EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Kayli Collins

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/2/2024

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

Faculty eSignature: Nicholas A.

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 Feedback	Faculty
Care Map Grading Rubric	Documentation
Administration of Medications Reflection Simulation Scenarios	Clinical

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)

Skills Demonstration

Evaluation of Clinical Performance Tool

Clinical Discussion Group Grading Rubric

Lasater Clinical Judgment Rubric

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	Fina
Competencies: **a.** Identify spiritual needs of patient (Noticing).									NA	NI S	S	NA	S	NA	NA	S
b. Identify cultural factors that influence healthcare (Noticing).									NA	NI S	S	NA	S	NA	NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
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	S
		NS				BL	CB	CB	CB	NS	NS	NS	NS	NS	NS	NS
Clinical Location; Patient age**		Meditech				No Clinic	NA	3T, 70	NA	4N, 80	4N, 74		4N, 87	NA	NA	Final

	Orientation				al										

Comments

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

Week 8(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 (1a, b): I put NI for these sections because I found it very difficult and awkward when actually the patient if he had any religious practices. I only asked one question because my patient was not very talkative in the morning but I feel I should have tried talking to him about his religion more when he was more talkative. Kayli, I appreciate the self-reflection for these competencies. This isn't something that will come up in every clinical. Some patients will make their spiritual/cultural wishes known, others we may have to ask. I will keep these as NI since you self-rated; however, consider rating yourself as satisfactory moving forward if you simply ask the patient "do you have any spiritual or cultural considerations I should be aware of." You can keep it simple, since it can be an awkward topic of conversation depending on the situation. NS

Week 9 1(c,d) – You did a great job this week respecting your patient's wishes and needs when coordinating your care for the day. You were able to perform important nursing assessments, then respected his wishes to rest due to being awake most of the night. There are times patients will be resistive to care or refuse; however, there are certain tasks that are important to complete such as vital signs and assessments. I think you did well to manage your care effectively and were able to use Maslow's to first address his physiological needs, then followed up with his hygiene needs when he was feeling up to it. NS

Week 10 1(a-d) – Good work again this week coordinating your care appropriately. Your patient was overall fairly independent with most of his needs. However, you were able to prioritize your assessments while also respecting his wishes and needs. You did well to continually round and assess the needs of your patient while promoting

independence and comfort throughout the week. You were able to focus on his physiological needs related to bowel elimination in addition to his pain and discomfort. You promoted self-esteem and hygiene needs and used good communication to form a connection with your patient. NS

Week 12 1(a-d) – This week you were challenged with a different type of patient care experience then you have had previously. Your patient was admitted with a fall and subsequent hip fracture that required surgical repair. During your time caring for him, he was over a week post-op and was awaiting placement in a long-term care facility. AS a result, you priority focus was related to his mental status from underlying dementia, safety in the hospital environment, skin integrity, and history of dysphagia. As you noted, your approach to performing an assessment was altered due to his confusion related to dementia. You prioritized your care well, maintained his safety throughout the week, and implemented an appropriate plan of care related to his priority needs. Great job! NS

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

Objective																
2. 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	S	NA	S	NA	NA	S
b. Use correct technique for vital sign measurement (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						NA	NA	S NA	NA	S	S	NA	S	NA	NA	S
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	S	S	NA	S	NA	NA	S
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	S	NA	S	NA	NA	S
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	S NA	NA	NA	NA	NA	NA
g. Describe the findings and the rationale for diagnostic studies with the nursing implications									NA	S	S	NA	S	NA	NA	S

for assigned patient (Interpreting).																
		NS				BL	CB	CB	CB	NS	NS	NS	NS	NS	NS	NS

Comments

Week 8(2a,b): Kayli, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. Competency 2c was changed to a "NA" because you did not complete a fall assessment this week in clinical. CB

Week 9 2(A) – Good job with your assessments this week! You were able to notice deviations from normal in addition to normal findings. You noticed bilateral hand contractures, limited movement and unsteady gait, a lesion to his right ear, bruises and scabbing, and the use of an external male catheter. NS

