

**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:

ABSENCE (Refer to Attendance Policy)

- Skills Lab Competency Tool & Skills Checklists
- Simulation, Prebriefing, & Reflection Journals
- Nursing Care Map Rubric
- Meditech Documentation
- Clinical Debriefing
- Clinical Discussion Group Grading Rubric

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

Evaluation of Clinical Performance Tool

Lasater's Clinical Judgment Rubric & Scoring Sheet

Virtual Simulation Scenarios

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
2/19-20/2025	Impaired Physical Mobility	Satisfactory/MD	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	MakeUp	Final
Competencies:																	
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	S	NA	NA	S	NA	S	S	S						
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	NA	NA	S	NA	S	S	S						
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	NA	NA	S	NA	S	S	S						
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	NA	NA	NA	S	NA	S	S	S						
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	NA	NA	NA	S	NA	S	S	S						
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	NA	NA	NA	S	NA	S	S	S						
g. Assess developmental stages of assigned patients. (Interpreting)			S	NA	NA	S	S	NA	S	S	S						
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	NA	S	S	NA	S	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 <small>See above</small>	5T, 61, R quad tear. repaired	DH and IC	NA	ECSC	5T, 70, <small>See above</small>	NA	Midterm	4N, 79, Fall 4N 86 Fall	4N, 75, <small>See above</small>						
Instructors Initials	DW		RH	DW	DW	NS	MD	DW	DW	NS							

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

*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Comments:

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(c, d, e) This week you did a great job of discussing your patient's pathophysiology of their illness as well as discussion of their medications. You were able to correlate why each medication was related to their care. RH

Week 6 1(h) – You discussed the activity that you and your group developed for the ECSC in your CDG response this week. Great job considering a couple different domains to address in your activity. By preparing these activities in advance, taking into consideration some of the limitations that the clients may experience, you demonstrated effective preparation for the clinical experience. NS

Week 7 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

Week 9 1(a-h) – Great job this week discussing the alterations to your patient's health and implementing the nursing care required. I appreciate your level of interest in learning more about your patient through reviewing her chart and asking appropriate questions. During our discussions you were actively engaged and provided insight into what you learned through independent research. Well done. On day one you cared for a patient admitted with a UTI, sepsis, and NSTEMI. You did well to discuss the pathophysiology involved, including urosepsis as indicated by the elevated lactic acid level, urine culture positive for e. coli, and urinalysis positive for UTI. You also noticed a significantly elevated troponin level which you correlated to a type II NSTEMI related to demand ischemia. Good job researching complicated data. You correlated the symptoms she was experiencing including abnormal heart rhythm, falls, and confusion to the UTI. Diagnostic tests were identified and discussed. You did well correlating her pharmacotherapy, including the anti-platelet and anti-coagulant medications related to her afib and NSTEMI. You discussed the medical treatment of antibiotics and fluids for the UTI and urosepsis, and the heart cath procedure for her NSTEMI. Appropriate nursing measures were discussed related to the procedure, monitoring the insertion site for bleeding and signs of hematoma. Overall you did well discussing your patient's situation and enhancing your clinical judgement throughout the week. NS

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:																	
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	NA	NA	NA	S	NA	S	S							
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	NA	NA	NA	S	NA	S	S							
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	NA	NA	NA	S	NA	S	S							
d. Communicate physical assessment. (Responding)			S	NA	NA	NA	S	NA	S	S							
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	NA	NA	NA	S	NA	S	S							
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	NA	NA	S	NA	S	S							
	DW		RH	DW	DW	NS	MD	DW	DW	NS							

**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: (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 change a dressing on your patient's abdominal wound on Wednesday and a leg wound on Thursday. 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 7 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

