EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Morgan Allison

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)

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	S	N/A	S	N/A	N/A	S
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	S	N/A	S	N/A	N/A	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						S	N/A	N/A	S	S	S	N/A	S	N/A	N/A	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						S	N/A	N/A	S	S	S	N/A	S	N/A	N/A	S
		NS				BL	CB	CB	CB	HS	HS	HS	HS	HS	HS	HS
Clinical Location; Patient age**		Meditech Orientation				3T (Age)	NA	NA	NA	3T 84	3T 63	No Clinical	3T 88	No Clinical		

Comments

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

Week 6-1(c) Morgan, excellent job this week providing care to your patient while respecting her individual preferences, values, and needs. BL

Week 9 (1c)- You did an excellent job planning your care for your patient this week especially when you asked the patient while getting ready for hygiene care, "how do you do it at home." Great job! You allowed for the patient to have a say in their care while asking a specific question such as that. HS

Week 10 (1c,d)- Great job being respectful of patient's values and preferences while coordinating care for your patient during this clinical rotation. Your patient needed minimal assistance with care however, you made sure to take her needs into consideration while providing the care. HS

Week 12 (1c)- 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	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
b. Use correct technique for vital sign measurement (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						~~S~~ NA	N/A	**N/A**	NA	S	S	N/A	S	N/A	N/A	**S**
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	S	S	N/A	S	N/A	N/A	**S**
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	S	N/A	S	N/A	N/A	**S**
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	NA	N/A	N/A	N/A	N/A	**NA**
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).									NA	S	S	N/A	~~N/A~~ S	N/A	N/A	**S**
		NS				BL	CB	**CB**	CB	HS	HS	HS	HS	HS	HS	**HS**

Comments

Week 6-2(a,b) Great job this week utilizing the correct technique for vital sign measurement, and completing a systematic head to toe assessment on your assigned patient. Your head to toe assessment was thorough and done in a timely manner. As a reminder, it is important to always remove articles of clothing on the patient to help you perform a thorough and accurate assessment. Your patient's priority assessment issue was her infected toe; therefore, it would be important to remove her sock in order to

properly inspect and palpate. With that being said, I know this was your first time and you were nervous. You did a great job consulting with the bedside RN for assistance in doing this, and in the future, you can always ask for assistance from your faculty member to help you if you are uncomfortable or unsure as well. 2(c) This competency was changed to "NA" because you did not have the opportunity to perform a fall/safety assessment and institute appropriate precautions for your patient this week in clinical. Going forward, you will have more opportunities to do this and become satisfactory. Keep up all your great work! BL
Week 9 (2a-d) You did a nice job this week with obtaining your assessment, vital signs, fall/safety and skin risk assessment for your patient. You were able to identify areas of concern based on her limited vision. HS

Week 10 (2a-e) You did a great job performing all assessments, especially focusing on her current diagnosis as well as incorporating her neuro and musculoskeletal assessments due to her history of a stroke. You also demonstrated the ability to gather information from assessments performed to determine a priority problem for your assigned patient. After determining the priority problem, you implemented all necessary interventions. HS

Week 12 (2a-e) (2a,c,d)- You did a great job performing appropriate assessments. You provided pertinent information from assessments, labs, and diagnostic testing to determine a priority problem for your assigned patient. Associated interventions were implemented that were relevant to the priority problem based off of information gathered.
(2g) I changed this competency because you reviewed the CXRAY and CT scan on your patient and were able to discuss the findings and how they correlated with your patient's condition. You also did a good 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).						~~NA~~ S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						NA	N/A	**N/A**	NA	S	S	N/A	S	N/A	N/A	**S**
c. Use appropriate medical terminology in verbal and written communication (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
d. Report promptly and accurately any change in the status of the patient (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
e. Communicate effectively with patients and families (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	S
		NS				BL	CB	**CB**	CB	HS	HS	HS	HS	HS	HS	~~HS~~

Comments

Due to my patient leaving for surgery I was unable to get a report and hand off report and had to conduct my own report.