Week 9 2(c) – You were able to perform the Johns Hopkins Safety/Falls assessment this week and noticed that your patient was a high fall risk. You were able to describe the factors that led to his increased risk in your CDG, noting that his frequent falls at home put him at an automatic risk. You were able to gain experience in implementing safety precautions, specifically setting up a chair alarm when transferring your patient to the bedside chair. NS

Week 10 2(d,e,g) – You carefully assessed your patient's skin integrity this week related to his surgical procedure performed to his abdomen. You were able to monitor the significant bruising that he was experiencing post-op. You discussed the use of a skin marker to outline the bruising to determine if it was spreading. Furthermore, you monitored his incision site, noting partial dehiscence to the lower aspect of the wound and ensured the dressing stayed dry and intact. (E) – you discussed your patient's nutritional intake in your CDG this week. You identified his clear liquid diet and discussed the rationale based on his diagnosis. Nice job correlating his abdominal pain and associated symptoms to his nutritional intake. (g) – you were able to discuss the diagnostic findings related to his abdomen xray and the findings of his open laparotomy procedure. NS

Week 12 2(a,c) – Your head to toe assessment required a different approach in data collection this week. Due to your patient's lethargy, confusion, and underlying dementia, you had to change your approach in collecting subjective data. You tailored your assessment to your patient's needs and documented your findings accurately. With safety being a priority concern for his pending discharge, you were able to conduct a thorough safety assessment and ensured all appropriate precautions were in place. You identified potential safety concerns related to medication administration and discussed ways to address these concerns. Well done! NS

* End-of-Program Student Learning Outcomes

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

Objective																
3. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*																
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**	**Fina**
Competencies: a. Receive report at beginning of shift from assigned nurse (Noticing).						NA	NA	U	U	S	S	NA	S	NA	NA	S
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	NA	S NA	NA	S	S	NA	S	NA	NA	S
c. Use appropriate medical terminology in verbal and written communication (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
d. Report promptly and accurately any change in the status of the patient (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
e. Communicate effectively with patients and families (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S

	NS				BL	CB	CB	CB	NS	NS	NS	NS	NS	NS	NS

Comments

I felt that I deserved a "U" for competency "A" because I had a hard time following what the nurse was saying during report at the beginning, I was only able to get little pieces of information and felt that I was missing key details until I was handed the report paper and able to fill it out on my own paper. I will try to practice with my mom on better understanding how to write all the information that I'll be given during report. Kayli, receiving report will become easier the more times you experience it. Just know you are always able to ask questions and look up information in the patient chart. CB

Week 8(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. Competency 3b was changed to a "NA" because you did not give a hand-off report to the RN before leaving the unit. CB

Week 9 3(a,b) – You are beginning to gain more experience and confidence in receiving and providing hand-off report. You were able to utilize the SBAR sheet to update the assigned RN on your patient's status prior to leaving the floor. (e,f) – you communicated well with the patient and the health care team throughout the day. You were accountable for your assessments and nursing interventions and participated as an active member of the health care team. Well-done! NS

Week 114(e) – You did well communicating with your patient this week despite his underlying confusion. You explained interventions to be performed, ensured he was comfortable with your care, and helped redirect him during times of confusion. You also gained experience in communicating with family members in the room. I noticed on day 2 when family came to visit that they were excited to see you. This shows that you were able to develop a rapport with the patient and his family. You also communicated well with your peer in allowing her to learn from your patient experience. Excellent teamwork and collaboration was witnessed. NS

* End-of-Program Student Learning Outcomes

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

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

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

Week 9 4(f) – Overall you did well to answer the question prompts for your CDG for week 9. See my comments on your post for further details/questions. You did a nice job responding to Cora and providing additional insight into the conversation with support from a reputable resource. One tip for future success with APA formatting, when providing an in-text citation such as the one you included for the Cleveland Clinic, be sure to include the publishing year in the in-text citation (Cleveland Clinic, 2024) for example. You can also state …. "The Cleveland Clinic (2024) states…." Unfortunately, this competency was changed to a "U" due to your initial post not including an in-text citation or a reference. According to the CDG grading rubric, posts that do not include a citation or a reference are marked unsatisfactory. Be sure to have the CDG grading rubric readily available to ensure all aspects are met. Also, be sure to address the "U" in a comment next week. Let me know if you have any questions! NS
I will be sure to include an in-text citation and a reference for all of my CDG posts moving forward. NS

