a nice job communicating with your patient while providing care. HS

Week 13 (3a,b): Good job this week receiving report from the off going shift and giving appropriate information to the bedside nurse when leaving clinical for the day. 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**
Competencies: a. Document vital signs and head to toe assessment according to policy (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
b. Document the patient response to nursing care provided (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				NI	NA	**NA**	NI	S	NA	S	NA	S	NA	**S**
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S							S	S	NA	S	NA	S	NA	**S**
e. Provide basic patient education with accurate electronic documentation (Responding).									NA	S	NA	S	NA	S	NA	**S**
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						~~S~~ NI	NA	**NA**	NI	S	NA	~~S~~ U	NA	S	NA	**S**
*Week 2 –Meditech		CB				CB	CB	**CB**	CB	HS	HS	HS	SA	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 6 (4f) Needs improvement: I felt like I did okay on documenting and locating in the patient's charts, however I needed directory from Chandra or Britney quite a bit. Granted it was a little overwhelming not being used to it, I want to improve by not having to ask so many questions. I will improve this by taking any chance in class of documenting and really paying attention and while working at the hospital as a pct, I will pay attention to the system more. Only using it for pct roles! 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, and it will become easier with more time and experience. Competency "4f" was changed to a "NI" because you did not include a reference for your peer response. Remember always have your grading rubric available when completing cdgs. CB

Week 9(4a,b,c) You did a nice job this week documenting all of the care and interventions you provided to your patient. You did a nice job reviewing the information within the chart to gain additional insight into the patient history and symptoms.
(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. Nice job! HS

Week 11(4a,b,c) You did a nice job on your documentation this week. You also did a nice job accessing the EMR to obtain information from the patients' chart. HS
(4f) This competency was changed to a U because you did not meet the requirement for submitting the peer response to the CDG by Saturday at 2200. Your initial CDG response provided good insight and conversation based on the questions, you also included an in-text citation and reference. HS

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.

Week 12 (4f): This has happened to me before where my postings did not post. I previously said I would double check to make sure that my post posted. I checked them both on Sunday and noticed my response to a peer was not under the person I posted it under. There for I copied my response from my word document and posted it again. To avoid this happening again I will be sure to check my posts on Saturday night to prevent any assignment being late. Thank you for responding. That is a great plan for future submissions. SA

Week 13 (4 a,b,c) Nice job with head to toe assessment, vital signs, and focused assessment. Your documentation continues to improve, be sure to double check that all interventions have been documented prior to submitting. 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) You met all of the CDG rubric requirements for this week for both your initial and peer responses. Be sure when identifying interventions for the priority problem and listing medications, that you only include those that are specific to the identified priority problem. HS

* 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).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
b. Apply the principles of asepsis and standard/infection control precautions (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).									NA	~~NA~~ S	NA	NA	NA	S	NA	**S**
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
e. Organize time providing patient care efficiently and safely (Responding).						S	NA	**NA**	S	S	NA	S	NA	S	NA	**S**
f. Manages hygiene needs of assigned patient (Responding).									NA	S	NA	S	NA	S	NA	**S**
g. Demonstrate appropriate skill with wound care (Responding).									NA		NA	S	NA	S	NA	**S**
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).						S	NA	**NA**	S							**S**
						CB	**CB**	**CB**	**CB**	**HS**	**HS**	**HS**	**SA**	**HS**	**HS**	**HS**

Comments

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

* End-of-Program Student Learning Outcomes

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

-On 3T there are several places these are located. There is a fire extinguisher and pull station at each end of the hall closest to the front of the hospital, next to the stair entrances. These are also located near the UC desk on the floor. They are also located in other spots throughout the floor across from some rooms. 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

Week 9 (5c)- I changed this to an S because your patient had a Foley this week and he also had some bleeding around the insertion site as you identified.
(5d,e)- You did a nice job going right in the patients room to get started, however the beginning of the day began with an interruption as X-ray took the patient down immediately. You did a nice job prioritizing your care and resuming the care after the patient returned to his room. 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