Week 9 3(a,e) – Good job with your assessments this week, noticing numerous deviations from normal. You prioritized your focused assessments well with good rationale. On day one, you noticed the irregular heart rhythm upon palpation and auscultation which was correlated with her afib. You also noticed significant lymphedema which was correlated to her history of breast cancer and DVT. You focused your assessment on her left upper extremity following the invasive procedure through her radial artery, noticing bruising underneath the pressure dressing. On day 2, you noticed significant bruising following a fall at home resulting in a subarachnoid bleed and fractured wrist. You focused your assessment on circulation to the fractured extremity and her neuro status related to the bleed. Overall nice job! NS

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	S	S	NA	S	S							
a. Perform standard precautions. (Responding)	S		S	S	NA	S	S	NA	S	S							
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	NA	NA	NA	S	NA	S	S							
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	NA	NA	NA	S	NA	S	S							
d. Appropriately prioritizes nursing care. (Responding)			S	NA	NA	NA	S	NA	S	S							
e. Recognize the need for assistance. (Reflecting)			S	NA	NA	NA	S	NA	S	S							
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S	NA	NA	S	NA	S	S							
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA	NA												
h. Implement DVT prophylaxis (early ambulation, SCDs, TED hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	NA	NA	NA	S	NA	S	S							
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S	NA	NA	S	NA	S	S							

j. Identify recommendations for change through team collaboration. (Reflecting)			S	NA	NA	S	S	NA	S	S							
	DW		RH	DW	DW	NS	MD	DW	DW	NS							

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

Comments:

Week 3: (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. RH

Week 6 3(j) – Great job working with a team of your peers to develop beneficial activities for the clients at the ECSC. You were able to work with the staff at the ECSC and your peers to identify limitations and implemented effective interventions that helped all clients to participate in the day. Great job! NS

Week 7 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	NA	NA	NA	S	NA	S	S							
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	NA	NA	NA	S	NA	S	S							
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	NA	NA	NA	S	NA	S	S							
m. Calculate medication doses accurately. (Responding)			S	NA	NA	NA	S	NA	S	S							
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			S	NA	NA	NA	S	NA	S	NA	S						
o. Regulate IV flow rate. (Responding)	S		NA	NA	NA	NA	S	NA	S	NA	NA						
p. Flush saline lock. (Responding)			S	NA	NA	NA	S	NA	S	NA	NA						
q. Monitor and/or discontinue an IV. (Noticing/Responding)			NA S	NA	NA	NA	S	NA	S	NA	S						
r. Perform FSBS with appropriate interventions. (Responding)	S		NA	NA	NA	NA	S	NA	S	NA	NA						
	DW		RH	DW	DW	NS	MD	DW	DW	NS							

**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: (3k-n, o, q) 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, SubQ, IV push, and topical medications this week. I changed (3q) to "S" because you did monitor your IV that your patient had on Wednesday. RH

Week 7 Rehab Clinical Objective 3: 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. You were also able to administer an IV antibiotic, accurately calculated the IV rate, flush an IV, and perform FSBS! Awesome medication pass! MD

Week 9 3(k-m) – You did a nice job with medication administration this week, administering several PO medications. The rights of medication administration were observed, and safety checks were performed. You were prepared to answer questions related to the classification, implications, side effects, and nursing considerations for each. Medications were safely administered and patient's questions were answered. Nice job! NS

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:																	
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	NA	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	NA	S	S	NA	S	S							
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	NA	NA	NA	S	NA	S	S NI	S						
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	NA	S	S	NA	S	S	S						
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	NA	S	S	NA	S	S	S						
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	NA	NA	NA	S	NA	S	S	S						
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			S	NA	NA	NA	S	NA	S	S	S						
			RH	DW	DW	NS	MD	DW	DW								

**Evaluate these competencies for the offsite clinicals:

DH: 4a, b, d

IC: 4b, d, e

ECSC: 4a, b, d, e

Comments:

Week 3: (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. RH

Week 4 (4e)- According to the CDG Grading Rubric, you have earned a satisfactory for your Infection Control discussion this week. Your discussion was thorough and backed by evidence from Davis's Diseases & Disorders. Overall, good job with your APA formatting; just one suggestion: 1. When you are citing a reference within your text, only the author's last name is used, not the first initial- for example (Sawyer Sommers, 2023). DW