Week 10 4(e) – Great work with your CDG prompts this week. See my comments on your posts for further details. All criteria were met for a satisfactory evaluation. NS

Week 12 4(e) – Overall your initial post provided good detail and answered the question prompts appropriately. You did well reflecting on your medication administration experience and provided insight into some of the challenges you experienced. Good research was demonstrated in discussing five different prescribed medications that were administered during your care. NS

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

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

Comments

****You must document the location of the pull station and extinguisher here for your first clinical experience. Both next to the nurses station, near exit Thank you! CB**

Week 8(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 5(a,d,e) – You were able to gain experience in transferring a patient using a x2 assist from the bed to the chair. In doing so, you performed safe body mechanics to maintain the safety of both you and the patient. Good job finding a team member to assist to prevent injury. (d) you were able to manage patient care well this week, experiencing some new situations and assisting your peers in other rooms. You used good time management to obtain important assessment data while also allowing your patient time to rest. Your good time management skills allowed you to observe other patient situations with your classmates. NS

Week 10 5(c) – This competency was changed to "NA" because your assigned patient did not have a foley catheter in place during your clinical experiences. Be sure to pay close attention to the competencies you are addressing. NS

Week 12 5(g) – This week you gained experience performing wound care to a non-healing head abrasion. You used good aseptic technique in removing the old dressing. You assessed the wound bed and surrounding tissue carefully, noting scant amount of drainage on the old dressing. You closely review the provider's orders for the new dressing change, and appropriately applied a new dressing, including proper labeling of the dressing change. The wound assessment was performed and documented accurately in the chart. Well done!

* End-of-Program Student Learning Outcomes

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

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

Comments

Week 9 6(a) – Clinical judgement skills were utilized to identify a priority nursing problem based on the patient care provided and assessments performed. You correctly identified circulation as a priority concern related to his AAA diagnosis and pending surgical intervention. NS

Week 10 6(a) – You are continuing to enhance your clinical judgement skills with each experience. This week you identified limited bowel motility as your patient's priority problem related to his recent open laparotomy surgery for possible bowel obstruction. You correlated his symptoms of abdominal pain and absence of a bowel movement in addition to diagnostic findings and risk factors to formulate your priority of care. NS

Week 12 6(a) -Good work identifying impaired skin integrity as a priority nursing problem this week. His immobility, dementia, poor nutrition, recent surgery with incision and wound vac, and various skin tears helped support this priority. You did well describing pertinent interventions

to be performed related to your priority problem in your CDG. During patient care, you used good clinical judgment skills in identifying his history of dysphagia and implementing interventions during medication administration to promote safety. Good work! NS

Week 14 6(a) – Satisfactory care map completion with the priority nursing problem of acute pain. See attached care map grading rubric. NS

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

Objective																
7. 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	S
b. Recognize patient drug allergies (Interpreting).									NA				S	NA	NA	S
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				S	NA	NA	S
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				S	NA	NA	S
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				S	NA	NA	S
f. Assess the patient response to PRN medications (Responding).									NA				S	NA	NA	S
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			S	S	NA	NA	S

*Week 11: BMV		NS							CB			NS	NS	NS	NS	NS

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 12 7 (a-g) – You did a great job this week with your first medication administration experience as a student nurse! Unfortunately, with this being your first experience, you were challenged with having to administer medication to a patient with dementia and dysphagia, requiring a different approach to medication administration. You did a great job researching your medications, including the classification, indication, side effects, and nursing implementation. You followed the 7 rights of medication administration closely, noting that several of the medications could not be crushed or chewed. You noticed in report that the night shift nurse stated he takes all of his medications crushed in applesauce. You used good noticing skills to identify pills that could not be crushed or split, and discussed alternate actions to be performed. You were able to gain experience administering several different PO medications, performing the three safety checks, and using the BMV scanner for patient safety. You carefully assessed for pocketing, ensuring the patient swallowed all medications mixed with pudding. This required frequent cuing and reminding to swallow. Experience was gained crushing appropriate medications and administering with pudding. Overall very well done with a challenging first experience! NS

