

**EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2025**

**Firelands Regional Medical Center School of Nursing
Sandusky, Ohio**

Student:

Final Grade: Satisfactory/Unsatisfactory

Semester: Spring

Date of Completion:

Faculty: Dawn Wikel, MSN, RN, CNE; Rachel Haynes, MSN, RN; Kelly Ammanniti, MSN, RN, CHSE;
Monica Dunbar, DNP, RN; Heather Schwerer, MSN, RN; Nick Simonovich, MSN, RN

Faculty eSignature:

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 Competency Tool & Skills Checklists
- Simulation, Prebriefing, & Reflection Journals
- Nursing Care Map Rubric
- Meditech Documentation
- Clinical Debriefing
- Clinical Discussion Group Grading Rubric
- Evaluation of Clinical Performance Tool
- Lasater’s Clinical Judgment Rubric & Scoring Sheet
- Virtual Simulation Scenarios

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make-up (/Date/Time)

Faculty’s Name	Initials
Kelly Ammanniti	KA
Stacia Atkins	SA
Monica Dunbar	MD
Rachel Haynes	RH
Heather Schwerer	HS
Nick Simonovich	NS
Dawn Wikel	DW

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 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, 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 boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
1/23/2025	Impaired Swallowing	S/NS	NA	NA
2/6/25	Ineffective Airway Clearance	S/KA	NA	NA

Note: Students are required to submit two satisfactory care maps over the course of the semester. If the care map is not evaluated as satisfactory upon initial submission, the student must revise the care map based on instructor feedback/remediation and resubmit. A maximum of two remediation attempts will be provided for a single care map and if still unsatisfactory, the student will be required to start fresh and initiate a care map on a new patient. At least one care map must be submitted prior to midterm.

Objective

1. Illustrate correlations to demonstrate the pathophysiological alterations in adult patients with medical-surgical problems. (2,3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S	S	S	NA	NA	S	S							
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	S	S							
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	S	S							
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	S	NA	NA	NA	S	S							
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	S	S	NA	NA	NA	S	S							
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	S	S							
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	S	S	NA	NA	NA	S	S							
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S	NA	S	NA	S	S							
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S	S	S	NA	S	S							
	Indicate your clinical site as well as your patient's age and primary medical diagnosis in this box weekly.	Meditech, FSBS, IV Pump Sessions	4N 81MEsophageal cancer	Rehab, 59 Lumbar radiculopathy	3T 66MInfluenza A	DH, IC	ECSC	Maternal child sim 1a, 55F		Rehab, 70, Rt ankle fx	3t 82, COPD, UTI						
Instructors Initials	HS		NS	RH	KA	DW	DW	HS	HS	MD							

**Evaluate these competencies for the offsite clinicals: DH: 1h IC: 1a, b, e, h ECSC: 1g, h

Comments:

*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Week 1 (1h)- During week 1, the Meditech, FSBS and IV pump sessions were all considered clinical hours. You came prepared to each of them and demonstrated competency accordingly. For this reason, you have earned an S for this competency. NS/SA/DW/HS

Week 3 1(a-h) – Mallory, you did a great job this week making correlations between your patient’s disease processes and the nursing care required. On day one you cared for a patient with newly diagnosed esophageal cancer, and on day two you care for a patient s/p hip surgery with CHF. In both instances, you did well to review the EHR to make connections and enhance your clinical judgement. You were prepared to answer the many question prompts I presented and demonstrated preparedness and willingness to learn in the clinical setting. On day one, you were able to correlate your patient’s abdominal tenderness to his recent PEG tube surgery. You were able to discuss the EGD findings resulting in the need for the PEG tube. In your care map you were able to correlate the potential complications, nursing interventions, and evaluation of the care provided. On day two, you also did well to discuss your patient’s symptoms related to the procedure and important nursing assessments to promote positive outcomes. You were able to make connections in discussing prescribed medications for current and past medical history. You understood the importance of artificial nutrition via the PEG tube for the cancer diagnosis and risk of malnutrition due to the ongoing swallowing issues. Overall a very successful week in developing and enhancing clinical judgment skills! NS

Week 4: (1 c, d, e) This week you did a great job making correlations with your patient’s diagnosis and their disease process. You were able to also discuss how each of their medications related to their diagnosis and how it would assist with their health journey. You were also able to discuss the surgery your patient had and how that was assisting with their recovery/pain. RH

Week 5 – 1a, b, c, e– You did a nice job discussing on clinical your patient’s disease process and what nursing was doing to help the patient. You were able to discuss symptoms we were monitoring and managing in your patient as well as pertinent labs for your patient diagnosis. You also set a goal for your patient and were able to discuss your patient’s work towards meeting that goal. KA

Week 5 – 1d – You did a nice job reviewing all your medications before you administered them to the patient. You were able to discuss the reason why the patient was taking the medication as well as what we were monitoring the patient for. You also were able to discuss what information was needed to determine if the medication should be administered (i.e. blood pressure, pulse). KA

Week 9 Rehab Clinical Objective 1 B-F: This week you were able to correlate the patient’s symptoms, diagnostic tests, pharmacotherapy, treatment, and nutritional needs based on their reason for being on the Rehab floor and their past medical history. You were able to bring these needs to light in your satisfactory care map of this patient as well. Great job! MD

Objective

2. Perform physical assessments as a method for determining deviations from normal. (3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S	S	NA	NA	NA	S	S	S						
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	S	NI	NA	NA	NA	S	S	S						
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	S	S	NA	NA	NA	S	S	S						
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	S	S	NA	NA	NA	S	S	S						
d. Communicate physical assessment. (Responding)			S	S	S	NA	NA	NA	S	S	S						
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	S	S	NA	NA	NA	S	S	S						
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	S	S	NA	NA	S	S	S						
	HS		NS	RH	KA	DW	DW	HS	HS	MD							

**Evaluate these competencies for the offsite clinicals: DH: N/A IC: 2f ECSC: N/A

Comments:

Week 1 (2f)- By attending the Meditech clinical update & providing your full, undivided attention during the demonstration of documenting IV solutions and the IV assessment, you are satisfactory for this competency. NS