Week 6 4(e) – Nice work with your CDG prompts this week related to your ECSC clinical experience. All requirements were met for a satisfactory evaluation. See my comments on your post for further details. NS

Week 7 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 swallowing and dysphagia that was interesting and detailed regarding your patient. The reference and in-text citation you provided were satisfactorily completed. Please see me if you have further questions! MD

Week 9 4(a,b) – Nice job with your communication this week with your patient, staff, peers, and faculty. You were able to provide therapeutic communication to your patient experiencing increased anxiety. As you learned, she has been isolated since the loss of her husband and did not have a strong support system outside of her grandson. I appreciate the time you took to talk with her, explain your interventions, and calm her nerves. Well done. NS

Week 9 4(c) – I changed this competency to “NI” related to not reporting the identified blood pressure of 220/110. This was discovered after the it had been charted, resulting in new orders being put in by the physician for BP management. When discussed, you identified that the cuff was having difficulty obtaining a reading and was causing discomfort to the patient. Once discovered and re-assessed, the BP was within normal limits. I changed this to “NI” because a medication could have been administered for hypertension when this was not an accurate result. Furthermore, 220/110 is a hypertensive emergency and should be addressed promptly. Remember in the future to report all abnormal vital signs. On day 2, you did learn from the experience and promptly reported changes to your patient's Spo2 and responded quickly. The NI is just a reminder for the future. NS

Week 9 4(e) – Great job with your CDG related to SDOH that could impact your patient's health outcomes. You identified some important factors, most notably her lack of support and transportation and mindset of doing everything herself. With her complex medical problems, this could pose difficulties in follow-up care. Your response to Abbi provided additional insight and enhanced the conversation. I am glad you were able to learn a little bit more about SNAP benefits and how it can positively impact low-income households. Good job conducting further research. All criteria were met for a satisfactory evaluation. NS

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: a. Describe a teaching need of your patient.** (Reflecting)			S	NA	NA	NA	S	NA	S	S							
			S NI	NA	NA	NA	S	NA	S	S							
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			RH	DW	DW	NS	MD	DW	DW	NS							

****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:

Week 3 5a- A teaching need for my patient was to not get frustrated or discouraged when he couldn't do one of the therapies during his sessions. This is necessary because he has a history of depression and anxiety and I want to keep him from falling back into one of these episodes. **This is a good educational need, but what resource did you use for this? You only addressed 5a here, and 5b is asking for the resource you used. Note that in the future, this will be marked as a "U", but since it is the first week, I will put NI so you can review the competency closer. RH**

Week 7 5a/b- A teaching need for my patient was proper swallowing technique because she had a new onset of dysphagia due to her recent stroke. I would remind her to turn her head to the left and not tuck her chin when she swallows to avoid coughing. She needed to be cued on this 2-3 times per meal. I did this in order to help keep her safe and comfortable while she ate. She would be uncomfortable if she did not turn her head because she would be coughing and she would not be safe because this cough put her at risk for aspiration. I would correct her swallowing and then she would perform it. I used Skyscape as my resource for this teaching need.

Myers, E. (2023). *RNotes: Nurse's clinical pocket guide* (6th ed.). F. A. Davis Company: Skyscape Medpresso, Inc **Perfect! You also did an awesome job detailing this in your CDG this week! MD**

Week 9 5a/b- A teaching need for my patient on day two was the need for oxygen. She stated that the only receives supplemental oxygen while she is the hospital and does not use an oxygen tank at home. She was receiving 2L of oxygen via nasal cannula and her SpO2 was usually at 95%. Since she does not receive oxygen at home, I wanted

