EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2024

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Yasmin Perez

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/2/2024

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

Faculty eSignature: Nicholas A.

Teaching Assistant: Stacia Atkins, BSN, RN

DIRECTIONS FOR USE:

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

METHODS OF EVALUATION:

Skills Lab Checklists
Care Map Grading Rubric
Administration of Medications
Simulation Scenarios
Skills Demonstration
Faculty Feedback
Documentation
Clinical Reflection

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)
10/10/2024	2H	Missed Documentation Lab	10/14/2024
11/6/2024	5H	Clinical Absence	11/13/2024
11/9/2024	1H	Late Simulation Survey	11/11/2024
11/15/2024	2H	Week 13- late cdg post	11/16/2024

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	N/A	N/A	N/A	S	S	NA	S
b. Identify cultural factors that influence healthcare (Noticing).									NA	N/A	N/A	N/A	S	S	NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).						n/a	n/a	S	S	S	S	N/A	S	S	NA	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).						n/a	n/a	S	S	S	S	N/A	S	S	NA	S
						CB	CB	SA	SA	NS	NS	NS	NS	CB	NS	NS
Clinical Location; Patient age**						NA	NA	3T 67 year old male	NA	4N 86 year old male	4N 86 year old F	N/A	4N 76 year old F	4N 74 year old female		

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. SA

Week 9 1(c,d) – You did well this week to coordinate your care appropriately based on your patient's preferences and needs. You used Maslow's to appropriately prioritize your care, promoting safety in the post-operative period following hip replacement surgery. NS

Week 10 9(a-d) – Yasmin, you did well this week coordinating your care appropriately. You performed your assessments in a timely manner to ensure her physiological needs were met. You used motivation and encouragement to ensure her nutritional needs were addressed by assisting her in selecting food choices to promote appetite and intake to assist in the healing process. On numerous occasions you provided hygiene care related to bowel incontinence to promote skin integrity and self-esteem. Nice job! NS

Week 12 1(a-d) – Good job coordinating your care effectively this week using appropriate priority setting frameworks in planning care for the day. NS

Week 13(1a,b,d): Great job this week ensuring that all spiritual and cultural factors were taken into account when caring for your patient. You did a nice job meeting the needs of your patient, using Maslow's. CB

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

Comments

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

Week 9 2(a) – Nice job with your assessment this week, noticing numerous deviations from normal in addition to normal assessment findings. Notably, you identified abnormal musculoskeletal findings including an unsteady gait, limited movement, and muscle weakness as a result of his recent hip replacement surgery. You noticed the use of a walker for ambulation assistance. You also noticed abnormal findings to the integumentary system, including a hip incision with healthy appearing surrounding skin, dryness to the lower extremities with rough skin, and the presence of a wound vac to the incision site. Good work! NS

Week 9 2(d) – this competency was changed to "S" because you were able to perform an assessment of the wound vac to the right hip and the skin surrounding the dressing. NS

Week 10 2(c,d) – You were able to identify safety concerns with your patient this week and implemented appropriate interventions to maintain her safety during her hospital stay. You noticed that your patient had not been out of bed in her long-term care setting since July, and interpreted this as a risk factor for numerous complications. When transferring your patient to the chair and back to bed, you used appropriate safety measures and body mechanics to prevent injury. NS

Week 10 2(e) – On day one caring for your patient, you noticed decreased oral intake. On day 2, you promoted her nutritional status by going over her breakfast menu and encouraging foods that she enjoys. You were able to provide her with a protein supplemental to promote healing. Good work! NS

Week 10 2(g) – In your CDG discussion this week you were able to correlate various abnormal lab/diagnostic findings to her priority nursing problem. You discussed her abnormal sodium and hemoglobin level and correlated these findings with potential issues with mobility and activity tolerance. NS