Week 3 2(a,e) – I thought you did a nice job this week identifying numerous deviations from normal in your assessments. These findings were interpreted appropriately and communicated in the EHR. Among your abnormal findings, you were able to notice a firm, tender, and distended abdomen following PEG tube placement. You also were able to assess wound characteristics during a dressing change. When assessing the PEG tube, you assessed for patency, gastric residual volume, and tolerance of the medications and feedings being administered via the tube. You discussed the importance of assessing skin integrity due to his chronic wounds and lack of protein intake. On day 2, you prioritized a circulation assessment to the affected extremity and discussed potential abnormal findings that would alert you of complications occurring. Nice job focusing your assessment on priority problems and being observant throughout the week. NS

Week 4: (2a-f) This week you performed a full head to toe assessment on your patient as well as a fall/safety assessment and skin assessment. You were able to identify your patient's laceration dressing was loose and did a wound assessment after removing the dressing. You were able to communicate any abnormalities in your assessment to myself and the nurse. You charted all your findings in the EHR appropriately. RH

Week 5 – 2a, d – You did a nice job thoroughly assessing your patient and notifying your nurse of any pertinent information. You were able to identify the focused assessment needing to be completed for your patient related to their diagnosis and monitored abnormal assessment findings. KA

Week 5 – 2b – You completed a fall assessment on your patient and recognized they were a high fall risk, but after completing your morning assessment you left the patient's bed in a high position versus lowering back to the ground. This is a major safety concern that did not cause harm to the patient, but could have if it was not caught promptly by the PCT and corrected. You were more vigilant with safety throughout the remainder of clinical. KA

Week 5 – 2f – You utilized the EMR to research your patient and determine what care needed to be provided to your patient throughout the day. You also utilized the EMR to research your patient's health history and information related to the patient's current hospital visit. KA

Week 9 Rehab Clinical Objective 2 A, D, & F: While you were on clinical you performed a satisfactory physical assessment, communicated abnormal assessments to myself and to the primary nurse, and you were able to satisfactorily document all information to Meditech documentation. MD

Objective

3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:	S		S	S	S	S	S	NA	S	S							
a. Perform standard precautions. (Responding)	S		S	S	S	S	S	NA	S	S							
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	S	NI	NA	NA	NA	NI	S	S						
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S	S	NA	NA	NA	S	S							
d. Appropriately prioritizes nursing care. (Responding)			S	S	S	NA	NA	NA	S	S							
e. Recognize the need for assistance. (Reflecting)			S	S	S	NA	NA	NA	S	S							
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S	S	S	NA	NA	S	S							
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA													
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	S	S	NA	NA	NA	S	S							
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S	S	NA	NA	NA	S	S							
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S	S	S	NA	S	S							
	HS		NS	RH	KA	DW	DW	HS	HS	MD							

**Evaluate these competencies for the offsite clinicals: DH: 3a IC: 3a, f, i ECSC: 3a, j

Comments:

Week 3 3(b) – You were able to perform SEVERAL new nursing skills this week, awesome job! In performing these skills you implemented nursing measures skillfully and safely throughout the week. You demonstrated competence in managing a PEG tube, providing hydration flushes and bolus feedings as prescribed by the physician.

Nice job with your dexterity and doing so. One tip to remember is to always ensure you are grasping the syringe at the PEG tube connection site to prevent spillage. Additionally, you were able to gain experience in performing a packed wound dressing using appropriate aseptic technique, very well done. You also gained experience in flushing an IV site, discontinuing an IV, and administering a subcutaneous injection. In each of these measures you were calm, confident, and did a great job. (d) you did well prioritizing your care this week. You prompted me to complete the dressing change following other patient care to ensure that it was performed before he was discharged. This was a great thought process and allowed you to have a great experience. (f) asepsis was followed during the dressing change, well done. (h) DVT prophylaxis was implemented through the administration of enoxaparin as a subcutaneous injection per physician orders. Nice job this week! NS

Week 4: (3a, b, d) You used proper hand hygiene throughout both clinical days. You were able to care for your patient while assisting therapy in helping your patient with their ADLs all while keeping safety in mind. You also were able to prioritize your day and organize your day in a way that allowed you to get all things done in a timely manner. You did great working around and with all the various therapies your patient had this week. You did a good job educating the patient on the use of SCDs and/or TED hose for the prevention of DVT since your patient did not have lovenox ordered. RH

Week 5 – 3b – You completed your patient’ assessment and elevated the bed to ensure proper body mechanics, but after completing your assessment you left the patient’s bed in a high position versus lowering it back to the ground. This is a major safety concern that did not cause harm to the patient, but had the potential to have an adverse outcome if it was not caught promptly by the PCT and corrected. You were more vigilant with safety throughout the remainder of clinical, but remember to make safety a priority with all interactions with your patients. KA

3b – You had the opportunity to care for a patient on droplet precautions. You ensured proper precautions were followed throughout the day until they were discontinued. You made sure proper signage was visible and that the necessary supplies were easily available for those entering the patient’s room. You also did a great job managing your patient O2 which was being administered via nasal canula. You made sure to complete a focused respiratory assessment and vital sign assessment to ensure for effectiveness of the therapy. You also worked with the nurse to titrate the patient’s oxygen to ensure the pulse ox was maintained at the prescribed levels. Nice job! KA

Week 9 Rehab Clinical Objective 3 C & D: While caring for your patient you were able to identify all of the priority needs for your patient based on their condition and report you received from the night shift nurse. You were able to communicate your priority assessments for the day and what interventions needed to be completed during your shift. Great job! MD

Objective

3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S	S	NA	NA	NA	S	S							
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	S	S	NA	NA	NA	S	S							
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	S	S	NA	NA	NA	S	S							
m. Calculate medication doses accurately. (Responding)			S	S	S	NA	NA	NA	S	S							
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			S	NA	S	NA	NA	NA	S	NA	S						
o. Regulate IV flow rate. (Responding)	S		NA	NA	NA	NA	NA	NA	S	NA	NA						
p. Flush saline lock. (Responding)			S	NA	S	NA	NA	NA	S	NA	S						
q. Monitor and/or discontinue an IV. (Noticing/Responding)			S	NA	NA	NA	NA	NA	S	NA	S						
r. Perform FSBS with appropriate interventions. (Responding)	S		S	NA	NA	NA	NA	NA	S	NA	NA						
	HS		NS	RH	KA	DW	DW	HS	HS	MD							