Week 6-3(a) This competency was changed to an "S" because although you did not receive a full bedside report on your patient, you did participate in the handoff report process and listened to the brief updates that were given on your patient. Moving forward, you will have more opportunities to observe and participate in more thorough bedside report/handoff experiences. 3(e) You did an excellent job communicating with your patient this week during clinical, as well as providing discussion related to your communication in your CDG. BL

Week 9 (3a-f) You were able to get a report from the night shift nurse and update the nurse prior to leaving at the end of the shift. You did a nice job communicating with your patient and the other members of the healthcare team during the shift. HS

Week 10(3a-f) Great job receiving and providing pertinent information during shift report, and hand off report. You were able to identify after receiving report and then going in to assess your patient that she was able to communicate with you much better than what you were told during report, and you passed this information on to the primary nurse caring for the patient. Appropriate medical terminology was used during all communications provided. Good job communicating appropriately to staff RN and other health care disciplines when necessary. HS

Week 12 (3d,e)- You have demonstrated the ability to respond appropriately to any changes that may occur with your assigned patient. Reporting changes from assessments, vital signs, or symptoms has been prompt and to appropriate reporting structure. You acting promptly in notifying the nurse of the elevated heart rate, and the indication for the prn medication. You have also displayed the ability to communicate appropriately with patients and their families. Great Job! HS

* End-of-Program Student Learning Outcomes

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

Objective																
3. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Document vital signs and head to toe assessment according to policy (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
b. Document the patient response to nursing care provided (Responding).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S							S	S	S	N/A	S	N/A	N/A	**S**
e. Provide basic patient education with accurate electronic documentation (Responding).									NA	S	S	N/A	S	N/A	N/A	**S**
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).						S	N/A	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
*Week 2 –Meditech		NS				BL	CB	**CB**	CB	HS	HS	HS	HS	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 6-4(a) Excellent job with your documentation this week in clinical. Your documentation for both your vital signs and head to toe assessment were thorough and accurate. 4(c) Great job in your CDG discussing the use of informatics and technology in the clinical setting. You provided a nice description of how you utilized the patient's vital signs data to look for trends and identify any changes. 4(f) Satisfactory completion of your CDG this week. Keep up all your hard work! BL

Week 9 (4a,b)- You did a nice job this week documenting your assessment and vital signs within the EMR.
(4f) (4e)-Nice job on your initial CDG post and peer response this week, you met all of the rubric requirements. HS

Week 10 (4a,b,c) You did a good job with the documentation this week, this will continue to improve. You were able to locate the necessary information from the EMR in order to gain a full understanding of the patients current and past medical information and care provided during the hospitalization. HS
(4f) You did a nice job this week on your initial CDG and peer response and met all of the requirements per the rubric. However, be sure when thinking of a priority problem that we specifically link it to a problem and not a body system or medical diagnosis. For example, fluid volume deficit if the patient does not have an appropriate amount of intake. HS

Week 12 (4 a,b,c) Great job with head to toe assessment, vital signs, and focused assessment. You documented in a timely manner with a couple areas to correct, be sure to take your time and double check the documentation. 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 interventions that you include a frequency for each intervention. HS

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

Comments

****You must document the location of the pull station and extinguisher here for your first clinical experience.There was a fire pull station by the staff lockers and the front desk, and the extinguisher is by the back stairs.** Great job! BL

Week 9 (5d,e,f)- You did a nice job working with your patient and healthcare team and organizing care based on the other disciplines that were in and out of the room. You were able to prioritize and get all of the necessary care completed in a timely manner. HS

Week 10(5d,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. HS

Week 12 (5e): Great job with time management this week with your medication administration. You were able to organize your time and prioritize your patient's needs. HS

* End-of-Program Student Learning Outcomes

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

Objective																
5. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).									NA	S	S	N/A	S	N/A	S	**S**
		NS							CB	HS	HS	HS	HS	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 10 (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 12 (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				S	N/A	N/A	**S**
b. Recognize patient drug allergies (Interpreting).									NA				S	N/A	N/A	**S**
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				S	N/A	N/A	**S**
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				S	N/A	N/A	**S**
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				S	N/A	N/A	**S**
f. Assess the patient response to PRN medications (Responding).									NA				S	N/A	N/A	**S**
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			U	S	N/A	N/A	**S**
*Week 11: BMV		NS							CB			HS	HS	HS	HS	**HS**

Comments

Week 11 (7g) – You did not self-evaluate yourself in this competency therefore it is a U. You did complete BMV in week 11. You attended 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: I received a U because I didn't make sure I filled out all the necessary things II needed to do. Moving forward I will make sure everything is filled out completely to avoid this from happening in the future. HS

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. HS

Week 12 (7a-d, g)- Great job with medication administration! 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)						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
b. **Reflect on areas for self-growth with a plan for improvement. **** (Reflecting)						U	~~N/A~~ U-	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
c. Incorporate instructor feedback for improvement and growth (Reflecting).						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
g. Comply with patient's Bill of Rights (Responding).						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
i. Actively engage in self-reflection. (Reflecting)						U	~~N/A~~ U	**N/A**	S	S	S	N/A	S	N/A	N/A	**S**
*		NS				BL	CB	**CB**	CB	HS	HS	HS	HS	HS	HS	**HS**