* End-of-Program Student Learning Outcomes

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

Objective																
8. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. **Reflect on areas of strength****(Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	S
b. **Reflect on areas for self-growth with a plan for improvement. **** (Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	S
c. Incorporate instructor feedback for improvement and growth (Reflecting).						NA	NA	S	S	S	S	NA	S	NA	NA	S
d. Follow the standards outlined in the FRMCSN policy, “Student Code of Conduct” (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
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	S
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
g. Comply with patient’s Bill of Rights (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
h. Respect the privacy of patient health and medical information as						NA	NA	S	S	S	S	NA	S	NA	NA	S

	required by federal HIPAA regulations (Responding).															
i.	Actively engage in self-reflection. (Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	S
*			NS				BL	CB	CB	CB	NS	NS	NS	NS	NS	NS	NS

**** 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 8:
Strength: I felt I was able to effectively explain to the patient that I was going to perform a head to toe assessment and vital signs, I explained each step as I was doing it, stopping whenever the patient felt they needed to eat or use the bathroom, etc. Kayli, great job communicating with your patient and explaining what you were doing. CB
Weakness: I forgot most of the leg assessment during the head to toe, including both pulses and capillary refill. I will practice my head to toe assessment with my boyfriend during this week so I can remember all the steps. Kayli, you have a great plan in place to ensure that you are completing a thorough head to toe assessment. CB

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

Week 9:
Strength: I felt that I achieved all of my assessments and documentation safely and effectively. I gained a lot of confidence since the first clinical and trusted my judgements and asked questions when I felt that I needed something to be clarified or explained more. That's great to hear! Good strength to note when comparing your first clinical experience to your second. The more question you ask and more experience you can obtain, you will notice your confidence continue to increase. Always ask questions and seek clarification, that is how you will become a well-rounded nurse! Great job. NS

Weakness: While I did complete all of my initial documentation in a timely manner I still struggled with finding the right section to edit my documentation for things like pupil reaction time. In order to get better at this I will focus more on where everything is located when we do Meditech in lab. Your comfort level with meditech will increase with each experience. Don't hesitate to ask questions related to documentation! I think you have a good plan for improvement moving forward. Keep up the hard work! NS

Week 10:
Strength: I feel much more confident in all my abilities, I fixed things that I was struggling with during the last couple clinicals. I think my biggest strength during this week was understanding the patients needs. I offered him chanced to go to the bathroom and found his nurse when he needed PRN medications before asking all the questions that I needed to, so that he would be more comfortable. This is great to hear! This entire purpose of reflection is to help guide improvement through experiences. It seems like you were able to reflect on past experiences to help improve your confidence and abilities. Good job communicating with both your patient and his assigned RN to ensure his care needs were met. NS

Weakness: During the first day I felt that I didn't go into the patient's room and check with him enough. I made sure to do this the second day though. In order to fix this I will continue to make it a point to go in and check on my patient throughout the day during future clinicals. Patient rounding is an important nursing task to ensure their care needs are met. We can eliminate a lot of call lights and promote patient satisfaction by frequently checking on our patients. We can also identify complications sooner by continuously laying eyes on our patient. Good thoughts! NS

Week 12:
Strength: I had a different type of patient this week. He was unable to perform most activities on his own and was confused most of the time. I think I did a good job getting everything done (like assessments and medications) while still maintaining the patient's privacy and comfort. Whenever he would try to get out of bed because he thought he was late to something during an assessment I found that saying things like "we'll get you there on time" or "you don't need to leave yet, we'll do this and then get up" calmed him down. Kayli, I thought you did a great job caring for a new type of patient this week then what you previously experienced. You took on the challenge and did a great job providing care to him throughout the week! Good job using redirection to help orient your patient and promote safety. NS

Weakness: Since he was so confused and hard to wake I feel that I did not try hard enough to ask him questions. With previous patients I asked them about their families and jobs, etc. I feel I could've attempted to do this more with my patient this week. I will review communication techniques for my next clinical experience. Overall you did well communicating with him. Its hard to know if his long-term memory was still intact to be able to answer questions. However, the only way to find out is to ask! Something to think about for future clinical experiences. Keep up the hard work! NS