**Evaluate these competencies for the offsite clinicals: DH: N/A IC: N/A ECSC: N/A

Comments:

Week 1 (3o)- During the IV pump session, you actively participated in the programming and maintenance of the Alaris IV pump. Additionally, you accurately identified abnormal IV site assessment data with an IV site monitoring activity. HS

(3r)- The student was able to satisfactorily perform a Quality Control check of the glucometer as well as demonstrate skills and knowledge required for proper fingerstick blood glucose measurement with the ACCU-CHEK Inform II glucometer. SA/DW

Week 3 3(k-r) – You did well with your first medication administration experiences this semester! You were able to identify the rights of medication administration, performed three safety checks, and utilized the BMV scanner for safe administration. You gained valuable experience in crushing medications to be administered via a PEG tube. You used sound clinical judgement in questioning one of the medication labels stating do not crush, which was clarified with pharmacy. You used appropriate

technique in crushing each medication separately and diluting in water for safe administration. On day 2 you gained experience administered several PO medications, providing patient education and ensuring her medications were swallowed safely. Additionally, you were able to gain experience performing a FSBS appropriately, and administered insulin via the corrective scale with proper dosage calculations performed. You were able to demonstrate accurate technique in withdrawing a medication from a vial, performing accurate dosage calculation, and administering an IV push medication. While doing so, the medication was administered at a safe rate while also monitoring for signs of complications to the IV site. A saline flush was performed prior to and after administration of the medication. Lastly, you were able to gain experience in discontinuing an IV catheter safely. Great job in all of these medication related skills! NS

Week 4: (3k-m) You did great with your medication administration this week. You identified all medications and were able to provide me with detailed information about each medication, why the patient was getting the medications, and what to look for after administering the medications. You performed all checks prior to administration. You were organized and diligent while administering medications. You were able to scan all medications in the EMAR and chart them appropriately. You administered PO medications this week. RH

Week 5 – 3k – You did a nice job administering your medications this week. You observed the rights of medication administration and was able to answer all questions about your medications. You had the opportunity to pass PO, SQ, and IV push medications this week. You performed the medication administration process with beginning dexterity. KA

Week 5 – 3n – You had the opportunity to practice drawing up medication from a vial and administering the medication slow IV push to your patient. You performed all IV skills with beginning dexterity. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

Week 5 – 3p – You did a nice job flushing your patient's IV this week and ensuring patency of the IV line. You were able to document this appropriately in the EMR. KA

Week 5 – 3q – You did a nice job monitoring your patient's IV site this week and documenting your assessment in the EMR. Great job! KA

Week 9 Rehab Clinical Objective 3 K-L: This week on Rehab you were able to identify the rights of medication administration appropriately and provided a comprehensive analysis of the medications you administered to your patient. Included in the analysis was the type of medication, side effects, and nursing implications for each medication. You were able to provide further information based on the medication you were administering that was included in the nursing implications you discussed. You also were able to identify safe practice for medication administration and performed them well. You also were able to use the BMV and document in the EHR appropriately. Awesome medication pass! MD

Objective

4. Use therapeutic communication techniques to establish a baseline for nursing decisions. (1,5,7)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S	S	S	S	NA	S	S							
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S	S	S	NA	S	S							
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			S	S	S	S	S	NA	S	S							
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	S	S	NA	NA	NA	S	S							
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S	S	S	NA	S	S							
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	S	S	S	NA	S	S							
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S	S	NA	NA	NA	S	S							
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			S	S	S	NA	NA	NA	S	S							
			NS	RH	KA	DW	DW	HS	HS	MD							

**Evaluate these competencies for the offsite clinicals: DH: 4a, b, d IC: 4b, d, e ECSC: 4a, b, d, e

Comments:

Week 3 4(a,b) – I thought you did well with communication this week, including with your patients, peers, and health care team members. I appreciate you sharing your learning experiences with your peers and communicating with them the interventions you were performing to help them learn as well. Great job being a team player! NS

Week 3 4(e) – You did a great job with your CDG requirements this week. All areas of the CDG grading rubric were appropriately addressed for a satisfactory evaluation. See my comments on your initial post and response post for more details. A couple tips for future success related to APA formatting: For your reference, when typing out the article’s title, only the first word and any word following a colon (:) are to be capitalized. Also, the journal title should be in *italics*. For your in-text citation, when citing work completed by three or more authors, you only need to include the first author’s last name followed by et al and the publishing year. For your journal, correct APA in-text citation would be (Chen et al., 2023). Proper APA formatting for your reference is as follows:

Chen, B.-L., Lien, H.-C., Yang, S.-S., Wu, S.-C., Chiang, H.-H., & Lin, L.-C. (2023, October 20). Impact of mobile apps in conjunction with percutaneous endoscopic gastrostomy on patients’ complications, quality of life, and health-related self-care behaviors: Randomized clinical trial. *JMIR mHealth and uHealth*, 11.
<https://pmc.ncbi.nlm.nih.gov/articles/PMC10625096/>

These are just tips as you get more comfortable with APA formatting. Purdue OWL is also a great resource. NS

Week 4: (4b, e, f, g) You did a good job staying in communication with the nurse caring for your patient this week. You were able to use SBAR communication to keep the nurse informed of the care you provided and if there were any changes in your patient’s status. You were also able to provide an SBAR handoff at the end of the day to the next provider of care. You did great with your clinical discussion post and finding an evidence-based article that related to your patient this week. For your reference, remember that the journal article is not italicized, it is the name of the journal that is italicized. (*JAMA*). RH

Week 5 – 4b – You completed the SBAR worksheet and provided your RN with handoff communication related to your patient utilizing the SBAR you developed. You made sure all pertinent information and changes in patient status were communicated to your nurse during hand-off report. You also practiced your SBAR during debriefing and provided an accurate report to your classmates and faculty. KA