Week 13(2a,d,g): Yasmin, great job performing your head to toe assessment, being very thorough and detailed. Although you are unable to document a skin assessment, this was also performed during your head to toe. You did a nice job describing labs and diagnostic test that you patient had performed related to their priority problem. CB

* End-of-Program Student Learning Outcomes

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

Objective

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

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

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. Good job participating according to (f) by attending to your patient's needs and walking him to the restroom.SA

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

Week 10 3(d,e,f) – You were an active and accountable member of the health care team by providing thorough nursing care and collaborating with the assigned RN, your peers, and the PCTs on the floor. On numerous occasions you used strong teamwork and collaboration for mobility, hygiene, and safety needs. You were able to assist with an IV insertion, helping to comfort the patient during the procedure. You communicated well with your patient and reported all abnormal findings to the faculty and assigned RN. NS

Week 11 3(d) – You promptly reported your patient's bleeding IV site to a faculty member to ensure it was addressed quickly. Good job prioritizing this finding and seeking assistance to address the problem. NS

Week 13(3e): Excellent job this week communicating with your patients, peers, and floor staff. You did a nice job communicating during your medication pass, ensuring that your patient was aware of what meds they were receiving. CB

* End-of-Program Student Learning Outcomes

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

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

Comments

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

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

completed your first cdg, meeting all requirements per the grading rubric, excellent job! For future reference remember to appropriately utilize the sheet that Brittany and Nick handed out with proper APA formatting, by siting something out of the reference. Example; you stated, "In our nursing foundations book, I was able to see the table how to assess for pitting in the edema", this is where I would paraphrase in your own words what specific information related to edema, and then your in text would look like this (Potter et. al, 2023). SA

Week 9 4(a,b) – Good job with your documentation this week. You communicated your findings in a timely manner to ensure appropriate understanding of the patient's condition for all members of the health care team. NS

Week 9 4(e) – Overall you did very well with your CDG this week. You identified the correct priority problem related to impaired mobility and did well to explain your assessment findings to support your discussion. You utilized a reputable resource to enhance the discussion and included an in-text citation and reference appropriately. In your response to Marilyn, I have one tip for future success: Be sure that your in-text citation and reference match. You provided an in-text citation for (Myers, 2023) but referenced Sawyer-Sommers (2023) diseases and disorders. The reference author(s) should always match the author(s) of the in-text citation. Otherwise, all criteria were met for a satisfactory evaluation. NS

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

Week 13(4c,e,f): You did a great job this week accessing your patient's information on the electronic medical record. You were able to verify medication and provide education related to medication taking. You did a great job on your cdg this week, but the initial post was submitted after the due date and time, per the rubric automatically scores "U". 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. CB

Week 13 4F To fix this "U" I will make sure I double check to see my initial post is posted by Friday before it is due. I will make sure I have it in my reminder calendar so I remember to check. NS

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

Comments

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

There was a fire extinguisher across from room 3036 and a pull station by the nurse director's office Thank you SA

Week 8(5a,b): Great job utilizing correct body mechanics and raising the bed while performing an assessment. I know there was confusion to your patient's ambulatory status, but you did a great job by asking for help taking him to the restroom. You did a great job ensuring that you foamed in/out when entering/exiting patients' rooms as well. SA

Week 9 5(d,e) – Yasmin, you did very well this week with your time management and organization. You provided all patient care in a timely manner to ensure his needs were met. As a result, you were able to observe and participate in other patient care activities with your peers to enhance your learning experience. Nice job! NS

Week 10 5(a,d,f) – Your patient required extensive mobility and hygiene needs this week as a result of her prolonged bedrest and recent surgical procedure. You were able to gain experience with transferring a limited mobility patient and used appropriate body mechanics to maintain the safety of yourself and the patient with the use of assistive devices. You noticed your patient was incontinent and prioritized her hygiene needs to promote skin integrity. You also gained experience in managing an external catheter for accurate urine output measurement and successfully placed a Purwik catheter. NS

