

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Brianna Dobias

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/4/2024

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

Faculty eSignature: Fran Brennan MSN, RN

Teaching Assistant: Stacia Atkins, BSN, RN

DIRECTIONS FOR USE:

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S)**, **Needs Improvement (NI)**, **Unsatisfactory (U)**, and **Not Available (NA)**. The faculty member will initial if in agreement with the student's evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, U, or NA". If the student does not self-rate, then it is an automatic "U". A student who submits the clinical evaluation tool late will be rated as "U" in the appropriate competency(s) for that clinical week. Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

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

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
Faculty's Name			Initials
Chandra Barnes			CB
Frances Brennan			FB
Amy Rockwell			AR
Nicholas Simonovich			NS
Heather Schwerer			HS
Brittany Lombardi			BL

Stacia Atkins	SA
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PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

Satisfactory (S): Safe, accurate each time, efficient, coordinated, confident, focuses on the patient, some expenditure of excess energy, within a reasonable time period, appropriate affective behavior, occasional supporting cues, minimal faculty feedback needed related to written clinical work.

UNSATISFACTORY CLINICAL PERFORMANCE

Needs Improvement (NI): Safe, accurate each time, skillful in parts of behavior, focuses more on the skill and self rather than the patient, inefficient, uncoordinated, anxious, worried, and flustered at times, expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues, faculty feedback required in several areas of clinical written work.

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U", the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

***Grey shaded weekly competency boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Objective																
1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Identify spiritual needs of patient (Noticing).									NA	S	S	NA	S	NA	NA	S
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	S	NA	S	NA	NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						U	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).						U	NA	S	S	S	S	NA	S	NA	NA	S
Clinical Location: Patient age**		NS				BL	CB	CB	CB	FB	FB	FB	FB	FB	FB	FB
		Meditech Orientation				No Clinical	NA	NA	NA	T3 51	T3 67	No clinical	T3 82, 75			

Comments

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

Week 6-1(c,d) 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

This week I received a "u" on my competencies because I did not complete the self-evaluation. I plan to resolve this issue in the future by making sure all of the boxes are filled out and turned in properly. Bri, thank you for addressing the “U” rating you received and having a plan to ensure that each competency is filled out properly in the future. CB

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 able to recognize physiological needs of your patient when performing head to toe assessment. CB

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

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

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

* End-of-Program Student Learning Outcomes

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

Objective																
1. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:						U										
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).							NA	S	S	S	S	NA	S	NA	NA	S
b. Use correct technique for vital sign measurement (Responding).						U	NA	S	S	S	S	NA	S	NA	NA	S
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						U	NA	S NA	S	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	NA	NA	NA	NA	NA	NA
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).									NA	S	S	NA	S	NA	NA	S
		NS				BL	CB	CB	CB	FB	FB	FB	FB	FB	FB	FB

Comments

Week 6-2(a-c) 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

This week I received a "u" on my competencies because I did not complete the self-evaluation. I plan to resolve this issue in the future by making sure all of the boxes are filled out and turned in properly. Bri, thank you for addressing the “U” rating you received and having a plan to ensure that each competency is filled out properly in the future. CB

Week 8(2a,b): Bri, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. I changed competency “2c” to a “NA” because you did not perform a safety assessment during this clinical. CB

Midterm (3c): You are Satisfactory in this competency at midterm by addressing a plan to ensure all areas of the clinical tool are filled out properly. CB

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

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

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

* End-of-Program Student Learning Outcomes

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

Objective																
2. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:						U	NA	S	S	S	S	NA	S	NA	NA	S
a. Receive report at beginning of shift from assigned nurse (Noticing).						U	NA	S	S	S	S	NA	S	NA	NA	S
b. Hand off (report) pertinent, current information to the next provider of care (Responding).						U	NA	NA	NA	S	S	NA	S	NA	NA	S
c. Use appropriate medical terminology in verbal and written communication (Responding).						U	NA	S	S	S	S	NA	S	NA	NA	S
d. Report promptly and accurately any change in the status of the patient (Responding).						U	NA	S	S	S	S	NA	S	NA	NA	S
e. Communicate effectively with patients and families (Responding).						U	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).						U	NA	S	S	S	S	NA	S	NA	NA	S
		NS				BL	CB	CB	CB	FB	FB	FB	FB	FB	FB	FB

Comments

Week 6-3(a-f) 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

This week I received a "u" on my competencies because I did not complete the self-evaluation. I plan to resolve this issue in the future by making sure all of the boxes are filled out and turned in properly. Bri, thank you for addressing the “U” rating you received and having a plan to ensure that each competency is filled out properly in the future. 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. I changed competency “3b” to a “NA” because you did not give a hand off report on your patient at the end of clinical. CB