to avoid her becoming dependent on it, so I attempted to wean her off of it. I lowered the O2 to 1L and reassessed her SpO2 15 minutes later. Upon reassessment she was at 84% so I raised the O2 back up to 2L. After raising the O2 and her SpO2 returning to 95% I explained why I raised her O2 again. I explained the normal SpO2 range (95-100%) and what some symptoms may occur if SpO2 is lower than the normal range. She nodded that she understood and that she will let someone know if she starts experiencing symptoms like SOB and dizziness. Myers, E. (2023). *RNotes: Nurse's clinical pocket guide* (6th ed.). F. A. Davis Company: Skyscape Medpresso, Inc. **Very good, Kayli! I love the you included your patient in these interventions and provided education for her understanding so that she can notify nursing staff if complications arise. It is important that we try to return patients to their baseline prior to discharge, especially with oxygen. We don't want her becoming reliant upon it if she doesn't have to be. You implemented effective interventions and did most important thing, which was re-assess, in which you noticed she was unable to maintain her SPO2 with decreased levels of oxygen. Good education and good thoughts provided! NS**

Week 10 5a/b- A teaching need for my patient this week was the need to get out of bed and move throughout the day. He was comfortable lying in bed during the day but once he was educated on the importance of moving, he was more open to the idea of getting up. I explained to him how even just getting out of bed and sitting in the chair can help to get his bowels moving and it can also help with his SpO2. The thought behind his SpO2 being lower was that the distension of his abdomen was pressing on his lungs while he was laying down, by sitting in the chair some of that pressure is relieved. During the day his SpO2 would sit around 90% but at 1200 I checked it while he was sitting up in the chair and he was at 96%. Myers, E. (2023). *RNotes: Nurse's clinical pocket guide* (6th ed.). F. A. Davis Company: Skyscape Medpresso, Inc.

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)			NA	NA	NA	NA	S	NA	S	NA	S						
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 NI	NA	NA	NA	S	NA	S	S	S						
			RH	DW	DW	NS	MD	DW	DW	NS							

****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.

Week 3 6b- My patients SDOH were financial and transportation related. **How did you correlate these to his care? Did you provide resources to assist with these? RH**

Week 7 6b- My patients SDOH were physical activity. I correlated this with her care by taking extra time to make sure she was comfortable in her wheelchair, that her wheelchair was where she wanted it, that are her belonging were close by, and offering her assistance with anything else she wanted. While in her room she wouldn't want to leave the wheelchair but she performed all the exercises during physical, occupational, and speech therapy. **This is a very important SDOH! What other factors would you anticipate for your patient? MD**

Week 7 Rehab Clinical Objective 6 A: This week you were able to develop a satisfactory care map based on impaired physical mobility. Please see rubric for additional comments! MD

Week 9 6b- My patient on day one had a few SDOH. She had a history of mental health issues, she couldn't drive herself, she couldn't afford some of her medications, and she was living alone at 79 years old. I worked with by offering to talk with her about anxiety and depression that she might be feeling while in the hospital, I also talked with her and her son about transportation. Her son lived in a different state and drove a truck to visit her, she was unable to get into this truck. Since she was being discharged, they were working out a plan to get her home. I talked with them about how much time they had before she was released from the hospital's care so that the son was able to switch out the truck for a car that the patient was able to get into; I also offered resources like cabs and rough estimates of cab fees. **As we learned during the**

clinical week, her recent loss of her husband had a major impact on her mental health. You did well to help address these concerns through therapeutic communication. Furthermore, I appreciate your effort in advocating for your patient regarding discharge planning. You sought advice from the clinical educator and followed up on information you were not fully confident in. Good collaboration with other health care team members to address her concerns and SDOH to help promote positive outcomes. Well done. NS

Week 10 6b- My patient's SDOH this week were occupational and educational. He is 75 years old and a full-time farmer which can put him at risk for many injuries and infections. He was a very smart man but lacked some medical knowledge. He doesn't normally go to the hospital or see a doctor but would rather deal with medical issues at home. While caring for him we talked about when an appropriate time would be to go to the hospital for injuries or illnesses. I also helped educate him and his wife about medications he was receiving at the hospital and why he was receiving those.