Week 11 5(c) – This competency was changed to "S" because you cared for a patient with a suprapubic catheter, which requires the same type of maintenance and care of an indwelling foley catheter. Great job! NS

Week 13(5e): Great job with time management this week with your medication administration. You were able to organize your time and prioritize your patient's needs. CB

* End-of-Program Student Learning Outcomes

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

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

Comments

Week 9 6(a) – Clinical judgement skills were utilized to identify a priority nursing problem based on the patient care provided and assessments performed. You correctly identified impaired mobility as a priority concern related to his post-operative status following hip replacement surgery. NS

Week 10 6(a) – You continue to enhance your clinical judgement skills with each clinical experience. This week you identified numerous nursing priorities and identified impaired mobility as your priority nursing problem related to her recent hip surgery, altered mental status, and prolonged bedrest in the long-term care facility. Good work discussing the assessment findings, risk factors, and diagnostics that supported your priority problem in your CDG. NS

Week 13(6a): You were able to develop a plan of care for your patient related to their priority problem this week in clinical, good job! In your cdg, you listed appropriate interventions you implement for your patient's priority problem. CB

Week 14 6a – Satisfactory care map submission on the priority nursing problem of impaired mobility. See attached grading rubric. NS

* 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				N/A	S	NA	**S**
b. Recognize patient drug allergies (Interpreting).									NA				N/A	S	NA	**S**
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).									NA				N/A	S	NA	**S**
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				N/A	S	NA	**S**
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				N/A	S	NA	**S**
f. Assess the patient response to PRN medications (Responding).									NA				N/A	S	NA	**S**
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			S	N/A	S	NA	**S**
*Week 11: BMV									SA	NS		NS	NS	CB	NS	**NS**

Comments

Week 11 (7g) - You are satisfactory for this competency by attending the Bedside Medication Verification (BMV) clinical orientation, actively listening, observing, and discussing accurate medication documentation and safe administration with the use of the BMV scanner. NS/CB
Week 11 7(a-g) – Medication administration will be performed during the make-up clinical day on 11/13/2024. NS

Week 13(7a-d, g): Yasmin, you did a great job with medication administration. You were able to identify why your patient was receiving the medication, potential side effects, and appropriate patient education. You reassessed your patient after giving medications, ensuring their safety. You followed the 7 rights of medication administration with 3 medication checks, verifying the correct patient and their allergies. You were able to utilize the BMV for medication administration documentation. CB
* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

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

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

My strength I felt was being able to put my nerves aside and think about the patient's needs first. My weakness was locating posterior tibial pulses. I will keep practicing posterior tibial pulses with my family members at home this weekend. I will try on my kids and husband so by next clinical I am able to perform. I could also use a doppler if the patient has a weak pulse. I am glad you recognized your strengths and weaknesses! This is a great plan to practice on your family as well as future plans for assessments! Do not be too hard on yourself as you are learning, it is great you also put your nerves aside and made the patient's needs your priority, that is what will make an excellent nurse! SA

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. SA

Week 9A Strength for me is being able to get my patient to perform self-hygiene care. At first, he kept saying no and was saying I asked to many questions but I kept conversating with him and said we could do it later. After helping him with his breakfast and getting him situated he felt better and agreed with self-hygiene and even did self-shaving. Awesome strength to note! While patient's at times may be resistant to personal hygiene care, it is important for many different reasons. Sometimes some education and discussion go a long way in promoting ADLs to be performed in the hospital setting. For his sake, he will feel more refreshed, reduce his chance of infection, and improve his post-operative outcomes. Well done! NS

Week 9B my weakness in this clinical was knowing where some things were that a patient needed. For example, knowing where there the menu to order food was. To improve where to find stuff I will go to 4 north before my clinical starts and recognize the rooms where the nutrition is at, the bed changing and where the medical equipment is at. You will get more familiar with the clinical unit as the weeks progress. However, I love your plan for improvement in this area and it will benefit you moving forward. Keep up the hard work! NS

