

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Aaron Brummett

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/2/20024

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: Heather Schwerer 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)
11/30/2024	1 hr	Simulation survey late	12/1/2024 1hr
Faculty’s Name			Initials
Chandra Barnes			CB
Frances Brennan			FB
Amy Rockwell			AR
Nicholas Simonovich			NS
Heather Schwerer			HS
Brittany Lombardi			BL

Stacia Atkins

SA

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

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

OTHER

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

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

Objective																
1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*																
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Identify spiritual needs of patient (Noticing).									NA	S	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).						NA	NA	S	S	S	S	NA	S	NA	NA	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						NA	NA	S	S	S	S	NA	S	NA	NA	S
		NS				BL	CB	CB	CB	HS	HS	HS	SA	HS	HS	HS
		Meditech Orientation				No Clinical	NA	FRMC 3T, AGE: 79	NA	FRMC 3T, AGE: 90	FRMC 3T, AGE: 60	No clinical	FRMC 3T, AGE: 72	No Clinical		

Clinical Location:
Patient age**

Comments

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

Week 8(1c,d): Great job showing respect for your patient's needs, being compassionate and kind while delivering care. You also demonstrated the appropriate use of Maslow's hierarchy of needs during the head to toe assessment performed on your patient during this clinical experience, being you able to recognize physiological needs of your patient when performing head to toe assessment. CB

Week 9 (1c, d)- You encouraged your patient to participate in the care based on her preferences when assisting her with eating and attempting to perform hygiene care. HS

Week 10 (1c,d)- You did a nice job this week allowing your patient to be involved with his care especially since he had to solely depend on you due to his condition making him unable to move himself or assist in his care. Your patient was young and had to depend on family to provide care while at home, and you made sure to discuss all care with him prior to providing it while he was in the hospital. Great job! HS

Week 12 (1d)- Great job being mindful and showing respect for your patient during medication administration. You recognized that with your administration the patient may feel some discomfort and apologized to them prior to administration. SA

* End-of-Program Student Learning Outcomes

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

Objective

1. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
b. Use correct technique for vital sign measurement (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).						NA	NA	NA	NA	S	S	NA	S	NA	NA	S
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	S	S	NA	S	NA	NA	S
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	S	NA	S	NA	NA	S
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	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	HS	HS	HS	SA	HS	HS	HS

Comments

Week 8(2a,b): Aaron, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. CB

Week 9 (2a-d)- You did a nice job this week completing all of your assessments. Your patient was a bit more challenging since she preferred to sleep for most of the morning however, you were able to obtain all of the necessary information. HS

Week 10 (2a-d) Your patient was very complex and his head to toe assessment had many abnormal findings that needed to be assessed and documented appropriately, you did a nice job of this. You also did a nice job assessing his skin and identifying his risk factors that increased his potential for pressure injury and implemented the appropriate precautions. HS

Week 12 (2a, g)- Great job performing and completing your assessments in a timely manner this week. You remembered to re-assess your patient on day 2 for post procedure string placement as well as other risks. SA

* End-of-Program Student Learning Outcomes

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

Objective

2. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*

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

Comments

Week 8(3a,c,d,e): Great job receiving hand off report on your patient. Good job using medical terminology while communicating with your patient, reporting abnormal findings, and communicating effectively with your staff RN. Competency 3b was changed to a "NA" because you did not give hand-off report to the RN before we left the unit. CB

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)- You did a nice job receiving report, and you also kept the primary nurse informed of all changes throughout the shift. You notified her as you performed the necessary care and interventions prior to the patient going to surgery. You also did a nice job communicating with the patient's daughter as well. HS

Week 12 (3e)- Excellent job communicating with both of your patients this week. Your patient on day 2 talked at length many times, but you did a great job redirecting them and creating a boundary to be able to perform your nursing tasks. SA