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	NA	S	S	NA	S	S							
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		S	S U	S	S	S	NA	S	S							
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		S	S	NA	S	S	NA	S	S							
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		S	S	NA	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	NA	S	S	NA	S	S							
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	S		S NI	S	NA	S	S	NA	S	S							
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		S	S	NA	S	S	NA	S	S							
h. Actively engage in self-reflection. (Reflecting)	S		S	S	NA	S	S	NA	S	S							
	DW		RH	DW	DW	NS	MD	DW	DW	NS							

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: I feel a strength I had was I was able to pick up on the new skills relatively easily and was still confident in the skills I learned from Nursing Foundations. **Great! Was there a one specific skill you felt most confident in (one new and one old)? DW**

7b week 1: An area of improvement I noticed was that I had a very difficult time doing manual drip rates on the IV pumps. The biggest problem I had was counting for the first 15 seconds, I think I was looking on the clock wrong. In order to fix this I will keep practicing with a clock that has a second hand so I can confidently count the full 15 seconds and again with 60 seconds. **Kayli, this is a great idea and one that I would consider freshening up on at regular intervals. This skill is not required on a daily basis in the clinical setting, so the time will come that you need it when you are least expecting it, but you will be prepared. Keep up the great work! DW**

7a week 3: I feel a strength I had was being very personable with both my patients on 5T. I was able to sit and talk with them and learn things about them that you cannot find in your charts. I think this made them feel more welcoming to me providing care. **You did a great job communicating and making your patients feel comfortable with you. RH**

7b week 3- A weakness I had was organization. I felt I was bouncing around between assessments, therapy, med passes, etc. I need to work on scheduling enough time for every part of patient care so that I don't feel rushed and so the patient doesn't feel anxious or nervous. I will practice this in my everyday life by balancing enough time for studying, homework, work, and relationships. **This can be difficult on the rehab floor due to the always changing therapy schedule. I encourage you to continue balancing your time in your personal life, but also giving yourself some grace since this floor is a bit different than a traditional floor of a hospital. RH**

Week 3: (7f) This was changed to NI due to you initially turning in the wrong format for the tool. **Please remember for future tools to turn in a word document so we are able to provide feedback to you. RH**

7a week 4: I feel a strength I had was being confident in what I knew about caring for patients pre and post-op and being able to ask questions for both IC and DH. **Love the confidence! DW**

7b week 4: A weakness I had was not being as confrontational as I should have been. During IC I knew me and my partner were running out of time but I chose not to say anything. During DH I should've asked the staff again if they were ready for us instead of sitting and waiting since it caused us to start a little late. **I appreciate the reflection here, Kayli! Advocating for yourself while you are learning and growing can be challenging, yet necessary. With that said, may I suggest a slightly different approach to your wording? Instead of being confrontational (which no one really likes to be), maybe you would want to be more "assertive" in pointing out the start time. Do you see the difference here...one seems a little less aggressive and more professional? Now, how can you set a goal to improve in this area? I don't see that you've mentioned what you want to do, how often you want to do it and when you want to do it by, as required for 7b. Unfortunately, this will result in a U for 7b. Sometimes you need to think outside of the box in order to create change. Additionally, it is important that when you identify a gap or opportunity for improvement that you actually work to improve it in real time, instead of just waiting for another opportunity to present itself and hoping that you respond differently. If you want to work on being more assertive, maybe you could take an active role in organizing and leading a group project that you have in this course and not waiting for one of your other group members to initiate discussion- completing this at least 2 weeks before the project deadline (or) maybe it's a matter of introducing yourself to 3 new people in the clinical setting that you normally wouldn't have even addressed as a way to take yourself out of your comfort zone- completing this during the next two clinical experiences. Lastly, please review the directions on p. 1 of this document for requirements in addressing this U. You must include a comment below on how you have/will improve the U for the next week of clinical. Failure to do so will result in a continued U until completed. Please let me know if you have any questions. DW**