Week 10a my strength was being able to control my face expressions to the smell of bowel incontinence. At first, I felt like throwing up but my concern for helping the patient helped me put my senses aside and help her get cleaned up. I feel like I am not used to it but with time I know I will be. This is always challenging. In nursing, you will come across many things that can make your stomach uneasy. This was a unique incontinence experience that required you to overcome these feelings. Nice job maintaining your composure to make the patient feel comfortable. Good work! NS

Week 10b my weakness for this week was learning how to get the patient with a brief cleaned from lying in bed when they have a bowel movement. There were 3 of us student nurses and we have never done this before so with her left fracture hip we did not want to lift her leg up to much. We didn't know how to clean her. We had help from an RN to show us how to use a pillow and put her left foot on tip and the other under and then turn her to her left side to wipe her. I think the way I could do learn more is looking at videos of how patients are turned and moved when they get changed and being immobile in bed. This will help me next time, so I don't have that issue. Good reflection! I like how you used teamwork and collaboration to provide patient care. You knew your resources and sought assistance when needed and learned from the experience. Nice plan for improvement! NS

Week 12A. My strength this week was feeling fully confident on being able to assist the patient to the bathroom and helping her sit on the chair by myself. I was able to know if I was able to do it on my own or if I needed help. Good! You are becoming more familiar and confident with mobility and proper body mechanics in the acute care setting. This take time, practice, and asking questions to understand how your patient moves safely. Good strength to note this week! NS

Week 12B. My weakness for this week was to be able to set up the chair alarm. I needed to ambulate the patient to the chair but she was a high fall risk so I was told to set the chair alarm. I had to go get help and see how to set it up. By watching someone else I was able to learn so next time I can do it on my own. I will review my safety content for fall precautions before my next clinical experience. I am glad you were able to observe so that you will be prepared to initiate the chair alarm in the future! NS

Week 13A. My strong for this week was being able to give medications and be confident in giving them and being able to know which medications were needed to give. You did a great job passing medications in the clinical setting for the first time. CB

Week 13B my weakness was taking long in writing down the medications, adverse reactions, and what you would assess before giving them and what you would look out for. There was so much to write down I did not know what to pick from. Yasmin, I see how this can be a weakness, especially when you are in a hurry. Although, you listed a weakness, you did not explain your plan in how you will grow in this area, therefore I changed competency 8b to a "NI". CB

Week 13(8f,g,i): 8f was changed to an "U" due to submitting your clinical tool late, and competency 8g was not self-rated. 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. Yasmin, thank you for reflecting on your first medication pass in your cdg! As you experience passing medications in future clinicals, you will gain confidence and education on more medications. CB

Week 8F to fix this unsatisfactory I will submit my clinical tool evaluation on time and make sure its turned in in time by setting my reminder alarm. NS
Week 8g to fix this unsatisfactory I will check my clinical twice before submitting my clinical tool so I know all boxes are rated and that none are left blank NS

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

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/18/2024	Impaired Physical Mobility	*S/NS	*NA/NS

Note: Students are required to submit one satisfactory care map by 11/18/2024 at 0800. If the care map is not evaluated as satisfactory upon initial submission, the student may revise the care map based on instructor feedback/remediation and resubmit one time by 11/25/2024 at 0800 to receive a satisfactory evaluation. ***See Attached Nursing Care Map Grading Rubric**