* End-of-Program Student Learning Outcomes

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

Objective

3. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:									S							
a. Document vital signs and head to toe assessment according to policy (Responding).						NA	NA	S	S	NI	S	NA	S	NA	NA	S
b. Document the patient response to nursing care provided (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
c. Access medical information of assigned patient in Electronic Medical Record (Responding).		S				NA	NA	S	S	S	S	NA	S	NA	NA	S
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).		S							S	S	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).						NA	NA	S	S	S	S	NA	S	NA	NA	S
*Week 2 –Meditech		NS				BL	CB	CB	CB	HS	HS	HS	SA	HS	HS	HS

Comments

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

Week 8(4a,b,c,f): Satisfactory job with documentation of the head to toe assessment and vital signs of your patient. Make sure to note any areas you may have forgot to assess, so that assessments and documentation are thorough and accurate. You did a good job utilizing Meditech for documentation and to look up patient information. You completed your first cdg, meeting all requirements per the grading rubric, excellent job! CB

Week 9 4a: - I put that I need improvement in this area because I missed to include important information about my patients neurological aspect of the assessment. This information is crucial especially with my patient since she was having acute confusion and an altered mental status. Next time when documenting I will slow down and focus on getting all of the information included. You did miss a couple areas, but were able to correct the documentation. This will get easier with additional clinical experiences. HS

Week 9 (4f) Nice job on your initial CDG post and peer response this week, you met all of the rubric requirements including the intext citation and reference. When thinking of a priority problem for this patient you mentioned that the patient has a UTI, that is a medical diagnosis. Thinking more toward a priority problem for her consider impaired mobility related to her being confused and very tired and not wanting to get out of bed, and the different interventions that you implemented into her care. HS

Week 10 (4a,b,c)- You did a nice job documenting the care that you provided to your patient. You were also able to retrieve the necessary information from the chart regarding the patients history and other pertinent information. HS

(4f)- Nice job on your initial CDG post and peer response this week, you met all of the rubric requirements including the intext citation and reference. HS

Week 12 (4c,e)- Good job this week with your documentation. You utilized your resources to locate information on both patients this week for their diagnoses and procedures. SA

(4f)- Great job providing detail on your initial CDG post and peer response this week, you met all of the rubric requirements including the intext citation and reference. SA

* End-of-Program Student Learning Outcomes

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

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

Comments

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

5h. – One location I noticed for the fire extinguishers was right next to the nurses station on the left hand side when looking towards the nurses station. One location I noticed for one of the pull stations was right next to the directors office right outside of the door. Thank you! CB

Week 8(5a,b): Great job utilizing correct body mechanics and raising the bed while performing an assessment. You did a great job ensuring that you foamed in/out when entering/exiting patients' rooms. CB

Week 9 (5d,e,f)- You did a nice job during clinical especially since your patient was not being very participative during her care. You were able to wait until she became more awake and then provided the appropriate care. HS

Week 10 (5c)- You did an excellent job on maintaining sterility and following all of the appropriate steps when inserting the Foley catheter on your patient. (5d,e) You have demonstrated great management of care for your assigned patient making sure all pertinent interventions were completed. You organized your time appropriately to provide safe, efficient care to ensure positive patient outcomes. HS

Week 12 (5b,d)- You did an excellent job this week with hand hygiene this week. You also displayed appropriate dexterity techniques when administering the patients medication into the ear. SA

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

Comments

Week 9 (6a)- You did a nice job utilizing clinical judgement skills based on your patient’s priority problem and then identifying interventions specific to the patient and developing the plan of care. HS

Week 10 (6a)- Excellent job utilizing your clinical judgment skills to care for your complex 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)- Great job handling both of your patients this week. You were able to utilize clinical judgement appropriately for both of them and in a timerly manner as well. SA

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	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, intramuscular, 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			HS	SA	HS	HS	HS

Comments

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

Objective

2. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies:																
a. Reflect on areas of strength** (Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	S
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)						NA	NA	S NI	NI	S	S	NA	S	NA	NA	S
c. Incorporate instructor feedback for improvement and growth (Reflecting).						NA	NA	S	S	S	S	NA	S	NA	NA	S
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
g. Comply with patient's Bill of Rights (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).						NA	NA	S	S	S	S	NA	S	NA	NA	S
i. Actively engage in self-reflection. (Reflecting)						NA	NA	S	S	S	S	NA	S	NA	NA	S
*		NS				BL	CB	CB	CB	HS	HS	HS	SA	HS	HS	HS