5g- I gave myself an S for this because on Wednesday my patient had a wound on her left foot. Even though I did no dressing changes or anything to the wound itself, I made sure she was bathed and such to reduce the chance of her getting an infection in that area. Along with that I was able to experience some of what the podiatrist did to the wound and dressing to keep an idea of the plan to heal the wound. HS

(5d,e,f) You did a nice job this week planning and organizing your care for your patient each day. You had a new patient on the second day with a different diagnosis compared to the prior day. You were able to identify your priority problem and what interventions would be appropriate for the plan of care. HS

Week 13 (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. Good job with time management this week with your medication administration. Nice job with the Foley insertion. HS

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	S	NA	S	NA	S	S	**S**
									CB	HS	HS	HS	SA	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

Week 13 (6a)- Good job this week assessing your patient and gathering information from the electronic medical record to help you identify your patient's priority problem, and centering patient care around that. HS

Week 14 (6a)- Great job on your care map! You were able to identify a priority problem based on your abnormal assessment findings, lab values, and risk factors. You then successfully identified the plan on care and determined interventions specific to the patient. 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**
Competencies: a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).									NA				NA	S	NA	**S**
b. Recognize patient drug allergies (Interpreting).									NA				NA	S	NA	**S**
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				NA	S	NA	**S**
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				NA	S	NA	**S**
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				NA	S	NA	**S**
f. Assess the patient response to PRN medications (Responding).									NA				NA	S	NA	**S**
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			S	NA	S	NA	**S**
*Week 11: BMV									CB			HS	SA	HS	HS	**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

Week 13 (7a-d, g)- Great job with medication administration this week of both oral and SQ! You were able to identify why your patient was receiving the medication, potential side effects, and appropriate patient education. You reassessed your patient after giving medications, ensuring their safety. You followed the 7 rights of medication administration with 3 medication checks, verifying the correct patient and their allergies. You were able to utilize the BMV for medication administration documentation. HS

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

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Week 6:
Reflection - Areas that I feel strength in was being able to have good communication with the patient. I was able to learn some things about the patient unrelated to health, the patient even thanked me for "using" him as my patient. I enjoy talking to people and making them smile. A weakness I felt that I had was not much confidence, the entire assessment I was worried of missing something or not doing things right. This can be improved by continuing to practice on family and paying attention to lecture to be sure that I am comfortable with the material and can implement it with confidence. Brooke, if you have great plan in place by practicing on family members to ensure that you are completing all steps of a head to toe assessment, and with time and experience it will become easier and less stressful. CB
Week 6(8d,f,h): Competency "8a,b" were changed to a "S" because you completed an area of strength and weakness. Excellent job following the student code of conduct, exhibiting professionalism while in the clinical setting, and ensuring that patient privacy was respected. CB

Week 8:
8A: Areas that I felt strength in for my clinical was being able to answer any questions that I was asked by my instructor or patient's nurse. However, a weakness I experienced with this was not really feeling confident in my answer as I wasn't sure if I was thinking too far into the question or not far enough. Both my instructor and patients nurse reassured me that I am doing just fine and answered the questions asked well. Throughout my clinical I was asked several questions as to why things might be the way they were for the patient, why a medication was passed, why my patients vital signs changed, etc. I also felt confident in myself that I provided thorough care the entire time I was there, and I was very interested in my patients' diagnosis/symptoms. You did a nice job putting the pieces together. HS

8B: To improve feeling not so sure of my answers, I am going to try to work on having more confidence in myself and remind myself that every day is a learning experience. I know that one day all of what I am learning and implementing into clinical/practice will all click and make sense. You will continue to gain confidence with additional clinical experiences and exposure to different situations. This will come with time. HS

(8F)- This competency was changed to a U due to the fact that you did not submit the clinical tool by the designated deadline. 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. Please be sure to include this on your Week 10 tool. If you have any questions about this process, please do not hesitate to reach out. HS