Student Name: Yasmin Perez

Date or Clinical Week: Week 10

Course Objective: 6

	Criteria	3	2	1	0	Points Earned	Comments
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	**(lists at least 7*) *provides explanation if < 7**	**(lists 5-6)**	**(lists 5-7 but no specific patient data included)**	**(lists < 5 or gives no explanation)**	3	A thorough list of 15 abnormal assessment findings were listed based on the care provided during the week 10 clinical experience. Consider being more specific with some of the assessment findings. For example, "pain 5/10" you would want to describe where the pain is located to be more specific. For "confused" you would want to include "alert and oriented x 1" to be more descriptive. You may also want to include her mobility score and fall score as assessment findings for an impaired mobility plan of care. A detailed list of abnormal labs/diagnostics were identified in the EHR. Specific patient data was included. 15 abnormal findings were listed. Numerous risk factors were identified based on the patient's current and past medical history. Consider highlighting her age as a risk factor for impaired mobility. Also, he living in a long-term care facility can be a risk factor for impaired mobility.
	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	A thorough list of priority nursing problems were identified based on the care provided. Based on the assessment findings and admitting problem, impaired physical mobility was appropriately identified as the top priority nursing problem.
	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	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	

	top priority nursing problem.						A specific and appropriate goal was determined as a positive statement reflecting the impaired mobility. While this patient will not return to her full level of mobility, ambulating to the chair for meals is a great goal considering she had not been out of bed at the nursing facility in numerous months. Most relevant data were highlighted from the noticing section to support the top priority problem of impaired mobility. Consider highlighting her abnormal gait and muscle weakness as findings to support impaired mobility. Also, consider highlighting syncope and age in the risk factors as supporting data. Based on the top priority problem of impaired mobility, three priority potential complications were identified: DVT, Impaired skin integrity, and falls. Each potential complication listed was supported with specific signs and symptoms to monitor for.
	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**	2	A list of 11 nursing interventions were listed. Most of your interventions were assessment or medication focused. Try to think about interventions that you performed during your clinical experience to help develop individualized interventions. As nurses, there are many interventions were can perform beyond assessments and medications. For example, your stated goal was for the patient to ambulate in the chair for all meals. The only was to achieve this is to include an intervention related to ambulating the patient. You could also collaborate with PT/OT to develop mobility goals. Some of your assessment findings and potential complications focused on the risk of skin breakdown. Because she has impaired mobility, we as the nurse would perform interventions such as turning and repositioning every 2 hours, assessing skin integrity, provide peri care as needed, etc. We could also perform active/passive ROM to promote
	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	

							muscle strength. These are some examples to consider. Interventions were prioritized appropriately with assessments taking highest priority. All listed interventions included an appropriate frequency. Listed interventions were specific to the patient with individualized medications orders.

	Criteria	3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Rationale was provided for each listed intervention.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	2	Re-assessment findings were listed in the evaluation section to demonstrate progress towards the stated goal. Be sure to re-assess all highlighted assessment findings from the noticing section. You would want to re-assess her confusion, perineal redness, coccyx ulcer, muscle weakness, etc. Based on the re-assessment findings, it was appropriately determined to continue the plan of care.
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

Reference

An in-text citation and reference are required.
The care map will be graded "needs improvement" if missing either the in-text citation or reference, but not both.
The care map will be graded "unsatisfactory" if both in-text citation and reference are not included.

Total Possible Points= 45 points
45-35 points = Satisfactory
34-23 points = Needs Improvement*
< 23 points = Unsatisfactory*
***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

*****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *****

Faculty/Teaching Assistant Comments: **Yasmin, you did a great job with your first care map submission on a patient with the priority problem of impaired physical mobility! You have received 42/45 points for a satisfactory evaluation. Overall it seems like you did well to connect the various pieces related to patient care during week 10 to develop a plan of care aimed at improving her mobility. As you progress in the program, be sure to consider the comments provided in the grading rubric. The main area to focus on is the interventions, thinking about interventions the nurse can perform beyond simply assessing and medicating. Otherwise, you were detailed in your descriptions and developed a good plan of care. Keep up the hard work! NS**

Total Points: 42/45 - Satisfactory

Faculty/Teaching Assistant Initials: NS

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

Simulation Evaluation Performance Codes: **S**: Satisfactory **U**: Unsatisfactory	Simulation #1 (2,3,5,8) *	Simulation #2 (2,3,5,7,8) *
	Date: 11/5/2024	**Date: 11/25/2024**
Evaluation (See Simulation Rubric)	U	S
Faculty Initials	NS	CB
Remediation: Date/Evaluation/Initials	11/11/2024 S NS	NA