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

Week 6 a. I was able to get my assessment done efficiently because my patient was headed to surgery without previous knowledge of the patients diagnosis and medical history. Morgan, you did an excellent job completing your vital signs and head to toe assessment in a timely manner. BL
Week 6 b. I forgot to raise the bed when I was doing my assessment, so next time I will be sure to raise the bed and perform proper nursing body mechanics. Great job identifying an area for self-growth. For future clinicals, don't forget to include a detailed plan for improvement. See the example above to help guide you in doing this. BL

Week 6-8(a-i) These competencies were rated as "U" because you did not self-rate. According to the performance code on page 2 of this document, if a 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. Please be sure to include this on your Week 7 tool. If you have any questions about this process, please do not hesitate to reach out. BL

Week 7(8a-i): Morgan, these competencies will remain rated an "U" until you address on this clinical tool under this objective, how you plan to meet a Satisfactory level. Please read Brittany's original comment for week 6. CB
Week 6&7: I plan to meet satisfactory level by double checking to make sure I have all my objectives completed and looking when I turn them in that they saved. I understand the consequence that can occur when not checking and/or submitting the right material. I will ensure to use that during the remainder of the semester and as I continue on with nursing school, so I don't miss any objectives that needed done. Morgan Allison 10/8/2024 Morgan, thank you for addressing the competencies that were rated an "U" and having a plan to ensure that they remain "S" the rest of the semester. CB

Midterm (8a-i): These competencies are now Satisfactory since you addressed the "U" ratings and have a plan to ensure that all are filled out the remainder of the semester. CB
Week 9 a. I was able to engage with my patients on a one-to-one basis and get to know them outside of their diagnosis. I was able to get my patient to take about her life when she was younger, and I couldn't do that before. Communication gets a little easier with each patient interaction, asking questions often opens the door and allows them to trust you and open up. HS
Week 9 b. One thing I could improve in the fluid and CHO count during meals and how to properly count those. I plan on looking back at my lecture notes and practicing that so I can improve how I calculate it. Be sure to keep the slip from the dietary tray so that you have the exact numbers for each item and then write it down directly on the sheet prior to putting it in the computer. HS
Week 10 a. I received in report that my patient was not really verbal and when walking in the room I was a little nervous on how to communicate with my patient. I went in a tried my best by asking questions about her life and smiling. By the end of my clinical she was able to hold a full conversation with me. That is why it is always important to get your own assessment after receiving report. HS
Week 10 b. My patient had a really low blood pressure on my morning vitals. I freaked out a little bit with knowing what to do and panicked. Next time, I will be sure to go over symptoms of abnormal vital signs and ask/look at trends of my patient's vitals to promote a calm environment. It is important to remain calm in stressful situations, and further assess the patient to determine if they are symptomatic. An appropriate plan to improve upon this area of improvement would be to review the normal vital signs and those symptoms that are associated with abnormal vital signs. HS
Week 12 a. I was able to apply what we learned in lecture about oxygenation to my patient's situation. When walking into the room in the morning she was very short of breath but she was laying down. Using my knowledge that we've obtained in lecture I was able to raise her head in the bed and she felt so much better as well as her lung sounds sounded better. HS
Week 12 b. When giving my patient the liquid form of the medication the MAR said nothing about mixing the med in with juice or water. I feel in the future I shouldn't just rely on the MAR for administration directions, and I should read the package thoroughly before handling the medication. HS

Final comment- Morgan, 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 or Foley catheter, 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

* 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	Impaired gas exchange	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: Morgan Allison **Date or Clinical Week:** 11/18/2024				**Course Objective:** 6			
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	You provided a good list of abnormal assessment findings for your patient. You provided a list of 3 lab findings/diagnostic tests for you patient. Consider on future care maps to include additional abnormal lab findings for the patient. You provided a thorough list of risk factors specific to the patient. 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**	2	You provided a list of 3 nursing priorities, others to consider may include risk of falls, impaired nutrition, and ineffective coping just to list a couple. You identified a goal specific to the top priority for the patient. You highlighted the related data to support the priority problem and identified appropriate potential complications and the signs and symptoms to monitor 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	You provided a thorough list of relevant interventions specific to the top nursing priority, you prioritized them and made them specific to the patient. Several of the interventions did not have a frequency listed. You duplicated a couple of the interventions such as assessing lung sounds, and monitoring breath sounds which are the same. Monitor the use of an incentive spirometer and having the
	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**	3	

							patient demonstrate use would also be a duplicate. If you administer a medication for an intervention be sure that the frequency is included as well. HS