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

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

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

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

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

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

Comments

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

Week 6-4(a-c, f) 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

This week I received a "u" on my competencies because I did not complete the self-evaluation. I plan to resolve this issue in the future by making sure all of the boxes are filled out and turned in properly. Bri, thank you for addressing the “U” rating you received and having a plan to ensure that each competency is filled out properly in the future. 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. I changed competency 4b to a “S” because by documenting vital signs and a head to toe assessment, you are documenting the patient’s response to care provided. 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 a,b,c) Great job with head to toe assessment, vital signs, and focused assessment. You documented thoroughly and in a timely manner. Nice job accessing pertinent information and additional information within the electronic medical record. You were able to identify and gather important information regarding your patient’s problems and testing to provide an accurate plan of care, nice job! (4f)- CDG was appropriately posted following the CDG rubric, on time, and in a substantive manner. Your response to a peer also followed all the CDG rubric guidelines. Keep up the great work. FB

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

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

* End-of-Program Student Learning Outcomes

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

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

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

Week 6-5(a,b,d,e,h) 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

This week I received a "u" on my competencies because I did not complete the self-evaluation. I plan to resolve this issue in the future by making sure all of the boxes are filled out and turned in properly. Bri, thank you for addressing the “U” rating you received and having a plan to ensure that each competency is filled out properly in the future. CB

Week 8- There was a pull station next to room 3036 and an extinguisher next to the nurse’s station. Thank you! CB

Week 8(5a,b): Great job utilizing correct body mechanics and raising the bed while performing an assessment. Competency 5d was changed to “S” because you were able to manage basic care by obtaining vital signs and performing a head to toe assessment. You did a great job ensuring that you foamed in/out when entering/exiting patients’ rooms. CB

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

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

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

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

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

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

Comments

Week 9 (6a)- Great job providing patient centered care to your assigned patient during this clinical rotation. This competency was changed to a “S” because you implemented interventions while providing care to your assigned patient during this clinical experience. Providing care takes clinical judgment skills based on the knowledge you possess at this stage in your education. FB

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

Week 14/makeup (6a)- Your nursing care map was completed satisfactorily, receiving a 37 out of 45 points. See feedback in care map rubric attached below. FB

* End-of-Program Student Learning Outcomes

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

Objective																
6. Convert basic pharmacology principles into safe medication administration. (3,5,6,7)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).									NA				S	NA	NA	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			FB	FB	FB	FB	FB

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

Week 12 (7a)-Great job identifying the action, classification, rationale, and side effects of each medication administered during this clinical rotation. (7c,d)-You demonstrated the use of the seven rights of medication administration and correctly administered oral medications to your assigned patient. (7g) You demonstrated appropriate use of the barcode medication verification system for patient identification and administration of medications was saved. FB

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

**** 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 6-8(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

This week I received a "u" on my competencies because I did not complete the self-evaluation. I plan to resolve this issue in the future by making sure all of the boxes are filled out and turned in properly. Bri, thank you for addressing the “U” rating you received and having a plan to ensure that each competency is filled out properly in the future. CB

Week 8- This week in clinical I charted my assessment findings accurately with the need of a little help to clarify a few areas I was unsure of. One area I would like to improve on for my next clinical day is, remembering all of my head-to-toe assessment areas to cover. I plan to improve on my head-to-toe assessment by my next clinical day by going over my skills check-off list over the weekend and the night before clinical to give myself a reminder of all the areas I need to assess for my assessment. Bri, you did a great job with documentation and the more experience you get in Meditech the easier it will be to find things. You have a great plan in place to ensure that the areas you want to improve in the head to toe assessment are met by reviewing the check-off sheet. 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 (8a)-This week in clinical one of my strengths was that I performed a head-to-toe assessment without forgetting any steps. **(8b)-**One area I would like to improve on for my next clinical day is to complete my assessment in a more timely manner. I plan to improve my time management skills during my head-to-toe assessment by working through it in a more systematic and organized manner. I plan to go through my head-to-toe assessment check off list at least 2-3 times before my next clinical day to help refresh me on which assessments I should do for each body system. Great idea, practice will assist with the process and being able to finish in a quicker time frame.