Week 10: (8f) Here on out to receive a satisfactory for this I will be sure to always double check to make sure my assignment uploaded onto the drop box correctly. I have now learned that there can be issues with uploading assignments on there. I completed the assignment right after clinical but failed to be sure my assignment uploaded correctly. I will also double check this for any other assignments we have as well, so I do not run into this issue again. HS

Week 11(8a and b): This clinical I felt very involved in each one of my patients. I was able to learn more and more about my patients even just through conversation, I feel good about that because not always is it easy to carry on a conversation with someone who is lying in a hospital bed sick. I was able to detect different things that seemed abnormal and notify each one of my patient's nurses. I feel like I am getting the hang of a head-to-toe assessment and I'm becoming quicker each time. I also felt like I did a lot of digging into my patient's charts to learn more about them and their history, which was very interesting! HS Areas where I feel like I could improve is looking more into skyscape throughout clinical. I felt like the last two clinical days I did look up more on skyscape, however I want to learn more and I know that I should use skyscape more to become more knowledgeable on certain things I find. This was changed to a NI because you did not identify a plan to improve upon your identified weakness.
(8f) – This was changed to a NI because you submitted your CDG response to a peer late. Please be aware of deadline in order to turn in assignments by the designated deadline. HS

Week 12 (8A and B): I will always check to be sure that I have all the questions answered before submitting, I feel like at times I rush things because I get too overwhelmed and end up missing something. I will start to slow down and take my time, and stay relaxed while doing my assignments. SA

Week 12 (8F): As stated above I will continue to double check my postings the day they are due instead of day prior. I usually double check everything on Sunday and noticed my peer response wasn't there. I had this issue once before with my initial post not posting. I will be sure to check them on Saturday so they will not be late incase this happens again. SA

Week ~~12~~ 13 (8a): Areas that I felt strength in was the confidence I had in myself after administering medications, giving a subcutaneous injection and inserting a foley on a male. I typically struggle with confidence in myself, but the excitement of being able to do those things was very high. Along with that sometimes I am more of a shy person when around my patients due to the lack of confidence, this week I was able to create more conversations with my patient bringing her out of her shell a little more too. Being able to see/realize my growth over clinical motivates me so much more. Great job! With each experience you will gain more knowledge and comfort in the clinical setting. HS

Week ~~12~~ 13(8b): This week I felt like I was stressing too much about little things that was causing me to feel unorganized and becoming forgetful almost. I am not sure if it was nerves dealing with medications to give to the patient or all the action that was going on with the rest of the floor each day of clinical. There were times where I would easily get distracted by something, and that bothers me as it makes me feel unorganized and scatter brained. I know in the nursing field it's so easy for interruptions so I am going to use this as a learning experience and use it moving forward. This competency was changed to a NI because you did not state a plan of how to improve. You must explain your plan for how you will improve. HS

WEEK 14 in reference to week 13, I will try to start creating more of a plan before even starting anything but in a timely manner. Now that I have one clinical of medication administration, I feel that I will be more comfortable when doing so. I know by working in the hospital that things can get hectic in all areas of the floor, my goal is to just try to stay as focused as I can on my interventions if I am not needed in any other activates on the floor. HS

Final comment- Brooke, you did an excellent job this semester! You came to clinical each week ready to learn and gain new experiences. You have grown throughout the semester in your confidence, knowledge, and skill set. You did not get the opportunity to insert, care for, or remove an NG tube, so please seek out these opportunities in your MSN semester. I look forward to seeing you continue to grow next semester. Great job this semester! HS

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/18/2024	Impaired physical mobility	S/HS	NA