Week 5 – 4e – Mallory, you did a nice job choosing an appropriate EBP article and responding thoroughly to all the CDG questions this week. You made an initial post to the questions and responded to your classmate and added to the conversation on their article. You made sure to include an-text citation and reference in both of your posts. When in-text citing a direct quotation make sure to include the page number or the paragraph number if there are no page numbers. Also, make sure to capitalize the first letter of each word in the title of the journal article (*International Journal of Chronic Obstructive Pulmonary Disease*). Overall nice job and keep up the good work! KA

Week 6 (4e)- According to the CDG Grading Rubric, you have earned an S for your participation in the Infection Control discussion this week. Your post was thoughtful and supported by evidence. Nice job with your APA formatting. DW

Week 7 (4e)- According to the CDG Grading Rubric, you have earned an S for your participation in the Erie County Senior Center discussion this week. Your post was thoughtful and supported by evidence from the Nurse’s Pocket Guide. Here are a couple suggestions to get your APA formatting completely on track: 1. When you are citing a resource from Skyscape, please know that Skyscape is only a platform that houses multiple resources. Therefore, you wouldn’t say “According to Skyscape”; you would use the authors name instead. 2. The citation does not include the authors first name initials. 3. When you directly quote something from a resource, your in-text citation should also include the page or paragraph number that you found it. The paragraph number is only used when the resource does not have page numbers. Here is an example of the corrected citation: (Doenges et al., 2022, para 4). DW

Week 9 Rehab Clinical Objective 4 E: For clinical this week you provided a CDG that was satisfactory per the CDG rubric. In this CDG, you provided information on your patient’s Social Determinants of Health that was interesting and detailed about your patient. The reference and in-text citation you provided were appropriate and satisfactory. Please see me if you have further questions! MD

Objective

5. Implement patient education based on teaching needs of patients and/or significant others. (1,6)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S	S	NA	NA	NA	S	S							
a. Describe a teaching need of your patient.** (Reflecting)			S	S	S	NA	NA	NA	S	S							
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			S	S	S	NA	NA	NA	S	S							
			NS	RH	KA	DW	DW	HS	HS	MD							

****5a & b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab- describe the patient education you provided; be specific- include the topic, method of delivery, reason for teaching need, materials to support learning through above resources (if applicable), and method used to validate learning.**

Example: Education related to orthostatic hypotension (changing positions slowly by sitting at the side of the bed or chair for a few minutes before moving to another position, utilizing the walker when ambulating) was provided to my patient through discussion and demonstration. This was necessary to maintain patient safety as he/she was experiencing a drop-in blood pressure and dizziness when getting out of bed. A patient education sheet was printed from Lexicomp and given to the patient. The teach back method was used to validate learning.

Comments:

5a and B. week three A teaching need of my patient was to deep breath. I encouraged deep breathing to improve gas exchange because my patient was complaining of shortness of breath. I educated on such by instructing him on taking deep breaths and by assisting in raising the head of bed as this is another source that can help improve shortness of breath symptoms. I used Skyscape as a resource in helping me understand that when a patient has shortness of breath, I should auscultate breath sounds and observe for dyspnea. I was able to apply this Skyscape knowledge to my patients' education by seeing if the education helped by following up with the patient to see if his symptoms improved. With that being said, I used follow up to validate the learning. **Great job! I hope that these interventions and education were successful in helping with his shortness of breath. This will be especially important due to his risk of aspiration with his impaired swallowing and tube feedings. Good work following up with your education to ensure he understands how to perform the interventions and the importance of them. NS**

5a and B week four: A teaching need of my patient was to perform range of motion exercises when he was in bed. I encouraged my patient to do ankle circles, ankle curls and raises, and toe curls while he is in bed so that he can continue building muscle strength and flexibility. My patient had a strenuous injury that caused him to lose a lot of strength and to also spend a lot of time in bed, which is why I educated him on these exercises. I spoke with my patient about how to do the exercises as well as ensuring he understood the benefits of doing them, and I got my information from Lexicomp. **This would also benefit the patient in preventing DVT since he is not as mobile or active as before the injury. RH**

5a and b week five: A teaching need of my patient during week five was to cough and deep breath. He was admitted with respiratory distress and difficulty breathing, then was diagnosed with Influenza A and an acute COPD exacerbation so you can clearly see how he had difficulty expectorating sputum. Encouraging my patient to cough and deep breath would help him to move secretions out of the airway and improve his symptoms of shortness of breath, etc. I referred to Lexicomp for information on coughing and deep breathing and told my patient that according to Lexicomp, he should cough and deep breath 5-10 times every two hours while awake. I explained how to do it and had him perform it for me. **Great job providing him education that can help improve his respiratory status since this was his biggest concern. KA**

5a and B week 9: A teaching need of my patient this week was to make sure he is exercising at least 150 minutes a week (30 minutes, 5 days a week), or at least to get closer to this recommendation than averaging two days a week. This is because exercise is essential in all aspects of health and especially in promoting bone strength and healthy healing of his fracture. I used Lexicomp as a source on providing him back and hip range of motion exercises such as reaching forward to touch his toes. **Perfect! MD**

5 a and b week 10: A teaching need of my patient this week was to cough, deep breathe, and do incentive spirometry in order to promote any sputum expectoration and relieve her shortness of breath symptoms. I looked at Lexicomp for a resource which gave me instructions on how to do incentive spirometry, and I was able to explain to the patient to sit upright, breathe out normally, and then inhale into the machine with the mouthpiece attached. She was instructed to do so slowly and for as long as she can, then to hold her breath for at least 5 seconds as able. I collaborated with respiratory therapy on this education and had her demonstrate it for me to ensure she was doing it correctly.

Objective

6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
a. Develop and implement a priority care map utilizing the nursing process and clinical judgment. (Noticing, Interpreting, Responding, Reflecting)			S	NA	S	NA	NA	NA	S	NA	NA						
b. Identify factors associated with Social Determinants of Health (SDOH) &/or cultural elements that have the potential to influence patient care.** (Noticing, Interpreting, Responding, Reflecting)			S	S	S	NA	NA	NA	S	S	S						
			NS	RH	KA	DW	DW	HS	HS	MD							

****6b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab. Refer to CMS Social Determinates of Health Screening Tool in the Resources folder for the course.**

Comments:

See Care Map Grading Rubrics below.