	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**	3	Nice job on reassessing your abnormal assessment findings that were related to the priority problem within the evaluation portion of the care map. 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:

Morgan,

Nice job on your nursing 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. Nice job! 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: 11/12/2024	**Date: 11/26/2024**
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): Morgan Allison (A), Mallory Jamison (O), Sydney Fox (M)
GROUP #: 8
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/12/2024 1000-1100

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (1,2,4,6,7) * • 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, B/P 131/75. SpO2 of 90% RA. Did not notice low SpO2 (90%) as abnormal (discussed in debriefing). Pain assessment performed. Noticed cough. Asked patient about sputum, consistency, and color. Asked patient if it hurts when she coughs. Noticed tissues in patient's bed. Noticed yellow sputum in the tissues. Recognized lung sounds as crackles. Medication nurse introduced self and role when entering the room. Performed 7 rights of medication administration by using the BMV scanning system for patient safety. Accurately identified patient name and date of birth. Information obtain from patient about how medications are taken. Remember to ask about allergies. Noticed indications for atorvastatin and multivitamin. Noticed potential adverse reactions and side effects.
INTERPRETING: (1,2,4,6,7) * • 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) * • 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	Practiced standard precautions with hand hygiene before entering the room. Promptly performed pieces of a head-to-toe assessment. Did not palpate pulses, ask questions pertaining to LOC, or assess the integumentary system. (discussed in debriefing about reddened heels). Remember when auscultating lung sounds, to listen on the chest not over the gown. Elevated HOB when shortness of breath was noticed.

	Collaborative communication between assessment and medication nurse. Communicated with patient about interventions being performed, with questions answered appropriately. Responded to low SpO2 of 90% by raising the head of the bed and applying oxygen at 2L per nasal cannula as per physician's orders. Good body mechanics by raising the bed and lowering the side rails. Communicated am medications with patient. Education provided to patient on medication and side effects after prompted by the patient. Utilized BMV scanner for medication administration. Educated patient on use of incentive spirometer.
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Observers provided good insight during debriefing. Noticed the good infection control measures. Discussed initiating O2 via nasal cannula for low Spo2 per orders. Discussed strengths of both the assessment nurse and medication nurse. Constructive feedback was provided. Identified potentially having the patient sit up in bed to improve lung expansions to improve Spo2 levels. Observers discussed potential educational needs related to the scenario. Noticed the implementation of the six medication rights. Identified positive communication between team members and with the patient. Everyone participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement and discussed ways to make improvements in the future. Good discussions amongst all members of the team. Nice job!
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** • Demonstrate collaborative communication with	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.

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) *	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): Mallory Jamison (A), Morgan Allison (M), Sydney Fox (O)
GROUP #: 8
SCENARIO: NF #2
OBSERVATION DATE/TIME(S): 11/26/2024 1000-1100

CLINICAL JUDGMENT COMPONENTS					Observation Notes
NOTICING: (1,2,4,6,7) *					**Focused Observation** Focused observation on pain Focused observation on patient's vital signs Focused observation on respiratory status due to shortness of breath Focused observation on patient's cough **Recognizing Deviations from Expected Patterns** Noticed elevated BP (138/80), Noticed Spo2 88% on RA. Noticed patient's pain (7/10) Noticed cough and yellow sputum in tissues. Noticed crackles upon auscultation. Noticed reddened heels. Noticed improved Spo2 and pain. **Information Seeking** Confirmed name and DOB when entering the room and prior to medication administration. Compared with wrist band. Sought information on patient's cough and sputum production. Sought additional information on pain (rating, location, radiating, aggravating/alleviating factors) Looked at pain site, palpated. Sought patient understanding of medication to be administered. Remember to assess allergies prior to medication administration.
• Focused Observation:	E	A	D	B	
• Recognizing Deviations from Expected Patterns:	E	A	D	B	
• Information Seeking:	E	A	D	B	
INTERPRETING: (1,2,4,6,7) *					**Prioritizing Data** Prioritized asking patient about pain. Prioritized focused pain assessment. Prioritized focused respiratory assessment. Prioritized vital signs. Prioritized oxygen administration. Prioritized interventions for oxygenation. Prioritized pain medication administration quickly. Prioritized smoking cessation education. **Making Sense of Data** Made sense of crackles related to pneumonia. Made sense of reddened heels. Made sense of provider orders to maintain Spo2 >93%. Med nurse prioritized pain medication administration due to increased pain. Prioritized interventions for oxygenation. Made sense of dosage calculation for morphine administration. Made sense of pain causing reduced cough and deep breathing.
• Prioritizing Data:	E	A	D	B	
• Making Sense of Data:	E	A	D	B	