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: Brooke Schafer				**Course Objective:** 6			
Date or Clinical Week: 11/18/2024							
Criteria		**3**	**2**	**1**	**0**	**Points Earned**	**Comments**
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	**(lists at least 7*) *provides explanation if < 7**	**(lists 5-6)**	**(lists 5-7 but no specific patient data included)**	**(lists < 5 or gives no explanation)**	3	Good job identifying the abnormal assessment findings for your patient. You listed 3 abnormal lab findings, you could consider including diagnostic tests that were abnormal as well such as chest x-ray or the x-ray of his lower extremities. Nice job including a thorough list of risk factors. HS
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	You provided a nice list of nursing priorities and highlighted an appropriate top priority for the patient. Nice job with your goal for the priority problem. You did a nice job highlighting all of the related data to support the priority nursing problem. Nice job on the potential complications that you have identified as well as the signs and symptoms that you would monitor the patient for. HS
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	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**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Great job on the list of nursing interventions that you have prioritized and made specific to the patient. HS
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	

	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**	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	1	You included a lot of good information in the evaluation, however, the evaluation should be specific to a reassessment of the patient, in order to determine if the plan of care should be continued, modified or terminated. It appears that you put goals for the patient within this box rather than your findings from a reassessment. HS
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

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 both in-text citation and reference are not 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:
Brooke,
Nice job on your care map! You were able to identify the abnormal assessment, lab findings and risk factors in order to develop the plan of care for your patient. You were able to identify several potential problems for the patient and determine which one was the priority and then compile a thorough list of interventions specific to the patient. Just keep in mind that the evaluation should be a re-evaluation of the patient in order to determine how to proceed with the plan of care. Great job overall! HS

Total Points:43/45

Faculty/Teaching Assistant Initials: HS

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

Simulation Evaluation Performance Codes: **S**: Satisfactory **U**: Unsatisfactory	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Date: 11/5/2024	**Date: 11/25/2024**
Evaluation (See Simulation Rubric)	S	S
Faculty Initials	HS	HS
Remediation: Date/Evaluation/Initials	NA	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): Cora Meyer (O), Brooke Schafer (O), Nevaeh Walton (A), Jordan Lugtig (M)
GROUP #: 3
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/5/2024 1230-1330

CLINICAL JUDGMENT COMPONENTS	**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) *	**Focused observation**
• Focused Observation: E A D B	Focused observation on safety when entering the room
• Recognizing Deviations from Expected Patterns: E A D B	Focused observation on patient's vital signs
• Information Seeking: E A D B	Focused observation on patient's cough and shortness of breath and lung sounds.
	Focused observation on patient's assessment
	Recognizing deviations from expected patterns
	Noticed BP 132/76, Spo2 of 91% on RA, HR 80, RR 20, temp 99.2
	Noticed persistent cough
	Noticed crackles on auscultation
	Noticed tissues in the bed. Noticed yellow sputum.
	Noticed reddened heels.
	Information seeking
	Confirmed name and DOB when entering the room
	sought additional information related to sputum production, consistency, etc.
	Sought information related to orientation (mental status)
	Sought information related to pain (0/10)
	Assessed allergies, confirmed name and DOB prior to med administration.
	Asked patient how she takes her medications.
INTERPRETING: (1,2,4,6,7) *	**Prioritizing data**
• Prioritizing Data: E A D B	Prioritized vital sign assessment when entering the room

• Making Sense of Data: E A D B	Did not prioritize oxygen administration initially. Eventually recognized need for supplemental O2 due to continued shortness of breath and low Spo2. Prioritized placing pillow under her heels. **Making sense of data** Interpreted Spo2 as being low. Interpreted crackles as being related to pneumonia diagnosis Interpreted redness as being related to pressure. Made sense of guaifenesin prescription for persistent cough. Made sense of medications to be administered, made sense of the MAR.
RESPONDING: (1,2,3,4,5,6,7) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	**Calm, confident manner** Demonstrated confidence in nursing actions and communication with patient and team member. Answered patient's questions appropriately. **Clear communication** Introduced self and role when entering the room. Good communication with the patient throughout assessment. Educated patient on medications, including proper dose. Educated patient on placing of oxygen tubing. **Well-planned intervention/flexibility** Placed pillow under the heels for redness. Elevated the HOB for shortness of breath and cough Raised the HOB for medication administration. Re-assessed Spo2 prior to placing oxygen tubing. Applied O2 eventually for Spo2 less than 93% per physician orders. Consider re-assessing oxygenation status and vital signs after initiating oxygen to determine effectiveness. Did not assess bony prominences initially. When prompted by the patient noticed redness to heels. Elevated heels related to redness from pressure.