Week 12 (7a)- Excellent job on your first med pass this week. You were able to review and retrieve medications appropriately. You followed all guidelines and rights with administration as well. SA

* End-of-Program Student Learning Outcomes

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

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

Week 8: Strengths – When reflecting back on my first clinical experience I felt as if my strengths throughout my head-to-toe assessment were communication and compassion. I felt like I was building a bridge between my patient and I creating trust by talking and explaining my process when questions arised. **Aaron, great job! Good communication is a must as a nurse, because it creates safe patient centered care. CB**

Week 8: Weaknesses – Understanding that this was my first experience on being in a room and assessing my patient I know I have areas needed for growth. The growth I am striving for is being able to see abnormalities and know roughly what my next actions and plans of care could be. One other area that I could say that I need to get used to is being able to do my job and work effectively with my patient while others are in the room. During my head-to-toe assessment I think I had about 5-6 people come in and out of the room even though the door was shut and patient curtain was pulled back. **Aaron, you have areas of improvement listed here but you do not have an actual plan on how to improve upon them, therefore competency 8b has been changed to a "NI".**

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 9a: Strengths – When reflecting back to my second clinical experience I was hit with new challenges along the way. This being my patient was confused and very sleepy which made my assessment hard to gather correct and current information. Nonetheless, I pushed through and got my assessment done and asked for help when needed. **Yes, you did! Great job this week! HS**

Week 9b: Weaknesses – Some weaknesses I saw within myself and my assessment is that I missed a couple of areas when documenting and I know that this is a very important step. Without documentation it is like the care has never been provided, **and I plan to correct these mistakes by slowing down when I document and trying not to get distracted.** This was my first time in a shared patients room and I believe I stepped away to help someone for a second and that's when my train of thought of where I was at in my documentation was lost. **The documentation will continue to improve with additional experiences within the clinical setting, however interruptions will forever be a challenge. Consider making some sort of a checklist so that you can keep track of what has been documented and what still needs to be done. HS**

Week 10a: Strengths – Reflecting on my week 10 clinical experience, I was granted the opportunity to remove and insert an indwelling foley catheter. This was probably the one lab check off I felt the most confident in when working with a female mannequin. My situation with my patient was on the other side of the spectrum meaning my patient was a male and very much not a mannequin. I was eager and determined to successfully demonstrate my skills that I had learned in the skills lab. My strengths throughout this procedure was that I didn't shy away from the opportunity and I could identify all the steps as I was working through the motions. **You did an excellent job! HS**

Week 10b: Weaknesses – I identified one major weakness in myself when removing and inserting the indwelling foley catheter, which was my communication with the patient before doing anything. I am glad I had my instructor in the room with me to help keep the patient calm and collected throughout the procedure. Communication is one area I always perform well in when conducting my head-to-toe assessment but, I think I was more focused on performance and patient safety with sterility for this procedure. **My plan to improve this area of weakness is to try to be more verbal intentionally at home when doing simple tasks in hopes that it will help trigger a muscle memory effect when working with my patients. HS**

Week 12a: Strengths – Reflecting on week 12’s clinical experience, I was confident and eager to get my first medication pass under my belt. My patient said I did a good job on educating and making the process smooth for his medication pass that morning. I asked all the right questions before hand to get the full grasp of what each medication was compleable of and why this medication was needed for my patient. Great job utilizing your resources andobtaining the correct information to educate your patient. You did an excellent job! SA

Week 12b: Weaknesses – One weakness that I saw in myself during clinicals this week was that I struggled a bit opening the medications with gloves on in front of the patient. Also, when administering 5 drops into the ear I felt bad and uncertain on how to go about opening up the ear with him having a pretty large infection on the ear. My plan of action to get better at my areas of weekness are to practice handling and opening medications at home with gloves on whenever my kids, my wife, or myself get sick. Great Plan! Remember to take your time and do not the packages of medications discourage you from the administration. In time it will become easier! SA