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** Introduced self and role when entering the room. Med nurse introduced self and role when entering the room. Good teamwork and communication to prioritize care and complete interventions in a timely manner. Excellent communication with the patient regarding interventions to be performed. Educated on morphine 2ml to be administered. Good teamwork and collaboration with medications. **Well-planned intervention/flexibility** Elevated HOB for SOB. Applied O2 via nasal cannula at 2L for Spo2 88%. Performed full focused pain assessment due to complaints. Performed focused respiratory assessment. Considered ice/heat as non-pharmacological intervention for pain. Basin provided for sputum. Considered education on IS and coughing/deep breathing after medication administration. Educated on splinting when coughing for pain management. Educated on fluid intake for secretions. Educated on side effects of morphine administration Re-assessed pain after medication administration. Sought further information related to pain (5/10). Re-assessed vital signs. Considered nicotine patch during smoking cessation. education. Followed up with deep breathing and coughing. Followed up with education with IS. Re-assessed Spo2 after interventions performed. Re-assessed respiratory status. Educated on non-pharmacological smoking cessation techniques. **Being Skillful** Confirmed name and DOB prior to med administration, compared with wristband. BMV scanner used for patient safety. Selected subQ needle instead of IM. Dosage calculation performed accurately. Excess dose waste witnessed. Good teamwork and collaboration. 4mg to be administered. Remember to aspirate prior to injection. Good technique with administration. Good needle safety.

	Safety checks completed for med administration, 7 rights of administration observed.
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 subtle patterns and deviations from expected patterns in data and uses these to guide 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: Focuses on the most relevant and important data useful for explaining the patient's condition. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient's data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success. Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. 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. 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**

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:** 9/16,19/ 2024	**Date:** 9/23/2024	**Date:** 9/30/2024	**Date:** 10/7/2024	**Date: 10/14/2024**	**Date:** 10/21/2024	**Date:** 10/29/2024
Evaluation:	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Faculty Initials	HS	HS	AR	AR	AR	AR	FB	FB	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: Morgan Allison

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):

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 consecutive blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 132/74 and you identified it as 128/74. The second measurement was set at 108/62 and you interpreted it as 112/62. Great job! 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". You did a good job with your first Meditech documentation; please keep in mind the following for future documentation: you omitted the pulse rhythm as "irregular" and the strength as "strong"; you omitted the respiratory pattern as "normal"; you omitted the blood pressure position "supine". All other documentation was accurate. 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):

Excellent job in lab this week! You have satisfactorily performed a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall very well done. You paid close attention to detail and were clearly well-prepared. You did not require any prompts throughout your assessment, nice work! You demonstrated professional and informative communication. You were able to correctly identify the lung sounds as crackles (first identified as wheezing), and bowel sounds as hyperactive. Job well done!

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- all okay

Vital signs- all okay

Safety- omitted "education completed" comment; documented "yes" for commode pad used rather than "no"

Physical reassessment-

HEENT (nose)- Omitted- "no complaints, 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- sputum color documented "white" rather than "yellow"

Cardiovascular (edema)- documented "3+" to bilateral lower extremities rather than "2+"

Musculoskeletal- omitted comment "limited movement to left arm and shoulder, sling intact"

Integumentary- omitted "fingernails- normal, clear, pink"; omitted "left shoulder- bruised, warm, dry, elastic, smooth, ecchymotic"; omitted "no wounds"

Gastrointestinal- omitted "uses stool softener 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. AR

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. During insertion, you required one prompt related to documentation of NG insertion and care in Meditech. During removal of NG tube you required one prompt related to patient instruction to take a deep breath and hold it. Excellent patient education regarding the procedure for insertion, irrigation and removal were provided! You did not require any prompts during irrigation. Great job! You were able to verbalize understanding of the difference between irrigation and flushing. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! FB

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

You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. You did not require any prompts during the sterile glove application, Foley catheter insertion or the removal of the catheter. You had very good communication with your "patient". Great job! You correctly verbalized the differences in catheter insertion for a male patient. Actively participated in the Intake and Output stations, and completed Meditech documentation related to Urinary Catheter Management and Intake & Output. Keep up the great work!!! FB

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

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

You have demonstrated competence in the skill of wound assessment and wound care through guided observation of Dry Sterile Dressing and 1:1 observation of Damp to Dry Packed Wound Dressing Change. During the Damp to Dry Packed Wound Dressing Change, you did require a prompt for identifying yourself and assessing pain prior to the dressing change; you 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: Morgan Allison 12/2/2024_____