6b. Factors I noticed associated with the social determinants of health that could impact my patient's care include his living situation and safety. My patient came from home living alone, which applies living situation and safety as a social determinant of health to him because being home alone could cause him to have less support/awareness of his health. This makes safety a social determinant of health pertaining to my patient because by living home alone, his safety becomes compromised especially with his age in the risk that he could get injured and not have help. **Very good! I am surprised to hear that he was from home alone. Considering his story for coming into the hospital, he was having difficulty swallowing for a couple weeks prior to being seen, it makes sense. Now he is going home with a new diagnosis of cancer and newly placed PEG tube when he leaves the SNF after rehab. His SDOH and risk for poor health outcomes only increases if he doesn't have the social support or home environment to promote safety. I hope that he has some family near by that can be of assistance, because his course of medical treatment will be very difficult moving forward. Transportation, financial means to pay for medical bills, educational level related to understanding the complexity of cancer will all be at the forefront. This is where we can consult with a social worker or case manager to advocate for his needs. Good thoughts! NS**

6b week four: When asking my patient about his social history and getting to know him, I found that he doesn't have many social determinants of health that could negatively impact his care. This is because I found he has a spouse and daughter for support, adequate access to food and transportation, and also has two separate houses as far as living situation. However, something I did determine could impact his care is his safety. This is because he has an injury that causes impaired mobility, and this condition especially with having steps in his house could cause a safety risk such as him falling. Also, financial strain could possibly be an issue impacting my patient's care because he does not work due to being on disability from an injury in 2013. **Social Determinates of Health do not need to be negative things. The fact that your patient has a wife and daughter for support is an example of a positive SDOH. Since he has reported having steps in his home, physical therapy should be working with him to learn how to safely get up and down the stairs in his home. RH**

6 b week five: In week five I identified that some social determinants of health that could impact my patient's care include safety, transportation, and financial strain. His safety could be impacted because he has poor vision and hearing as well as COPD, which are all conditions that could pose him at risk for falling and other complications that could occur especially if help wasn't around. My patient also had limited transportation such as if he needed to get to appointments because he does not drive himself. He does have family/friends that drive him, but that could impact his care if they were busy at the time he needed a ride. Lastly, he may feel some struggles of financial strain when it comes to healthcare bills because he no longer works, he is retired. **Great job questioning potential concerns with the patient so that proper referrals can be identified to address any concerns there may be in the areas of his SDOHs. KA**

6b week 9: Some social determinants of health that could impact my patient's care this week include safety/living situation, transportation, and food. My patient was admitted with a right ankle fracture, and he also has four staircases in his house, which puts him at increased risk for falls and repeat or further injury. He does drive himself, however having a right ankle fracture could impair his ability to drive, making transportation another social determinant of health. Also, my patient explained to me that he has adequate access to food and never worries about running out, however being on a diet and needing to eat healthy may lead him to having limited access to nutritious foods. **Absolutely! You did an awesome job discussing these SDOH in your CDG as well! MD**

Week 5 – 6a – You satisfactorily completed your care map on your patient this week. Please see comments on the rubric at the end of the tool for details. KA

6 b week 10: A social determinant of health that I determined could impact my patient's care this week is mental health. This is because she has a history of anxiety, and expressed to me that she was feeling anxious during her hospital stay. In addition, she has a history of chronic illness and is widowed, putting her at risk for feeling hopeless and/or depressed, which may cause her to not seek out healthcare if needed. She has her son and daughter living with her and nearby to assist with ADLS, transportation, food, and she does not feel concerned related to any of the above.

Objective

7. Illustrate professional conduct including self-examination, responsibility for learning, and goal setting. (7)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
a. Reflect on an area of strength. ** (Reflecting)	S		S	S	S	S	S	NA	S	S							
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		S	S	S	S	S	NA	S	S							
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		S	S	S	S	S	NA	S	S							
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		S	S	S	S	S	NA	S	S							
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S		S	S	S	S	S	NA	S	S							
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	S		S	S	S	S	S	NA	S	S							
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		S	S	S	S	S	NA	S	S							
h. Actively engage in self-reflection. (Reflecting)	S		S	S	S	S	S	NA	S	S							
	HS		NS	RH	KA	DW	DW	HS	HS	MD							

**Evaluate these competencies for the offsite clinicals: DH: All IC: All ECSC: All

**7a and 7b: You must address these competencies in the comments section after each clinical experience. Please write a different comment each week. Remember that a goal includes what you will do to improve, how often you will do it, and when you will do it by (example- "I had trouble remembering to do the three checks of the six medication rights prior to administering medications. I will review the six rights and medication administration content in the textbook twice before the next clinical. Additionally, I will request to meet with my clinical faculty member to practice preparing and administering at least three medications before the next clinical.")

Comments:

- **7a Week 1:** An area of strength that I felt I exhibited in week one was coming into the new semester prepared by getting myself familiar with the course beforehand through the course orientation and getting ahead on some of the lessons. I was surprised to see how calm I felt on day one of the semester compared to how overwhelmed I felt on the first day of last semester. **Great job! HS**