Week 12 (8i)- Great job recognizing your productivity habits and identifying where improvements can be made in the CDG and tool. SA

Final comment- Aaron, 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 perform wound care, 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	Acute Pain	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: Aaron Brummett		Course 6					
Date or Clinical Week: 11/18/2024		Objective:					
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 did a nice job providing all of the abnormal assessment findings for your patient. You also provided a thorough list of his abnormal lab findings and his CT results. Nice job with the list of risk factors specific to your patient as well. HS
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	You provided a great list of nursing priorities specific to your patient, and included those not only associated with current concerns but also those related to his risk factors. You developed a goal specific to the priority problem. You did a nice job highlighting the related data. Good job identifying the potential problems and the signs and symptoms that you would monitor the patient for. HS
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Great job on the list of nursing interventions that you have prioritized and made specific to the patient. Be sure to include a frequency with each intervention. Education and medications should have a frequency listed as well. HS
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	2	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	2	You did a nice job reassessing your abnormal related assessment findings however be sure to also evaluate if there was a new CT scan completed, and if not include no new scan was completed within the evaluation section. HS
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> 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:

Aaron,
Nice job on your care map! You were able to identify the abnormal assessment, lab findings and risk factors in order to develop the plan of care for your patient. You were able to identify several potential problems for the patient and determine which one was the priority and then compile a thorough list of interventions specific to the patient. HS

Total Points:43/45

Faculty/Teaching Assistant Initials: HS

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

<u>Simulation Evaluation</u>	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
Performance Codes: S: Satisfactory U: Unsatisfactory	Date: 11/12/2024	Date: 11/26/2024
Evaluation (See Simulation Rubric)	S	U
Faculty Initials	HS	HS
Remediation: Date/Evaluation/Initials	NA	12/1/2024/S/HS

* Course Objectives

11/30/2024- Simulation survey not completed.
12/1/2024-Remediation completed- Simulation survey completed.

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Lexi Bores (M), Aaron Brummett (A), Colleen Camp (O), Jameson Lee (O)

GROUP #: 9

SCENARIO: NF #1

OBSERVATION DATE/TIME(S): 11/12/2024 1100-1200

CLINICAL JUDGMENT COMPONENTS	<u>OBSERVATION NOTES</u>
<p>NOTICING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B 	<p>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 80, RR 18, B/P 130/74. SpO2 of 91% RA. Noticed low SpO2 (91%) as abnormal and informed patient that interventions would be implemented. Pain assessment performed. Noticed cough and asked patient about how long it has been going on. Asked patient about sputum, consistency, and color. Noticed tissues in patient's bed. Noticed yellow sputum in the tissues. Asked patient about SOB. Recognized lung sounds as crackles.</p> <p>Noticed redness to heels when patient complained of pain (discussed in debriefing).</p> <p>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. Asked about allergies. Noticed indications for atorvastatin and multivitamin. Noticed potential adverse reactions and side effects.</p>
<p>INTERPRETING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p>Prioritized vital signs before completing a full head to toe assessment. Interpreted low SpO2 of 91% 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.</p>

<p>RESPONDING: (1,2,3,4,5,6,7) *</p> <ul style="list-style-type: none"> • 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 	<p>Practiced standard precautions with hand hygiene before entering the room.</p> <p>Promptly performed a thorough head-to-toe assessment.</p> <p>Elevated HOB when shortness of breath was noticed.</p> <p>Collaborative communication between assessment and medication nurse.</p> <p>Communicated with patient about interventions being performed, with questions answered appropriately.</p> <p>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.</p> <p>Responded to the patient's complaints of pain to bilateral heels by initiating a pillow to offload pressure.</p> <p>Educated on fall precautions and implemented bed alarm.</p> <p>Good body mechanics by raising the bed and lowering the side rails.</p> <p>Reassured respiratory status after oxygen applied.</p> <p>Communicated am medications with patient.</p> <p>Education provided to patient on medication and side effects.</p> <p>Utilized BMV scanner for medication administration.</p>
<p>REFLECTING: (1,2,4,5,6,8) *</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>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.</p> <p>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!</p>