7b correction: I will incorporate being more assertive and stepping out of my comfort zone throughout class projects and clinicals. Ways I will do this is through the EBP Poster project, I will reach out to my group early and set up a time for a us to meet to get the project done before the due date. This is something that I have been doing throughout the semester but in continuing to do this I believe I will gain more confidence in myself for future group assignments. In the clinical setting I will try and talk to more people working instead of just the nurse that I'm paired with for the day. These other people may be other nurses, doctors, wound care, etc. By doing this I feel I will gain more confidence throughout this course and clinicals. **DW**

Week 4 (7f)- Kayli, I understand you've been having issues related to submission of your clinical tool and I appreciate you communicating that to me. **With that said, in the future, the tool will be considered late if it is not submitted by the deadline. In order to avoid a U, please submit the correct version of the tool in a timely manner and communicate before the deadline if you are having issues with the formatting. It sounds like you've gotten everything straightened out and that's great, but I just wanted to give you a heads up in case this happens again. DW**

7a week 6: I feel a strength I had during this clinical was being more outgoing. I talked with the staff, after finishing assigned tasks I asked if they needed help with anything else, and I controlled my anxiety while reading trivia questions; my voice and my hands didn't shake, and I spoke clearly and loudly enough for all the seniors to hear me. **Awesome to hear! NS**

7b week 6: I feel like I should've spent more time with the seniors. I mostly talked to the staff, but I only interacted with the seniors during trivia. There weren't many opportunities to interact with the seniors other than trivia, but I feel I could have at least asked for their names, especially when they would win a trivia question. In order to improve on this, I will ask more personal questions to the patients I care for on clinicals, like how many kids they have or where they work. I can practice this in my day-to-day life by getting to know the new boyfriends/girlfriends that are dating my friends. Instead of waiting for them to talk to me I will start the conversation with them. Doing this with new people in my life will give me the confidence to do it with the

people I'll see during clinicals. **Very good, Kayli! I can attest to the difficulties of "small talk" when you may be more reserved in nature. Nursing has a way of making you more out-going. I think you have a great plan to help yourself get more comfortable! NS**

7a week 7: I feel my strength this week was documentation. I was able to quickly get my documentation done during my head-to-toe assessment and then after I would find a station or empty room and double check that all my documentation was thorough, accurate, and completed. The first clinical day I had a few corrections to make on my documentation after it was reviewed by the instructors, but the second day I didn't have any corrections to make. This really helped boost my confidence with documentation. **You did a great job with documentation! You also communicated with your patient well! MD**

7b week 7: My weakness this week was not being as fluid as I would have liked to have been with med pass. I would fumble between identifying the patient, verifying the patient, checking for allergies, and verifying the medications. In order to improve this, I will review videos and notes about med pass throughout the next few weeks to help me remember all the steps while I am giving meds during the next clinical. **This is a great goal! I have faith this goal will be met when you are in inpatient experiences! MD**

Midterm- Kayli, what a great first half of the semester you've had so far. It is evident that you are making great strides in the MSN course. Your tool demonstrates your ability to provide patient-centered care, prioritize and make appropriate clinical judgments. Your communication and teaching have been consistently satisfactory. Additionally, you have satisfactorily completed one of the two required care maps for this semester. At midterm, you are satisfactory for all clinical competencies within this tool. Please utilize all instructor feedback to ensure continued growth during your educational journey. Additionally, as an adult learner, it is important to be an active participant in your own learning. If you have any NA's at midterm, please seek these opportunities out over the next couple weeks left of clinical. Lastly, use this time over spring break to regroup so you can finish strong for the remainder of the semester. I am confident in you! Please let us know if you have any questions or need further clarification. Keep up the hard work and effort. DW

7a week 9: I feel my strength was really digging into my patient's charts and trying to understand why some of their issues may have happened. I learned about how a UTI may lead to a Nstemi, I also learned the difference between a nstemi and a stemi. I feel that by really trying to understand how one issue can lead to another I was able to make better decisions about my patients' plans of care. **This was a great strength to note this week! I could tell how eager and excited you were to dig deep and learn more about your patient. I appreciate the independent research and questions that were asked to help enhance your understanding. I thought we had a good discussion with your peers regarding your patients condition and the nursing care required. Great job having a spirit of inquiry! NS**