* Course Objectives

11/5/2024 Simulation #1 – Unsatisfactory for late submission of the simulation survey. Completed and satisfactory on 11/11/2024. See attached evaluation scoring sheet. NS

11/25/2024 – See attached evaluation scoring sheet. NS

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Isabella Riedy (M), Yasmin Perez (O), Kyla Prenatt (A)
GROUP #: 5
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/5/2024 1430-1530

CLINICAL JUDGMENT COMPONENTS					Observation Notes
NOTICING: (1,2,4,6,7) *					**Focused observation**
• Focused Observation:	E	A	D	B	Focused observation on vital signs when entering the room. Focused observation on patient's persistent cough and SOB. Focused observation on head-toe-assessment Focused assessment on patient's heels due to complaint of discomfort.
• Recognizing Deviations from Expected Patterns:	E	A	D	B	**Recognizing deviations from expected patterns** Noticed BP 130/74, HR 82, RR 20, Spo2 91%, temp 99.2 Noticed Spo2 of 91% on RA Noticed patient's persistent cough Noticed abnormal lung sounds. Did not notice tissues with sputum in patients' hand Did not notice reddened heels initially. When prompted by the patient of discomfort, focused assessment and noticed reddened heels.
• Information Seeking:	E	A	D	B	**Information seeking** Asked patients name and DOB when entering the room, remember to compare with the wrist band. sought additional information related to breathing status Sought information related to pain (0/10) Sought additional information related to patient's cough (duration, production, etc). Med nurse introduced self and role when entering the room. Sought information from the patient related to how she is feeling.

	Confirmed name and DOB with wristband prior to medication administration. Asked about patient allergies prior to medication administration. Sought information on normal bowel pattern Sought additional information related to elimination Asked patient how she takes her medications. Remember to ask about allergies prior to medication administration.
INTERPRETING: (1,2,4,6,7) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	**Prioritizing data** Prioritized vital sign assessment when entering the room. Prioritized oxygen administration immediately for low Spo2 Prioritized intervention for reddened heels Prioritized medication administration appropriately. **Making sense of data** Made sense of provider order for Spo2 to maintain greater than 93% Made sense of abnormal lung sounds related to pneumonia diagnosis Made sense of impaired skin integrity related to pressure Made sense of guaifenesin order Made sense of medications to be administered. Made sense of the MAR.
RESPONDING: (1,2,3,4,5,6,7) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	**Calm, confident manner** Demonstrated confidence in nursing actions and communication with patient and team member. Answered patient's questions appropriately. Great teamwork and collaboration **Clear communication** Introduced self and role when entering the room. Good communication with the patient when entering the room Educated on the use of oxygen

	Communicated assessment and vital sign findings with the medication nurse. Educated patient on medications to be administered. Good education on medication side effects. **Well-planned intervention/flexibility** Consider elevating the HOB for cough and shortness of breath. Consider educating the patient to cough and deep breath. Applied O2 via nasal cannula for low Spo2. Returned to head to toe assessment after prioritizing oxygen status. Re-assessed Spo2 after oxygen administration and noticed improvement. Placed pillow to offload pressure. **Being skillful** Elevated HOB for safe medication administration. Good body mechanics raising the bed and lowering the side rail HEENT assessment performed accurately. Neuro assessment performed – remember to ask orientation questions to determine mental status. Heart and lung sounds auscultated accurately. ROM assessed in all extremities Pulses assessed and compared bilaterally. Strength assessed in all extremities, cap refill assessed GI assessment performed accurately (looked, listen, felt) GU assessment performed accurately. Assessed integumentary system. Remember to look at bony prominences (heels). Used BMV scanner for medication safety Observed the 7 rights of medication administration Performed the three safety checks.
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B	Observers did a great job actively paying attention to detail throughout scenario. Constructive feedback was provided during debriefing. Observers provided good insight on safe medication administration, including the rights of medication administration. Observers also praised students for initiating O2 via nasal cannula for low Spo2 per orders while also discussing the need for prompt intervention. Constructive feedback was provided related to areas for improvement. Good discussion and support amongst those performing in the