- **7b Week 1:** An area of self-improvement that I noticed for myself from week one would be to get better at manually setting drip rates in the event that IV pumps or the power were out. My goal is to get better at this skill and I will do so by practicing setting drip rates a few times each time I have the access to a practice IV at school. I would like to accomplish this by the end of the semester. **Sounds like a great plan! HS**
- **7a week 3:** An area of strength I felt like I had in week three was keeping my calm and composure when the day became busy and I had a lot of interventions to complete. Instead of getting overwhelmed or anxious, I had a lot of fun with the day, learned a lot, and didn't worry about being behind others on time. **Excellent strength to note! If you were nervous or anxious, it certainly didn't appear that way! You were calm, cool, and collected in each new skill that you performed. You were quite busy and got to experience several new aspects of nursing throughout the week. I am so happy to hear that you had fun while learning! I thought you handled everything very well and did a great job with it all. Keep it up! NS**
- **7b week 3:** An area of improvement I had for week three would be to improve my confidence with giving injections. This is because I got to give three subcutaneous injections at this clinical, but I felt uneasy in that my dexterity was awkward or I was doing something wrong. To improve, I will jump at each injection opportunity I get as well as watch other students do it when they have the chance. I will do this every clinical and I would like to accomplish this goal by my next clinical on 4N. **Great plan! The more experiences you can get, the more comfortable you will be. I could tell improvement from the first to the last, which demonstrates your commitment. In the moment I didn't fully realize everything I was throwing at you, but I was proud of how you handled it and think it was a great experience for you. Good reflection! NS**
- **7a week 4:** An area of strength I noticed with myself in week 4 was through my communication with my patient. I felt this way because I feel like sometimes, I am shy or having a hard time connecting with my patient, but this week my patient and I talked a lot and got to know each other. This is important because it causes your patient to have trust in you as a nurse. **I feel like you had good communication/rapport with your patient this week when witnessing your interactions. RH**
- **7b week 4:** An area for improvement I can have after week 4 is to get more involved with physical therapy and occupational therapy in patient care. This is because being that I was on the rehab floor this week, I felt like I was kind of just awkwardly watching my patient with PT/OT. I want to learn more from them and see if I can actively participate in exercises with my patient to help them. To do so, I will make sure to be in the room with a patient when PT/OT is working with them, and ask questions. I want to accomplish this by the end of the semester. **You should have another opportunity to be on the rehab floor this semester, I encourage you to get more involved and see what more you can learn from them. RH**
- **7a week 5:** An area of strength I noticed in myself during week 5 was that I felt more confident in the dexterity of drawing up meds from a vial. When we first learned, it was very awkward dexterity of making sure you aren't drawing up any air and are moving the needle into the fluid, but I definitely feel like I am getting better with it. Drawing up meds is becoming easier with practice and is also a fun nursing skill! **Great job! I am glad you are becoming more confident in this skill. KA**
- **7b week 5:** An area for improvement I noticed during week 5 was that I need to make sure I am lowering a patient's bed before I leave the room. Unfortunately, during the first day of week five I was struggling waking up and happened to forget to lower my patient's bed. This is definitely important for the safety of patients so I want to practice this during every encounter I have with a patient and accomplish lowering their bed every time by my next clinical. **Thank you for recognizing this weakness and creating a plan on how you can prevent this safety concern in the future. I am glad you were more diligent after the initial interaction with your patient, but as you said with every patient every time. KA**
- **7a week 6:** An area of strength I felt like I had this week was asking questions and learning new things. For example, in my digestive health clinical I learned that diverticulosis and diverticulum are both things, when before I had only known what diverticulitis is. They are all similar things but at different stages. I was able to learn and identify what they look like on camera, such as diverticulum is the contents of the pouch, diverticulosis is presence of a pouch in the intestines, and

diverticulitis is when the pouches become inflamed and indicate infection. **Great job! Continuous learning will be a very important part of your nursing career moving forward. DW**

- **7b week 6:** An area for improvement I recognized with myself this week is saying something to people if they aren't doing hand hygiene. When I noticed people not foaming in or out, I marked it on my sheet but I could have said something to make sure they do it in the future and therefore increase the practices of infection prevention. I will practice my communication skills with this each clinical and my goal is to get better at doing so by the end of the semester. **DW**
- **7a week 7-** An area of strength I had this week was getting close with the seniors at the senior center and helping them with the activities. For example, I sat at the table with them during bingo and helped anyone that needed it find their numbers. This allowed me to build a relationship with them and learn how it's harder to find things as you age. **Wonderful! DW**
- **7b week 7-** An area for improvement I noticed with myself for week 7 was being more confident speaking in front of groups. This is because when I noticed that we had to speak through a microphone to explain our activity, I got nervous and didn't want to do it. My goal is to get more confident speaking in front of groups and I will accomplish this by practicing any chance I get such as during the evidence-based practice presentation at the hospital. I want to accomplish this before next semester. **Great goal! I know this can be hard, as I struggle with it myself. I am confident in you and one thing I've learned over the years is that the more you put yourself out there, the easier it is. DW**
- **7a week 9:** An area of strength I noticed within myself this week was taking my medication research further such as being able to think more deeply and determine how certain medications could impact laboratory values. For example, my patient had orders for medications that could impact serum glucose, serum calcium, and serum electrolyte levels. I was able to recognize this and check my patient's levels and write them down to discuss with the instructor without her needing to ask me/instruct me to do so. This was a growth point for me because earlier in the semester, I had been asked what lab values to monitor on a lab and what the patient's values were and I didn't know. **You did AMAZING with making all of the connections! MD**
- **7b week 9:** An area of improvement I noticed within myself this week was with making sure to closely monitor a medication when I go to give it. For example, my patient requested a pain medication after he was already in the rehab gym, and when I scanned his wrist band, I turned my back to the medication, leaving it sit on the counter. This poses a safety risk in that someone could take the med or swap it with a different one. I was able to quickly correct myself and point out my mistake before the instructor said anything, however my goal is to gain more confidence in passing medications to make the medication process go/feel more smoothly. I will do so by taking all the opportunities I can get at every clinical to pass medications and slowing down when doing such, and I would like to accomplish this by the end of the semester. **This is a great goal! I am very proud of you for identifying this in the clinical setting! We were able to remediate on it right away and develop how to work on this in the future. MD**

Midterm- Mallory, great job in the first half of this semester in the medical surgical nursing course! You have shown growth in both your skills and your critical thinking abilities this semester in the clinical setting. You have successfully completed both of your care maps satisfactorily, great job! You are satisfactory in nearly all of the competencies. In the one competency you received an NI for midterm, moving forward be sure to always lower the bed prior to leaving the bedside and perform nursing skills safely and this competency will end satisfactorily. Seek out opportunities involving care of a Foley catheter whether it is inserting, maintaining or removal. Continue to seek out additional experiences in the clinical setting to expand your knowledge base. Keep up the hard work through the last half of the semester! HS

7a week 10: A strength that I noticed within myself this week was being able to keep busy during the whole clinical experience through answering call lights and therefore helping the PCTs and nurses as well. I was also able to keep busy as team leader by overseeing all the students in my group to check their work and help them if they ever needed help with anything. It was a good feeling to know I was being helpful to those around me.