7b week 9: My weakness this week was not being as engaging with other clinical members like I have done in previous weeks. One student on the clinical team this week went to high school with me, and she and I had our fair share of issues in the past. I feel like I could've been more engaging with her because in real work settings it is possible to be on a team with someone you might not particularly like, but you have to work as a team for the safety of the patient(s). In order to improve on this, I will make a better effort to work with all members of the clinical team and engage more with them throughout the next few clinicals because they may have thoughts that could improve patient care. **Kayli, I appreciate this reflection. I will say, I did not notice this during the clinical experience so you did maintain professionalism during our interactions. However, having the self-awareness and insight to reflect on professional relationships shows maturity and growth as a person. As you made an important note on, we won't always get along with our peers or co-workers. However, we can't let this impact our care or patient outcomes. I think this self-evaluation will serve you well in the future as you noted the importance of remaining professional. Good reflection! Keep up the hard work. NS**

7a week 10: I feel my strength this week was correlating past diagnoses and surgeries, current and past medications, and current interventions to my patient's diagnosis while he was in the hospital. I was able to understand why Pepcid is used after a bowel resection, why there was need for a bowel resection with a small bowel obstruction, and how his past hernia surgery and possibly past radiation therapy led to his adhesions and small bowel obstruction.

7b week 10: I feel my weakness this week was not encouraging my patient to move as much as I could have. I would ask him if he wanted to get a few times a day and I educated him on the importance of moving about twice a day. I feel I could have been more encouraging. I think if I had pushed him a little bit more to get up he would've walked a little more. I did get up to the chair, to the bathroom, and back in the bed a few times throughout the day.

Student Name: Kayli Collins		Course Objective: Impaired Physical Mobility					
Date or Clinical Week: 2/19-20/2025							
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	All criteria met. MD
	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	All criteria met. MD
	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	
	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	All criteria met. MD
	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	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

R	individualized and realistic						
	Criteria	3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	All criteria met. MD
	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:

Total Points: 45/45 Satisfactory MD

Faculty/Teaching Assistant Initials: MD

Student Name:		Course Objective:					
Date or Clinical Week:							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)		
	2. 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. 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)		
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	5. State the goal for the top nursing priority.	Complete			Not complete		
	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		
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)		
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)		
	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete		
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete		
	12. All interventions are	> 75% complete	50-75% complete	< 50% complete	0% complete		

R	individualized and realistic						
	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		
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete		
	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		

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:

Total Points:

Faculty/Teaching Assistant Initials:

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

Student name: Kayli Collins								
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)*
	Date: 1/7/25	Date: 1/7/25	Date: 1/8/25	Date: 1/8/25	Date: 1/10/25	Date: 1/15/25	Date: 1/16/25	Date: 3/10 or 3/11/25
Evaluation:	S	S	S	S	S	S	S	
Faculty/Teaching Assistant Initials	MD	KA/RH	DW	NS	RH	DW	KA	
Remediation: Date/Evaluation/Initials	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 1/8/25. 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. DW

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: Kayli Collins							
	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	vSim- Yoa Li (Pharmacology) (*1, 2, 3, 4, 5, 6)
	Date: 1/27/25	Date: 2/10/25	Date: 2/24/25	Date: 2/26 or 2/27/25	Date: 4/9 or 4/10/25	Date: 4/14/25	Date: 4/24/25	Date: 4/25/25
Performance Codes: S: Satisfactory U: Unsatisfactory								
Evaluation	S	S	S	S				
Faculty/Teaching Assistant Initials	RH	DW	MD	DW				
Remediation: Date/Evaluation/Initials	N/A	N/A	NA	NA				

* Course Objectives

Comments:

Sim #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 dropbox. DW

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Kayli Collins (M) Yasmin Perez (A)