• Commitment to Improvement: E A D B	scenario and the observers. Everyone participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement and discussed ways to make improvements in the future. The assessment nurse and medication nurse demonstrated collaborative communication between the team members and the patient.
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Execute accurate and complete head to toe assessment (1,5,6,8) * • Select and administer prescribed oral medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) *	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Identifies obvious patterns and deviations, missing some important information. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of 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. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses. **Satisfactory completion of NF Scenario #1.**

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Yasmin Perez (A), Kyla Prenatt (M), Isabella Riedy (O)

GROUP #: 5
SCENARIO: NF #2
OBSERVATION DATE/TIME(S): 11/25/2024 1300-1400

CLINICAL JUDGMENT COMPONENTS	**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) *	Identified patient with name and DOB and compared to wristband for patient safety.
• Focused Observation: E A D B	Noticed low Spo2 (90%) when obtaining vital signs.
• Recognizing Deviations from Expected Patterns: E A D B	Focused respiratory assessment.
• Information Seeking: E A D B	Noticed cough and shortness of breath. Noticed sputum/tissues in the bed. Sought further information related to duration of cough and sputum.
	Noticed crackles upon auscultation.
	Noticed patient was in pain.
	Focused pain assessment. Sought additional information related to pain (precipitating factors, relief measures, rating, location). Noticed patient's pain 7/10.
	Sought additional information by re-evaluating the patient's breathing status after oxygen administration.
	Noticed order for morphine and need to perform dosage calculation.
	Sought information related to allergies prior to medication administration.
	Consider asking patient preference for injection location.
	Sought additional information after medication administration related to relief and comfort.
INTERPRETING: (1,2,4,6,7) *	Prioritized vital signs when entering the room.
• Prioritizing Data: E A D B	Prioritized applying oxygen and made sense of physician orders to maintain Spo2 >93%.
• Making Sense of Data: E A D B	Prioritized focused respiratory assessment related to pain on the right side and shortness of breath.
	Prioritized focused pain assessment due to patient complaint.
	Prioritized pain medications prior to performing full assessment for patient comfort. Collaborated with medication nurse due to patient's complaints (discussed in debriefing).
	Made sense of the MAR related to pain rating and need for dosage calculation to be performed.
	Prioritized correct PRN pain medication (morphine for pain 7/10).

RESPONDING: (1,2,3,4,5,6,7) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Identified self and role when entering the room for communication. Applied oxygen via NC at 2L per physician orders due to low Spo2. Elevated HOB for shortness of breath. Performed pain assessment in response to patients' pain. Consider focusing your assessment on the location of pain (look, auscultate). Consider additional interventions for pain management (reposition, splinting, etc.). (discussed in debriefing). Dosage calculation performed accurately to determine need to waste 1ml (2mg) of morphine. Ordered 4mg (2ml), administered 4mg (2mL). Did not have witness for waste of excess narcotics (discussed in debriefing). Confirmed name and DOB prior to medication administration. Educated patient on morphine ordered for pain when prompted. Cleaned injection site using aseptic technique. Selected appropriately sized needle for IM injection (22g, 1inch). Remember to aspirate prior to injection. Good technique (90 degrees), pushed slowly. Good needle safety. Remembered the use of BMV after medication was administered (discussed in debriefing). Re-assessed pain after medication was administered to determine effectiveness. Consider re-assessing vital signs. Re-evaluated patient's breathing after applying oxygen. Good communication with the patient regarding plan for pain relief. Good communication among team members. Good communication with the patient during assessment for comfort. Re-evaluated Spo2 of 94% after oxygen administration and additional interventions, re-evaluated patient's breathing status after medication administration. Encouraged patient to utilize incentive spirometer. Education provided on appropriate use of incentive spirometer. Encouraged coughing and deep breathing after medication. Educated patient on use of splinting with a pillow when coughing (discussed in 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**	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is