7b week 10: An area for improvement I recognized this week was with my organization of patient information. This is because as a team leader having three patients as opposed to one, it was difficult to have all the patient information/report in a neat manner and have it easily accessible. My goal is to improve the organization of my report sheets by the end of the semester, and I will do so by taking the time to prepare the papers I need before each clinical and reviewing my SBAR/ the patient chart before handing off.

Student Name: Mallory Jamison		Course Objective: 6					
Date or Clinical Week: Week 3							
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	Twelve abnormal assessment findings were listed based on the care provided during the clinical experience, including objective and subjective data. Nine abnormal diagnostic findings were identified with specific patient data included. A thorough list of risk factors were included relevant to the patient based on current and past medical history.
	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	Seven priority nursing problems were identified. Consider including some psychosocial problems as priorities in his care. Think about his new diagnosis of esophageal cancer, need for a PEG tube, inability to eat/drink favorite foods. This can lead to depression, anxiety, etc. Otherwise a strong list was provided. An appropriate goal statement directly related to the priority problem was stated and relevant to the patient situation. All relevant patient data from the noticing section was appropriately highlighted related to the impaired swallowing priority problem. Three priority potential complications were listed, with specific signs and symptoms to monitor for each.
	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	A strong list of 17 nursing interventions were listed. Great job including the educating on chin tilting for oral intake. t point was deducted for prioritization of interventions. According to the care map guidelines, assessment interventions should always take highest priority. Some of the assessment interventions were listed as lower priority then action interventions. Remember, we must always assess first, then act, then educate. Each listed intervention includes an appropriate frequency. All interventions listed are individualized, including specific medication dosages and artificial nutrition
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	2	
	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	

							orders and are realistic to the patient situation.
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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	Appropriate rationale is included for each intervention listed.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	A list of re-assessment findings were included to evaluate the effectiveness of the plan of care. When stating things such as “WBC improved” be sure to be specific with the data demonstrated improvement by listing what the most recent result is (same for blood glucose – which actually unfortunately worsened as his body was adapting to nutrition). Based on the re-assessment findings, it was appropriately determined to continue the plan of care.
	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: Mallory, you did a great job with your care map submission for the priority problem of impaired swallowing. It seems that you were able to make connections in understanding the patient care required and are doing well to develop and enhance your clinical judgement. I think that was a great learning opportunity for you this week. If you have any questions on the rubric don't hesitate to reach out. NS

Total Points: 44/45 - Satisfactory

Faculty/Teaching Assistant Initials: NS

Student Name: Mallory Jamison		Course 6					
Date or Clinical Week: 5		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 identifying all abnormal assessment findings, lab/diagnostics, and risk factors for your patient. KA
	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 did a nice job listing all nursing priorities and highlighting the highest nursing priority. You set a realistic goal and highlighted all supporting data in the noticing section for your chosen nursing priority. You listed 3 complications and signs and symptoms the nurse would assess for with each complication. KA
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	You did a nice job listing all pertinent nursing interventions and made sure they were prioritized, included frequencies, were individualized, realistic, and included rationales. Terrific job! KA
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

Criteria	3	2	1	0	Points Earned	Comments
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	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	You did a nice job reassessing all highlighted data from the assessment and lab/diagnostic sections. You identified you would continue you patient's plan of care. KA
	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: You satisfactorily completed your second care map! Congratulations. See comments above for areas to think about when creating care maps in the future. KA

Total Points: 45/45

Faculty/Teaching Assistant Initials: KA

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

Student name: Mallory Jamison								
Skills Lab Competency Evaluation	Lab Skills							
	Week 1	Week 1	Week 1	Week 1	Week 1	Week 2	Week 2	Week 9
	Insulin (2,3,5,7)*	Assessment (2,3,4,5,7)*	IV Math Application (3,7)*	Lab Day (1,2,3,4,5,6,7)*	IV Skills (2,3,5,7)*	Trach (1,2,3,4,5,6,7)*	EBP (3,7)*	Lab Day (1,2,3,4,5,6,7)*
Performance Codes: S: Satisfactory U:Unsatisfactory	Date: 1/7/25	Date: 1/7/25	Date: 1/8/2025	Date: 1/8/2025	Date: 1/10/25	Date: 1/15/2025	Date: 1/15/2025	Date: 3/10/25
Evaluation:	S	S	S	S	S	S	S	S
Faculty/Teaching Assistant Initials	MD	KA/RH	HS	NS	HS	DW	KA	MD
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA

*Course Objectives

Comments:

Week 1

(Insulin)- You were able to correctly prepare an insulin pen and administer subcutaneous insulin. Insulin requirements were accurately identified and calculated through the corrective scale and carbohydrate coverage orders. MD

(Assessment)- You were able to satisfactorily demonstrate the Basic Head to Toe Assessment during lab. KA/RH

(IV Math)-You satisfactorily participated in the IV Math learning session on 1/7/25 as well as the assigned IV Math practice questions and the IV Math Application lab on 1/8/2025. KA/DW/HS/SA

(Lab Day)- You satisfactorily completed the mandatory lab review of nursing foundational skills. This was achieved through simulating care for a patient in a scenario requiring competency in assessment, communication, medication administration (including PO and IM injection), nasogastric tube insertion and removal, patient mobility and hygiene, use of PPE for Contact Isolation, wound care, foley insertion and removal, development of nursing notes, and providing SBAR hand-off report. NS/MD/RH

(IV Skills)- You have satisfactorily completed IV lab including a saline flush, IV push medication administration with reconstitution, priming and hanging a primary and secondary IV solution, adjusting a flow rate to run by gravity, discontinuing IV therapy, and monitoring the IV site for infiltration and signs of complications. HS

Week 2

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. DW/RH/NS/SA

(EBP Lab)- You actively participated in the online searching process for evidence-based practice literature, as well as reviewing example articles to determine appropriate selection and information needed when summarizing a research article. KA/LK