Final Clinical Comments – Kayli, **congratulations** on completing your first semester of clinical in nursing school with a satisfactory evaluation, certainly an accomplishment worth celebrating! It was a pleasure to work with you throughout this semester. You have shown tremendous growth in just this one semester and I am excited to see you continue to grow throughout your time here. From your first clinical day to your last, your confidence rose and your skills improved. It was awesome to watch as you put things together and light bulbs began to light up with clinical judgement and understanding your patients as a whole. You made great use of your time and put in the effort to learn more about your patients. You were honest with yourself and your areas of weakness, and you worked hard to improve on these areas through self-reflection. You asked good, appropriate questions to enhance your learning and to promote positive outcomes for your patients. It is evident that this means a lot to you and that you truly care about your patient's well-being. Overall you had a very successful first semester! I look forward to working with you next semester as you continue your journey and take one step closer to achieving your goals. Great job and keep up the hard work! NS

* 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
11/18/2024	Acute Pain	*S/NS	*NA/NS

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**

Student Name: Kayli Collins	**Course Objective:** 6
Date or Clinical Week: Week 11	

	Criteria	**3**	**2**	**1**	**0**	**Points Earned**	**Comments**
Notic	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	Five abnormal assessment findings were listed. A description was provided explaining why less then seven were identified. However, there were some additional assessment findings that should have been included. You could include his flatulence but lack of BM, firmness of the
	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)**	2	

ing	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	abdomen, use of glasses, abdominal incision from surgery, etc. Three abnormal labs/diagnostics were listed. There were some important diagnostics that were omitted, such as; d-dimer of 305, BNP of 112, low total protein of 5.5, low albumin of 3.2. Most importantly, the abdominal x-ray and CT scan were omitted which demonstrated gaseous distention, constipation, and possible small bowel obstruction. Since his pain was primarily from the constipation and delayed gastric motility, these would be important to note and include. Seven risk factors were identified based on the patient's current and past medical/surgical history. There were some others that could have been included, such as history of lumbar decompression, bladder surgery, carpal tunnel surgery, cholecystectomy, and most importantly, the open laparotomy that he underwent during this hospital stay. The open procedure resulted in incisional sites and extensive bruising that contributed to his priority problem of pain.
Interpretin	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	1	Two nursing priorities were identified, with acute pain being selected as the top priority problem. I would consider stating his top priority problem as being the delayed gastrointestinal motility, as this was the primary cause of the pain he was experiencing. However, pain was his main problem while caring for him so it would be appropriate to prioritize this as the top priority. One point was given for this section because there are numerous other priority problems that could/should have been listed. Consider his recent surgery and subsequent incision and lack of PO intake.
	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	

g	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	I would consider including risk of infection, constipation, impaired skin integrity, impaired nutrition as some examples of additional priorities to list. You want to be thorough in identifying priority problems and intervening appropriately. The goal statement is a positive statement directly related to the top priority problem. Potential complications were identified: limited mobility, altered mental status, and abuse of pain medications. Each listed complication included signs and symptoms to monitor for.
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	A list of 11 nursing interventions were included in the plan of care. The listed interventions are relevant to the patient situation and appropriate for the plan of care. Based on the patient situation, several interventions were omitted. Consider including interventions regarding his nutrition, such as advancing diet as tolerated. His total protein was low and he was on a full liquid diet. It would also be important to perform a focused assessment of the GI system, since this was the cause of his pain. You would also want to assess skin integrity related to the incision site and perform skin care to reduce the risk of infection. You could also encourage fluid intake to promote bowel movement, administer stools softeners or laxatives, etc. Interventions were prioritized appropriately with assessments taking highest priority. Each listed intervention included a frequency. One point was deducted for interventions being individualized, due to several interventions that were performed during your care not being listed as mentioned above. The listed interventions are realistic to the patient situation.
	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**	2	
	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	