<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p> <p>Scenario Objectives:</p> <ul style="list-style-type: none"> • 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) * 	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>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. 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.</p> <p>Interpreting: Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse.</p> <p>Responding: Generally, displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally, communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy.</p> <p>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.</p> <p>Satisfactory Completion of NF Scenario #1.</p>
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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): Jameson Lee (A), Colleen Camp (M), Lexi Bores (O), Aaron Brummett (O)

GROUP #: 9

SCENARIO: NF #2

OBSERVATION DATE/TIME(S): 11/26/2024 1100-1200

CLINICAL JUDGMENT COMPONENTS	Observation Notes
<p>NOTICING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B 	<p><u>Focused Observation</u></p> <p>Focused observation on vital signs when entering the room Focused observation on patient's pain (7/10) Focused observation on full head to toe assessment instead of focusing on respiratory system. Consider a focused observation on breathing status, lung sounds, and cough related to pain and low Spo2.</p> <p><u>Recognizing Deviations from Expected Patterns</u></p> <p>Noticed tissues and sputum. Noticed patient's cough. Noticed patient's pain (facial grimacing, grunting, 7/10). Noticed Spo2 of 87% on RA. Noticed crackles in the lungs. Noticed reddened heels.</p> <p><u>Information Seeking</u></p> <p>Sought information on mental status Sought additional information on pain (rating, alleviating factors, aggravating factors, radiating pain, location). Sought additional information on sputum production. Assessed allergies prior to medication administration.</p>
<p>INTERPRETING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p><u>Prioritizing Data</u></p> <p>Prioritized full vital sign assessment. Prioritized oxygen administration. Prioritized interventions for oxygenation (elevate HOB, educate on incentive spirometer, etc). Prioritized full pain assessment. Consider prioritizing pain medication administration sooner. Identified the patient's pain, but did not intervene until head to toe assessment was completed. Could consider alternative pain relief techniques while waiting on medications. Consider prioritizing focused respiratory assessment prior to completing head to toe assessment. Address the current problem, then return to gather additional data.</p> <p><u>Making Sense of Data</u></p> <p>Made sense of physician orders to maintain Spo2 >93%</p>

	<p>Made sense of reddened heels. Made sense of crackles and pain being related to pneumonia diagnosis. Made sense of MAR for morphine administration for pain >7/10 Did not make sense of MAR for scheduled AM medications already administered. When prompted by the patient, stated would double check to confirm medication already administered. Made sense of dosage calculation. Made sense of syringe and medication concentration.</p>
<p>RESPONDING: (1,2,3,4,5,6,7) *</p> <ul style="list-style-type: none"> • 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 	<p><u>Calm, Confident Manner</u> Overall handled the situation well. At times, seemed unsure on how to communicate with the patient regarding pain. Hesitant with education. Limited communication among team members at times. Some patient comments were ignored/not addressed due to uncertainty.</p> <p><u>Clear Communication</u> Introduced self and role when entering the room Confirmed name and DOB and compared with wristband. Explained interventions to be performed. Good communication with the patient during assessment. Educated patient on morphine administration. Educated on side effects to monitor for (vital signs/respirations). Confirmed name and DOB with wristband prior to medication administration. Educated on injection to be performed and injection location. Consider more teamwork and collaboration through communication to notify of patient's pain.</p> <p><u>Well-planned Flexibility/Interventions</u> Applied O2 via NC at 2L for Spo2 87%. Educated on coughing/deep breathing Elevated HOB for pain with coughing. Focused on full head to toe assessment vs. focused assessment on the problems at hand (pain, oxygenation). Consider implementing interventions for pain relief before continuing assessment. Implemented safety precautions. Pillow provided for heel pressure. Education provided on incentive spirometry. Consider education when pain is under control. Educated patient on morphine administration. Educated on side effects to monitor for (vital signs/respirations). Returned to educate on incentive spirometry when pain was controlled. Return demonstration provided. Educated on splinting while coughing. Re-assessed pain and vital signs after interventions performed to determine effectiveness.</p> <p><u>Being Skillful</u> Safety checks performed, rights of medication administration observed. Remember to scan the medication prior to administration. Educated on injection to be performed and injection location. Dosage calculation performed accurately, 2mL to be administered (4mg). Excess</p>