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

<u>Simulation Evaluation</u>	Student Name: Mallory Jamison							
	Performance Codes: S: Satisfactory U: Unsatisfactory	vSim- Vincent Brody (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	vSim- Juan Carlos (Pharmacology) (*1, 2, 3, 4, 5, 6)	vSim- Marilyn Hughes (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Simulation #1 (Musculoskeletal & Resp) (*1, 2, 3, 4, 5, 6, 7)	Simulation #2 (GI & Endocrine) (*1, 2, 3, 4, 5, 6, 7)	vSim- Stan Checketts (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	vSim- Harry Hadley (Pharmacology) (*1, 2, 3, 4, 5, 6)
	Date: 1/27/25	Date: 2/10/25	Date: 2/24/25	Date: 2/27/25	Date: 4/9 or 4/10/25	Date: 4/14/25	Date: 4/24/25	Date: 4/25/25
Evaluation	S	S	S	S				
Faculty/Teaching Assistant Initials	RH	KA	HS	HS				
Remediation: Date/Evaluation/Initials	N/A	NA	NA	NA				

* Course Objectives

Comments:

Simulation #1- Please review the comments placed on the Simulation scoring sheet below. In addition, review the individual faculty feedback placed within the Simulation #1 Prebrief and Reflection Journal dropboxes. HS

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Jamison (M), Rodisel (A)

GROUP #: 2

SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory

OBSERVATION DATE/TIME(S): 2/27/25 0800-1000

CLINICAL JUDGMENT COMPONENTS	<u>OBSERVATION NOTES</u>
<p>NOTICING: (2) *</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>Notice patient has some difficulty breathing.</p> <p>Obtain vital signs (SpO2, T, BP, pulse, resp) notices elevated heart rate and blood pressure. Notices low oxygen saturation.</p> <p>Pain assessment. Location (leaves room/moves on to other assessment findings) When returns to pain assessment asks rating, radiation, movement.</p> <p>Respiratory assessment, does not state any abnormal lung sounds.</p> <p>Notices redness on right lower leg.</p> <p>Checks pedal and tibial pulses to check cardiovascular status.</p> <p>Notice refusal of SCD and PT/OT</p> <p>Notice patient is not compliant with medications at home and lack of aspirin use with a-fib puts patient at risk for clot.</p>
<p>INTERPRETING: (1) *</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p>Prioritize vital signs assessment.</p> <p>Begins pain assessment but moves into respiratory assessment prior to completing pain assessment.</p> <p>Prioritizes cardiovascular assessment upon visualizing right lower leg. Removes pillow from surgical pain.</p> <p>Begins to prioritize Percocet (PO) but then offers morphine. Does not have orders for morphine at this time.</p> <p>Makes sense of morphine dosage calculation.</p> <p>Interpret ABG as respiratory acidosis. Correct interpretation is respiratory alkalosis.</p> <p>Makes sense of lack of movement/refusal of PT with development of DVT/PE</p>

	Does not make sense of dosage calculation for enoxaparin. (administers 0.7mL)
<p>RESPONDING: (2,3,4,5,6) *</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>Introduce self upon entering room and ask patient name/DOB. Verify pronouns with patient and continue to use correct pronouns throughout scenario.</p> <p>Set head of bed up due to patient report of shortness of breath.</p> <p>Call healthcare provider. SBAR did not include situation or background, jumped right into assessment findings. Did not have all data gathered prior to calling.</p> <p>Return to room to finish assessment findings and calls healthcare provider back. SBAR only includes assessment findings, does not use SBAR when communicating. Receives new orders from healthcare provider. Does not read back orders. We always want to read back orders to ensure the correct order was heard and written down correctly.</p> <p>Update patient on status change and new orders. Begins educating on incentive spirometer and importance of movement to decrease risk of pulmonary embolism.</p> <p>Morphine administration: verify all checks and asks allergies. Identify need for witness waste of medication. Correct needle size used. Proper technique when administering medication. Needle safety used.</p> <p>Call healthcare provider with updates on labs and radiology reports. Receives new order for enoxaparin. Does not read back orders to healthcare provider.</p> <p>Education provided to patient on deep breathing exercises and incentive spirometry. Education provided on risk factors for blood clots (surgery, lack of movement). Education provided on compression socks in relation to decreasing risk for a clot. Reassure patient that they will not be alone and they will be educated on how to walk without falling while weightbearing is minimal.</p> <p>Enoxaparin administration: performs all checks. Educate patient on reason for medication and how medication. Use of correct needle size for injection. Injection administered at less than 45 degree angle, should be 90 or 45 for subq injections.</p>
<p>REFLECTING: (7) *</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B 	<p>Group led discussion regarding the patient scenario. Students began with description of report with off shift nurse and how it was not professional or appropriate to be dismissive of the patient. Group</p>

<p>• Commitment to Improvement: E A D B</p>	<p>members stated they were uncomfortable but did not know how to address it in that instance. Discussion of how to approach this or report it up the chain of command followed. Students moved onto discussion of scenario and what assessments took priority for their patient and why (1st group was 6 Ps and pain, second group was respiratory and cardiovascular). Discussion about risk factors for developing a DVT/PE and how patient came to develop these (SCD, lack o movement, non-compliant with medications). Discussion of compartment syndrome and what nursing interventions were needed to help prevent further damage to the limb (remove ice, pillow, pressure). Group review of medication math in regards to enoxaparin medication. All members able to perform math correctly. Discussion of how math was done during simulation and how the group came up with different numbers at that time. Review importance of reading back orders to healthcare provider. Discussion of liability and who would be held accountable for incorrect orders due to lack of readback. Each group member included a goal for improvement for the next simulation as well as something they thought they did well during this simulation.</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> <ol style="list-style-type: none"> 1. Select focused physical assessment priorities based on individual patient needs. (2)* 2. Implement appropriate nursing interventions based on patient’s assessment. (1,3,6)* 3. Communicate appropriately with the patient, family, team members, and healthcare providers incorporating elements of clinical judgment and conflict resolution. (4,7)* 4. Provide patient-centered care with consideration to cultural, ethnic, and social diversity. (2,3,6)* 5. Provide appropriate patient education based on diagnosis. (5)* <p>* Course Objectives</p>	<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. Identifies obvious patterns and deviations, missing some important information; unsure how to continue the assessment. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads.</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: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. Shows some communication ability (e.g., giving directions); communication with patients, families, and team members is only partly successful; displays caring but not competence. 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. Is hesitant or ineffective in using nursing skills.</p> <p>Reflecting: Evaluates and analyzes personal clinical performance with</p>

	<p>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>
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EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2025

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 and Date:

11/21/24