	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	Rationale was provided for each listed intervention.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	Based on the identified abnormal assessment findings, an evaluation that includes a list of re-assessment findings was included, showing progress towards the stated goal. Since the goal was not completely met, it was appropriately determined to continue the plan of care.
	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:
Kayli, overall nice work with your first care map submission for the priority problem of acute pain. I think you might have been better off with the priority problem of dysfunctional gastric motility, as this was the main cause of the pain and led to the surgery being performed, causing the bruising and skin integrity issues. However, I agree that pain was the main focus during your care. Based on that, there were some interventions that were pertinent to the gastric motility that would have also focused on the pain as well. Some points were deducted from the noticing section for not including all risk factors and labs/diagnostics that were available for you to view. Otherwise, you did a nice job of connecting the various pieces related to patient care during week 11 and developed a good plan of care to address the problems and promote achievement of your stated goal. Be sure to review the feedback provided for continued success with care maps throughout the program. Let me know if you have any questions! NS

Total Points: 38/45 – Satisfactory

Faculty/Teaching Assistant Initials: NS

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: 11/12/2024	**Date: 11/26/2024**
Evaluation (See Simulation Rubric)	S	S
Faculty Initials	CB	NS
Remediation: Date/Evaluation/Initials	NA	NA

* Course Objectives

11/5/2024 – See attached evaluation scoring sheet. NS

11/26/2024 – See attached evaluation scoring sheet. NS

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Jessica Bower (M), Kayli Collins (O), Gracey Crabtree (A), Brianna Dobias (O)
GROUP #: 7
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/12/2024 0900-1000

CLINICAL JUDGMENT COMPONENTS	**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) * • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	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, HR 88, RR 18, B/P 130/74. SpO2 of 90% RA. Did not notice low SpO2 (90%) as abnormal (discussed in debriefing). Noticed abnormal lung sounds as coarse/clear (discussed in debriefing- crackles). Noticed cough. Noticed tissues in bed. Did not notice sputum in tissues until prompted by the patient. Asked patient about sputum, consistency, and color. Noticed redness to heels when patient complained of pain (discussed in debriefing). 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. Allergies verified. Noticed indications for atorvastatin and multivitamin. Noticed potential adverse reactions and side effects.
INTERPRETING: (1,2,4,6,7) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	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.
• 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	Promptly performed pieces of a head-to-toe assessment. Did not perform a neuro, pain, musculoskeletal, or integumentary system assessment. Did not check pedal pulses, radial and dorsalis pedis pulses checked with thumb instead of index finger. Remember that a head to toe assessment is systematic from head to toe (discussed in debriefing). 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 91% by raising the head of the bed and applying oxygen at 2L per nasal cannula as per physician's orders. Responded to the patient's complaints of pain to bilateral heels by initiating a pillow to offload pressure. 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. Education provided on incentive spirometer. Education provided on fall precautions. Utilized BMV scanner for medication administration.
REFLECTING: (1,2,4,5,6,8) *	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!
• Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	

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.**

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Brianna Dobias (A), Kayli Collins (M), Gracey Crabtree (O), Jessica Bower (O)
GROUP #: 7
SCENARIO: NF #2
OBSERVATION DATE/TIME(S): 11/26/2024 0900-1000

CLINICAL JUDGMENT COMPONENTS	**Observation Notes**
NOTICING: (1,2,4,6,7) *	**Focused Observation** Focused assessment on patient vital signs Focused observation on patient's respiratory system due to patient's cough. Focused observation on patient's pain
• Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	**Recognizing Deviations from Expected Patterns** Noticed patient's vigorous cough. Noticed vital sign measurements. Noticed reddened heels. Noticed patient's pain with coughing (7/10) Did not notice Spo2 of 88% on RA initially. Eventually noticed SOB and Spo2 of 88%. Noticed improved Spo2 after oxygen administration. **Information Seeking** Sought information on how patient is feeling when entering the room Sought information on patient's cough and sputum production. Sought additional information on patient's pain (rating, location, radiating pain, aggravating factors, description). Consider looking at the pain site. Remember to assess allergies prior to medication administration. Consider asking patient preferred injection location.
INTERPRETING: (1,2,4,6,7) *	**Prioritizing Data** Prioritized vital sign assessment Prioritized full pain assessment. Prioritized oxygen administration for low Spo2. Prioritized interventions for oxygenation. Prioritized pain medication administration. Prioritized focused respiratory assessment prior to head to toe assessment. Prioritized pain management with medication administration.
• Prioritizing Data: E A D B • Making Sense of Data: E A D B	**Making Sense of Data** Made sense of MAR for pain medication orders indications. Made sense of crackles related to pneumonia. Made sense of pain related to pneumonia. Made sense of provider order to maintain Spo2 >93% Did not make sense of syringe for morphine dosage, incorrect dosage calculation. Made sense of reddened heels.