	<p>amount wasted with a witness. SubQ needle selected instead of IM. Remember to aspirate prior to injecting medication. Good needle safety. Good technique with injection.</p>
<p>REFLECTING: (1,2,4,5,6,8) *</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>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.</p>
<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p> <p>Scenario Objectives:</p> <ul style="list-style-type: none"> • 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) * 	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes 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.</p> <p>Interpreting: Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse.</p> <p>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 the most obvious data; monitors progress but is unable to make adjustments as indicated by the patient’s response. Displays proficiency in the use of most nursing skills; could improve speed or accuracy</p> <p>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.</p> <p>Satisfactory Completion of NF Simulation #2.</p>

Skills Lab Competency Tool

Student Name: Aaron Brummett

Comments:

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

- Edvance360 Learning Management System.
- Skyscape Resource System.

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: 8/28/2024	Date: 9/5/2024	Date: 9/10/2024	Date: 9/17/2024	Date: 9/24/2024	Date: 10/1/2024	Date: 10/8/2024 10/10/2024	Date: 10/15/2024	Date: 10/22/2024	Date: 10/29/2024
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	HS	HS	AR	AR	HS	AR	FB	HS	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**

- 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 128/72 and you identified it as 128/70. The second measurement was set at 106/60 and you interpreted it as 106/58. 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”. It is not mandatory to wear gloves

while obtaining the vital signs you were observed for today; however, you may want to get in the habit of wearing them in the clinical setting. Your Meditech documentation was accurate and complete, other than omitting “84” for pulse rate. 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. Great job! HS

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-** omitted “9” for pain rating; omitted “relaxation techniques” for management techniques to relieve pain
- **Vital signs-** omitted “99” for pulse rate
- **Safety-** omitted “pneumonia” as reason for isolation
- **Physical reassessment-**
 - Integumentary- omitted “no wounds”
 - Gastrointestinal (flatus)- omitted “present”; bowel sounds documented “hyperactive” rather than “hypoactive”

Mobility Lab 9/19/2024: Satisfactory completion of mobility lab through demonstration of the following: Logrolling/turning a patient, lifting a patient in bed, repositioning from lying to sitting, repositioning from sitting to standing, stand/pivot transfer from a bed to a chair, ambulating with a walker, ambulating with crutches, ambulating with a cane, use of a gait belt, and safe use of a wheelchair. Proper body mechanics were utilized to promote safety for the health care worker and the patient. Great job with active participation throughout the duration of the lab. HS

Week 6 (Personal Hygiene Skills):

Satisfactory with patient hygiene, making an occupied bed, shaving, oral care, hearing aid care, application of ace wraps, TED Hose/SCD’s, and clinical readiness scenario during guided practice. Completed Meditech documentation for Hygiene and Ted Hose. Keep up the great work! AR

Week 7 (NG Skills: Insertion, Irrigation, and Removal; Feedings):

Great job this week in lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. You are satisfactory in all NG skills. Excellent patient education provided! You did not require any prompts during insertion, irrigation, or removal. Great job! You were able to verbalize understanding of the difference between irrigation and flushing. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! FB

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

You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. You did not require any prompts during the sterile glove application, the 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!!! HS

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

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

You have demonstrated competence in the skill of wound assessment and wound care through guided observation of Dry Sterile Dressing and 1:1 observation of Damp to Dry Packed Wound Dressing Change. During the Damp to Dry Packed Wound Dressing Change, you did not require any prompts and initiated/maintained the “clean” field and followed aseptic technique throughout. 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. 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: 

12/3/2024