	Being skillful Used BMV scanner to patient safety. 7 rights of medication administration observed. Raised the bed for proper body mechanics HEENT assessment performed accurately. Auscultated heart and lung sounds accurately. GI assessment performed accurately (looked, listened, felt). Asked about last BM. Asked about nausea/vomiting, stool characteristics. GU assessment performed accurately. Asked about associated symptoms. Assessed ROM in all extremities. Good integumentary assessment. Did not assess bony prominences initially. When prompted by the patient noticed redness to heels. Pulses assessed and compared bilaterally. Assessed strength of the extremities. Assessed for capillary refill. Good body mechanics by raising the bed and lowering the side rails. Safety assessment performed Consider having meds looked up in full in order to provide education related to side effects.
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Observers did a great job actively paying attention to detail throughout scenario. Constructive feedback was provided during debriefing. Observers provided good insight on safe medication administration, including the rights of medication administration. Observers also praised students for initiating O2 via nasal cannula for low Spo2 per orders while also discussing the need for prompt intervention. Constructive feedback was provided related to areas for improvement. Good discussion and support amongst those performing in the scenario and the observers. 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. The assessment nurse and medication nurse demonstrated collaborative communication between the team members and the patient.

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: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. 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 most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale;. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could. 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.**

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Cora Meyer (M), Brooke Schafer (A), Nevaeh Walton (O), Jordan Lugtig (O)
GROUP #: 3
SCENARIO: NF #2
OBSERVATION DATE/TIME(S): 11/25/2024 1000-1100

CLINICAL JUDGMENT COMPONENTS	**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) *	Identified patient with name and DOB and compared to wristband for patient safety.
• Focused Observation: E A D B	Noticed low Spo2 (91%) when obtaining vital signs.
• Recognizing Deviations from Expected Patterns: E A D B	Noticed patient had a cough.
• Information Seeking: E A D B	Noticed patient was in pain after coughing and moaning. Sought additional information related to pain (rating, location). Noticed patient's pain 7/10.
	Noticed crackles upon auscultation.
	Noticed order for PRN breathing treatments.
	Noticed PRN medications for pain. Noticed need for dosage calculation based on physician order.
	Remember to seek information related to allergies prior to medication administration (discussed in debriefing).
	Consider asking patient preference for injection location.
	Sought additional information after medication administration related to relief and comfort.
INTERPRETING: (1,2,4,6,7) *	Prioritized vital signs when entering the room.
• Prioritizing Data: E A D B	Prioritized applying oxygen and made sense of physician orders to maintain Spo2 >93%. Applied oxygen but did not hook it up correctly, until prompted by patient and decreased SpO2 of 88% (discussed in debriefing).
• Making Sense of Data: E A D B	Prioritized focused pain assessment due to patient complaint.
	Prioritized focused respiratory assessment related to pain on the right side and shortness of breath.
	Made sense of the MAR related to pain rating and need for dosage calculation to be performed, along with witness for wasting of medication.