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** Introduced self and role when entering the room. Med nurse introduced self and role when entering the room. Managed the situation well. Did not show signs of stress/anxiety. Kept patient informed. Worked well as a team. **Clear Communication** Good teamwork and collaboration reviewing the MAR. Excellent teamwork and collaboration/communication. Good communication with the patient throughout. Interventions explained. Good education provided over various topics. **Well-planed intervention/flexibility** Elevated HOB for shortness of breath and low Spo2. Re-assessed Spo2 after elevating the HOB. Applied 2L NC for Spo2 of 88% on RA. Re-assessed Spo2 after oxygen administration. Elevated feet with pillows for reddened heels. Educated on coughing and deep breathing. Considered incentive spirometry after pain medication administration due to pain. Considered breathing treatment for SOB. Called Respiratory for breathing treatment. Re-assessed vital signs and respirations prior to morphine administration. Communicated findings with med nurse. Educated on morphine side effects (respirations). Educated on injection site in the deltoid. Re-assessed pain after medication administration. Re-assessed Spo2 after medication administration. Educated on splinting with coughing. **Being Skillful** Safety checks performed. BMV scanner used for patient safety. Confirmed name and DOB prior to med administration. Correct needle size selected. Good technique with injection, remember to aspirate prior to administration. Remember needle safety on the table not your finger. Administered 12mg of Morphine instead of ordered 4mg. (Main focus of debriefing on how to read a syringe and compare to the MAR related to medication concentration and syringe volume. Students did well discussing nursing measures to be performed if a medication error occurs. Discussed and remediated during debriefing).
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: 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 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: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. 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: Focuses on the most relevant and important data useful for explaining the patient's condition. 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. Communicates effectively; explains interventions; calms and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Is hesitant or ineffective in using some nursing skills.

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.

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: 9/4/24**	**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	NS	AR	CB	AR	FB	AR	CB	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

***Course Objectives**

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

Student Name: Kayli Collins

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

- Edvance360 Learning Management System.

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

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

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

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

Week 3 (Vital Signs):

Awesome work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two 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 98/64, which was slightly out of the range for a satisfactory result. The second measurement was set at 126/88 and you interpreted it as 120/90, within the desired range. The third measurement was set at 146/80, and you interpreted it as 148/82– within the desired range! 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 arm in which the blood pressure was obtained. The instructions stated to document the blood pressure as being obtained in the right arm. 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 2 prompts related to full pain assessment and completing vital signs. 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 inaccurate and 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**- Documentation was accurate and complete.
- **Vital signs**- oxygen omitted "room air"

- **Safety**- Documentation was accurate and complete.
- **Physical reassessment**- HEENT (nose)- omitted “no complaints, external nose normal, no discharge”. Psychosocial- Omitted comments “My husband died two weeks ago.” “I just don’t feel like taking meds anymore when I am at home.” Respiratory- omitted depth “shallow”; documented “nasotracheal suction” rather than “spontaneous”. Cardiovascular (edema)- omitted left upper extremity “non-pitting, puffy”. Neurological (coma scale)- documented verbal “oriented” rather than “confused” obtaining a total of 15 instead of 14.

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. One prompt was needed during the removal as a reminder to empty the foley bag prior to beginning the removal procedure. You did not require any prompts during the sterile glove application or insertion 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. 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 require a prompt related to using skin prep and initiated/maintained the "clean" field and followed aseptic technique throughout. Your communication with the patient was excellent. Documentation was completed related to wound care and patient rounds in the Meditech system. Additionally, you participated in the stoma care station to gain additional knowledge and skills. Clinical scenario questions were presented to the group with active participation from all students. Great job this week! CB

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: __Kayli Collins 12/02/2024_____