GROUP #: 6

SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory – Part 1

OBSERVATION DATE/TIME(S): 2/27/2025 1015-1215

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><u>Focused Observation</u> Full focused pain assessment performed to the injured extremity (rating, duration, location, aggravating factors, alleviating factors, description). Full neurovascular assessment performed (6Ps identified). Full set of vital signs obtained (BP, HR, RR, Spo2, Temp)</p> <p><u>Recognizing Deviations</u> Noticed pain, pressure, paresthesia, paralysis, pulselessness during neurovascular assessment. Noticed abnormal vital signs (HTN, RR-22, HR)</p> <p><u>Information Seeking</u> Asked patient about previous surgeries or infections. Asked patient about medication compliance at home. Exploring reasoning for not following provider’s prescription orders. Asked if pain being experienced has changed, asked when last dose of pain medication was administered to determine effectiveness. Asked patient when last tetanus shot was received. Asked about allergies prior to medication administration.</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><u>Prioritizing Data</u> Prioritized neurovascular assessment immediately following patient’s complaint of increased pain. Prioritized exposure of the patient’s limb by removing the sock. Prioritized fluids initially prior to new order received for morphine. During preparation of antibiotic, recognized importance of prioritizing pain relief and administered IM morphine first. Could have been done sooner, but appropriately addressed. Prioritized notifying the health care provider regarding emergent situation and change in patient status. Prioritized interventions for compartment syndrome by removing the pillow and ice to reduce pressure.</p> <p><u>Making Sense of Data</u> Recognized medical emergency and need to contact the health care provider once assessment details were collected first. Made sense of dosage calculation to be performed for IM morphine administration. 4mg to be administered in 2ml. Made sense of need to have antibiotic infusing prior to surgery.</p>
<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><u>Calm, confident manner</u> Calm demeanor in a stressful situation. Communicated with significant other providing update on plan of care. Reassured patient with communication with significant other.</p> <p><u>Clear communication</u> Most confident in interventions performed. Could improve in confidence with IV pump programming. Team members appeared unsure; however, good teamwork utilized. Did not always focus on calming the patient when focused on tasks such as IV programming. Confident in communicating with team member and health care provider.</p> <p>Communication amongst team members was strong, good collaboration throughout. Explained interventions being performed related to complication occurring. Could improve empathizing with the patient by</p>

	<p>continuously reassuring during an emergent situation. SBAR provided to health care provider. Situation described, remember to include full background. Assessment details provided related to neurovascular assessment. Be sure to read orders back to the provider for confirmation. Education provided related to compliance with medications. Educated patient on weight bearing status. Need to inform patient about expedited surgery to keep the patient involved in the plan of care. Conflict addressed professionally. Discussed actions to take during debriefing. Did not fully address social diversity. Asked preferred name to be called. Referred to “him” and “her” intermittently in communication. Discussed during debriefing.</p> <p>Well-planned intervention/flexibility Pain medication and antibiotic administered prior to surgery. Could improve timeliness in administering pain medication. Difficulty with IV pump hindered speed; however, was prioritized. Initiated IV fluids promptly. Pillow and ice removed to reduce pressure. Consider re-assessing vital signs and pain after medication administration. Used BMV for patient safety with medication administration. Notified health care provider promptly with change in patient status.</p> <p>Being Skillful Accurate dosage calculation performed. Appropriately determined need to administer 4mg (2ml). Medication wasted with a witness. This should be done prior to administration (discussed during debriefing). Saline flush performed to determine patency of IV site using aseptic technique. IM injection administered appropriately. Remember to aspirate prior to injection. Watch needle safety with your finger, use the bedside table to activate safety device to avoid potential needle stick. Primary fluids primed appropriately. Some difficulty with secondary infusion (leaking). Assistance required for programming of the IV pump requiring extended period of time. (remediated and discussed during debriefing). Be sure to read orders back to the provider.</p>
<p>REFLECTING: (7) *</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>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.</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 A= Accomplished D= Developing 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)* 	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family.</p> <p>Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient’s data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success.</p> <p>Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Is hesitant or ineffective in using nursing skills.</p> <p>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.</p>

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)*
* Course Objectives

Satisfactory completion of MSN simulation #1.

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