B= Beginning

Scenario Objectives:

- Demonstrate collaborative communication with patients and healthcare team members (1,3,8) *
- Differentiate between need for complete head to toe versus focused assessment and execute accordingly (1,5,6,8) *
- Select and administer prescribed oral and intramuscular medications following the six rights (1,4,5,7) *
- Identify and provide accurate patient education (1,2,3,4,5,7) *
- Recognize patient oxygenation and pain control needs and provide appropriate interventions (2,4,5,6,7) *

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. Displays proficiency in the use of most nursing skills; could improve speed or accuracy.

Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses.

Satisfactory Completion of NF Simulation #2!

Skills Lab Competency Evaluation

Lab Skills

Performance Codes:

S: Satisfactory

U:Unsatisfactory

	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:** **9/6/24**	**Date:** 9/10/2024	**Date:** 9/17/2024	**Date:** 9/24/2024	**Date:** 10/1/2024	**Date:** **10/8/24**	**Date:** 10/14/2024 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	NS	AR	HS	AR	NS	NS	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**

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

Student Name: Yasmin Perez

Comments:

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

- Edvance360 Learning Management System.
- Skyscape Resource System.
- Assessment Technologies Institute (ATI) / Virtual Simulation (vSim) Systems.

- Guided tour of library and computer lab. HS

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

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

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

Week 3 (Vital Signs):

Awesome work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two consecutive blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 134/78, and you identified it as 130/80, which was within the range for a satisfactory result. The second measurement was set at 108/64 and you interpreted it as 108/62, well within the desired range. 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 throughout the whole checkoff, great work! You provided accurate detail in your communication with the "patient". Your documentation was 100% accurate. Keep up the great work!! NS

Week 4 (Assessment):

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

Week 5 (Assessment; Mobility):

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**- your documentation was accurate and complete.
- **Vital signs**- omitted "regular" from pulse rhythm
- **Safety**- omitted comment "education completed"
- **Physical reassessment**-
    - Respiratory- omitted respiratory effort "tachypnea"
    - Cardiovascular (pulse)- bilateral dorsalis pedis and left and right radial, omitted "palpation"; (edema)- omitted comment "toes to knee bil. and the entire left upper extremity"
    - Gastrointestinal (bowel movement aid)- omitted "daily"

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

Week 6 (Personal Hygiene Skills):
Satisfactory with patient hygiene, making an occupied bed, shaving, oral care, hearing aid care, application of ace wraps, TED Hose/SCD's, and clinical readiness scenario during guided practice. Completed Meditech documentation for Hygiene and Ted Hose. Keep up the great work! AR

Week 7 (NG Skills: Insertion, Irrigation, and Removal; Feedings):
Nice job this week in the skills lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. You did not require any prompts throughout the entire process. You were able to remind yourself to rinse the irrigation equipment and to label it appropriately following irrigation. You were able to verbalize understanding of the difference between irrigation and flushing and aspiration precautions. You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! NS

Week 8 (Foley Skills: Insertion, Removal; Sterile Gloves; I&O):
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 required during insertion related to labeling the drainage bag appropriately. Otherwise, you did not require any additional prompts, nice work! You maintained the sterile field throughout the Foley insertion, and did not contaminate the catheter or your gloves at any point. You correctly verbalized the differences in catheter insertion for a male patient. You also 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! NS

Week 9 (Dressing Change: Dry Sterile, Damp to Dry Packed, Stoma Skills, Documentation Lab):
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
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. 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: **Yasmin Perez 12/03/2024**