	Prioritized correct PRN pain medication (morphine for pain 7/10). Consider administering pain medications prior to continuing full assessment for patient comfort (discussed in debriefing). Team members can collaborate to administer medications then return to complete full assessment. Did not make sense of MAR documentation related to morning PO medications already being administered initially, prompted by patient (discussed in debriefing). Prioritized returning medications to the pyxis for medication safety.
RESPONDING: (1,2,3,4,5,6,7) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Identified self and role when entering the room for communication. Applied oxygen via NC at 2L per physician orders due to low Spo2. Elevated HOB for shortness of breath. Offered fluids due to increase coughing. Performed pain assessment in response to patients' pain (rating, location). Consider focusing your assessment on the location of pain (look, auscultate). Consider additional interventions for pain management (reposition, splinting, etc.). (discussed in debriefing). Dosage calculation performed accurately to determine need to waste 1ml (2mg) of morphine. Ordered 4mg (2ml), administered 4mg (2mL). Witnessed waste of excess narcotics. Confirmed name and DOB prior to medication administration. Appropriately utilized the BMV for medication administration. Educated patient on morphine ordered for pain. Cleaned injection site using aseptic technique. Remember to aspirate prior to injection. Good technique (90 degrees), pushed slowly. Good needle safety. Selected appropriately sized needle for IM injection (22g, 1inch). Splinting a pillow while coughing to patient mentioned, no further detail given (discussed in debriefing). No education provided related to incentive spirometer, coughing and deep breathing, effectiveness of ambulation and being up in chair, or smoking cessation (discussed in debriefing).
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B	Each member actively participated in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement related to prioritization and IM injections

• Commitment to Improvement: E A D B	and discussed ways to make improvements in the future. Observers provided good insight on med safety and communication amongst team members and with the patient. Identified educational opportunities that were presented in the scenario. Reflected on clinical judgement and critical thinking that required. Emotions, thoughts and feelings were explored. Each member demonstrated a desire to improve nursing performance.
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) * • Differentiate between need for complete head to toe versus focused assessment and execute accordingly (1,5,6,8) * • Select and administer prescribed oral and intramuscular medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) * • Recognize patient oxygenation and pain control needs and provide appropriate interventions (2,4,5,6,7) *	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. 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: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. **Satisfactory Completion of NF Simulation #2!**

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

Student Name: Brooke Schafer

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

Skills Lab Competency Evaluation 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:** 9/4/2024	**Date:** 9/9/2024	**Date:** 9/16/2024	**Date:** 9/23/2024	**Date: 9/30/2024**	**Date:** 10/7,9/2024	**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	AR	AR	HS	AR	NS	AR	AR	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

- 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):

Excellent 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. The first blood pressure measurement was set at 112/60 and you identified it as 110/62. The second measurement was set at 144/86 and you interpreted it as

130/82 which was outside the set parameters. The third measurement was set at 132/74 and you interpreted it as 130/70. Great job, especially considering you didn't practice on the Vital Sim manikin prior to your 1:1 observation! 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 during completion of your 1:1 observation and provided accurate detail in your communication with the "patient". Your Meditech documentation was accurate and complete. Keep up the great work!! AR

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 about the last bowel movement and usual bowel habits. 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, there are some areas for improvement. You did a good job, overall, with your Meditech documentation. You documented on the interventions listed below; however, some areas were omitted. Please review each area of documentation within the next two weeks so you can examine areas that were omitted. I want you to feel comfortable and confident with Meditech documentation.

Pain- omitted documentation that "physician was already aware"
Vital signs- your documentation was accurate and complete.
Safety- your 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. HS
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. You were able to remind yourself to rinse the irrigation equipment and to label it appropriately following irrigation. 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. You did not require any prompts!! Your preparation for the skills checkoffs and communication with your "patient" were excellent! 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. One area to focus on in the future is to keep the packing gauze in your hand rather than laying it on the wound and surrounding skin. 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. Clinical scenario questions were presented to the group with active participation from all students. Great job this week! AR

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:

This semester I saw growth in myself, and I know there is lots of room for more growth. There were times that I made mistakes, but I have learned that everyone makes mistakes and it's all about learning from those things. Throughout all my clinicals I learned many things and was able to get my hands on different skills. I look forward to learning more and continuing to grow!

Student eSignature & Date __Brooke Schafer_____