Week 9 (8f) This competency was changed to an “U” because you did not submit the correct clinical evaluation by the due date and time. Make sure you are submitting the clinical evaluation tool that is returned to you via your dropbox. You are to be reviewing all feedback and implementing any improvement needs. Make sure to address this “U” as stated in the directions at the beginning of clinical evaluation tool. **A “U” in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the “U”, the faculty member (s) will continue to rate the competency unsatisfactory.** FB

Week 9 (8f): This week I received a “U” for not submitting the correct clinical evaluation tool on time. In order to prevent this from happening in the future I plan to double-check that I submitted the right clinical evaluation tool and correct any mistakes in submitting the evaluation tool before the due date. Thank you for addressing. It is always a great habit to adopt, double or triple checking your work is beneficial in making sure work is complete and thorough. FB

Week 10 (8a) This week in clinical I feel that I demonstrated a good understanding of how to perform a sterile wound dressing change and feel confident in doing so in the future. Great job with dressing change during this clinical rotation. FB (8b) One problem I had this week in clinical was running late and showing up to clinical right as we were supposed to be receiving report from the nurses. I plan to prevent this from happening in the future by leaving for clinical earlier and setting multiple alarms in the morning. This is a great idea, you do not want to miss time especially if you are healthy and physically feeling okay. FB

This week in the lab, I understood how to properly administer medication via oral, intramuscular, intradermal, and subcutaneous routes while maintaining an aseptic technique. One area I should improve on is making sure I leave the needle in place for a little longer before removal while administering medication via an intramuscular

route. I plan to avoid this issue in the future by taking a few extra seconds to make sure I remember all of the steps of administering medication instead of rushing through the process. It will also be of benefit to read over the process in your textbook. FB

Week 12 (8a-8b) This week in clinical I feel that I demonstrated how to administer oral medication and an IM injection while practicing the 7 rights of medication administration and 3 checks before administering any medication. One thing I would like to improve on is becoming more educated on the type of medications and their implications of use. I plan to understand medications better by doing my own research at home and studying the different type of medications so I can feel more confident in administering medications in the future. You did a great job following all rights of medication administration. You also demonstrated proper technique while administering oral medications and an intramuscular injection. Keep up the great work. FB

Week 13 This week in sim lab, I felt that I gained a better understanding of when to apply nursing interventions and utilize communication between others to provide appropriate patient care. One area I would like to improve on is understanding the correlation between medication implications and patient signs and symptoms to determine if the medication is currently needed. I plan to improve in this area by thoroughly reviewing the medication implications before administering medications to avoid missing small details of why the medication is to be administered. The more experience you get with medication administration the easier this will become. Familiarizing yourself with medication classifications will also help. There are new medications becoming available frequently, so always look up any medication you are not familiar with. FB

Final- Congratulations, you have satisfactorily completed the clinical component of the Nursing Foundations course. You demonstrated great growth with communication, discussion of rationale for various patient data, navigation in the electronic medical record, clinical judgment (noticing, interpreting responding, reflecting), and professionalism/ACE. You are an accountable member of the healthcare team and able to work independently or with a team. You are efficient and organized during delivery of patient care. It was a pleasure working with you on clinical, and I look forward to working with you in some of your future clinicals. Keep up the great work! FB

* End-of-Program Student Learning Outcomes

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

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/18/2024	Impaired Gas Exchange	* S/FB	*NA/FB

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: Brianna Dobias				Course Objective: 6. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*			
Date or Clinical Week: 11/18/2024							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	2	Good job identifying some of the abnormal assessment findings, lab/diagnostic tests, and risk factors for this assigned patient. Assessment findings missing would include “couple of beers daily”, diarrhea. The lab findings should be provided with information regarding the status of low or high results. Risk factors missing included type 2 diabetes, BPH, and use of home oxygen. Noticing abnormal information assists in a systematic and comprehensive process to determine the priority problem for a patient. The information gathered was both objective and subjective.
	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	Good job analyzing the data to determine the priority problem. The goal statement was generalized and provided as a positive statement. One priority problem that should be considered is knowledge deficit related to need for supplemental oxygen and risk factors contributing to oxygenation issues. The assessment finding that should have not been highlighted was near syncopal episode. A lab finding that would be significant would be the sodium level being low. Risk factors that were omitted were type 2 diabetes, BPH, and home O2 use. The use of oxygen at home would be highlighted due to the impaired gas exchange relevancy. The potential complications were appropriate but the signs and symptoms were not provided for each complication. Make sure you are referencing the nursing care map
	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)	0	

Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	guidelines when completing the care map. Good job providing several interventions that were prioritized and appropriate for the priority problem identified. Additional interventions that would be important to initiate for this patient would be: Assess RR, depth, use of accessory muscles every 4 hr and PRN to provide insight into the work of breathing and adequacy of alveolar ventilation. Monitor for dyspnea on exertion AAT, to evaluate degree of respiratory compromise. Monitor all lab values not just CO2 daily. Educate patient on chronic medical conditions that result in impaired gas exchange by discharge to promote prevention or health management.
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	A rationale was provided for each of the interventions listed.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	1	All highlighted reassessment findings were not reflected upon and evaluated for the nursing priority problem. Lab findings that were relevant such as sodium level, and magnesium level was not addressed. Magnesium level was done on day two and was low so this should have been addressed in evaluation box. None of the risk factors were provided. ALL highlighted findings are to be provided in the evaluation box. The plan of care is to be continued as stated.
	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.	Total Points: 37/45
***Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *** Faculty/Teaching Assistant Comments: Good job for your first care plan, please review comments provided above. Satisfactory completion. Keep up the great work. FB	Faculty/Teaching Assistant Initials: FB

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

<u>Simulation Evaluation</u> Performance Codes: S: Satisfactory U: Unsatisfactory	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Date: 11/5/2024 or 11/12/2024	Date: 11/25/2024 or 11/26/2024
Evaluation (See Simulation Rubric)	S	S
Faculty Initials	FB	FB
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): 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	<u>OBSERVATION NOTES</u>				
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) * - Calm, Confident Manner: E A D B - Clear Communication: E A D B - Well-Planned Intervention/Flexibility: 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 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).				

• Being Skillful: B	EAD 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) * • Evaluation/Self-Analysis: E • Commitment to Improvement: E	EAD B EAD 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	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

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) *	important, but also attends to less relevant or useful data. In simple, common, or familiar situations, is able to compare the patient's data patterns with those known and to develop or explain intervention plans; has difficulty, however, with even moderately difficult data or situations that are within the expectations of students; inappropriately requires advice or assistance. Responding: Is tentative in the leader role; reassures patients and families in routine and relatively simple situations, but becomes stressed and disorganized easily. Generally, communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses. Satisfactory Completion of NF Scenario #1.
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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 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.
• Recognizing Deviations from Expected Patterns:	E	A	D	B	
• Information Seeking:	E	A	D	B	

	<u>Information Seeking</u> 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: E A D B • Making Sense of Data: E A D B	<u>Prioritizing Data</u> 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. <u>Making Sense of Data</u> 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	<u>Calm, Confident Manner</u> 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. <u>Clear Communication</u> 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. <u>Well-planned intervention/flexibility</u> 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	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.

provide appropriate interventions (2,4,5,6,7) *	Satisfactory Completion of NF Simulation #2.
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Firelands Regional Medical Center School of Nursing
Nursing Foundations 2024
Skills Lab Competency Tool

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

***Course Objectives**

Student Name: Brianna Dobias

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 120/72 and you identified it as 120/70. The second measurement was set at 144/80 and you interpreted it as 142/80. 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 documented vital signs twice in Meditech; the second entry was accurate and complete. Keep up the great work!! AR

Week 4 (Assessment):

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

Week 5 (Assessment; Mobility):

Great job in lab this week! You have satisfactorily demonstrated a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall well done. You did require 1 prompt related to assessing for cough, sputum, ease of breathing, etc. You demonstrated friendly, professional, and informative communication. You were able to correctly identify the lung sounds as crackles and bowel sounds as hyperactive. 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- documented site observed as “left shoulder” rather than “WNL”; omitted that “physician is already aware”

Vital signs- all okay

Safety- omitted “education completed” comment; documented “yes” for chair alarm instead of “no”

Physical reassessment-

HEENT (nose)- omitted “no complaints, no discharge, normal sense of smell”

Respiratory (observation)- documented “grunting”

Neurological (pupils)- documented right pupil size as “4mm”

Gastrointestinal (abdomen)- omitted documenting “distended”

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):

Nice job this week in the skills lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. For the Insertion checklist, one prompt was required related to encouraging the patient to raise their hand during the procedure if they need to stop. For irrigation, no prompts were needed. For removal, you also did not require any prompts, well done. You were able to verbalize understanding of the difference between irrigation and flushing and aspiration precautions. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual.

Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! NS

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

You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. One prompt was needed during removal as a reminder to empty the foley bag prior to starting the removal process. 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 one prompt, you dried the wound bed prior to obtaining the wound culture. You were able to initiate/maintain 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! HS

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

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

Week 11 (Medication Lab):

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

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

I was given the opportunity to review my final clinical ratings in each course competency. I was given the opportunity to ask questions about my clinical performance. I have the following comments to make about my clinical performance/final clinical evaluation:

Student eSignature & Date: Brianna Dobias 12/03/2024