

EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Jessica Bower

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
2/6/25	Impaired Mobility	S/RH	N/A	N/A
3/17/2025	Impaired Gas Exchange	S/HS	N/A	N/A

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	N/A	S	S	N/A	N/A	S	S	S						
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	N/A	S	S	N/A	N/A	S	S	S						
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	N/A	S	S	N/A	N/A	S	S	S						
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	N/A	S	S	N/A	N/A	S	S	S						
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			N/A	N/A	S	S	N/A	N/A	S	S	S						
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			N/A	N/A	S	S	N/A	N/A	S	S	S						
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			N/A	N/A	S	S	N/A	N/A	S	S	S						
g. Assess developmental stages of assigned patients. (Interpreting)			N/A	N/A	S	S	S	N/A	S	S	S						
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	N/A	S	S	S	N/A	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 Sessions		Infection Control & Digestive Health	NA	Rehab 92M Limited Mobility	3T 78F UTI & AKI	Erie County Senior Center	N/A - SIMULATION LAB #1	MIDTERM	3T 92M Impaired Gas	5T 78M Functional Decline						
Instructors Initials	MD	MD	DW	DW	RH	HS	SA	MD	MD	HS							

****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 (Obj 1)- Jessica, at a very minimum, please be sure to evaluate the teal highlighted competencies for the alternative clinical sites listed above (DH, IC and ECSC). These are noted on all objectives in this tool. 1e should have also been evaluated. Please keep this in mind for your remaining Erie County Senior Center experience. DW

Week 5: (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 your patient's recent fall and how it was contributing to their stay and recovery. RH

Week 6 - (1 a, b, c, d, e)-Great job this week! This week you did a great job discussing your patient's pathophysiology of their illness, and her associated assessment findings. You were also able to review the diagnostics and discuss how they correlated with the patient's diagnosis. You were able to discuss the importance of the medications that your patient was taking and how they impacted the plan of care. HS

Week 9 (1a-e)- You did an excellent job this week looking into your patient current illness as well as his health history to determine what factors were associated with his current symptoms and the plan of care identified for him. You were able to identify the deficits he was experiencing related to his history of a stroke. You were also able to determine the importance of the prescribed medications in his treatment plan. HS

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)			N/A	N/A	S	S	N/A	N/A	S	S							
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			N/A	N/A	S	S	N/A	N/A	S	S							
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			N/A	N/A	S	S	N/A	N/A	S	S							
d. Communicate physical assessment. (Responding)			N/A	N/A	S	S	N/A	N/A	S	S							
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			N/A	N/A	S	S	N/A	N/A	S	S							
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		N/A	N/A	S	S	N/A	N/A	S	S							
	MD	MD	DW	DW	RH	HS	SA	MD	MD	HS							

****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 (2f)- Again please be sure to read all directions carefully when completing this tool (see teal highlighted guidance above). 2f should have been evaluated based on your performance of reviewing the EHR for the reason each patient is in isolation, as well as whether or not nurses were documenting appropriately. DW

Week 5: (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 communicate any abnormalities in your assessment to myself and the nurse. You charted all your findings in the EHR appropriately. RH

Week 6 (2a-f)- You did a nice job with your assessment as well as documenting it within the electronic medical record. You also did a nice job communicating your findings to the RN. You were also able to discuss your focused assessment and the reasoning behind your decision of focus. HS

Week 9 (2a-f)- You did an excellent job with your assessment as well as documenting it within the electronic medical record. Your documentation was very thorough this week. You also did a nice job communicating your findings to your team leader and your primary nurse. You were also able to discuss your focused assessment and the reasoning behind your decision of focus. HS

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

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

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

Week 5: (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 c, d, e)- You were able to prioritize your care for the day and adjust care when necessary based on changes that occurred during the day. You were available to help others when needed, and ask for assistance when needed. (3g)- This was changed because your patient did not have a foley. (3j)- Nice job discussing the plan of care with the primary RN and determining the importance of getting the patient up and moving and using the bathroom rather than the bedside commode. HS

Week 9 (3c,d,e)- You did a great job prioritizing care for your patient, and adapting the care that you provided for him based around his challenges due to his previous stroke. You identified those areas that needed extra care provided related to his deficits and also allowing him to assist you in how he normally completes basic tasks with his deficits. HS

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

**Evaluate these competencies for the offsite clinicals:

DH: N/A

IC: N/A

ECSC: N/A

Comments:

Week 1 (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 5: (3k-m) This week you performed medication administration. You identified all medications and were able to provide an analysis of all medications administered including type of medication, side effects, and nursing care performed after administration. You also performed all checks prior to administration to ensure you were giving the correct dosages of each medication to the correct patient. You were able to scan all medications in the EMAR and chart them appropriately. You administered PO and SubQ medications this week. RH

Week 6 (3k, l, m, p)- You did a nice job with medication administration this week! You were able to administer PO, SQ medications and administer an IV antibiotic and a saline flush during the medication pass. You followed the rights of medication administration and completed all checks prior to administering. You were able to research each medication and answer all questions related to the medications. (3r) You were able to complete a FSBS and determine the appropriate amount of insulin to be administered and administer the dose of insulin. HS

Week 9 (3k, l, m, p)- You did a nice job with medication administration this week! You were able to administer PO, SQ medications and administer an IV antibiotic and a saline flush during the medication pass. You followed the rights of medication administration and completed all checks prior to administering. You were able to research each medication and answer all questions related to the medications. HS

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	N/A	S	S	S	N/A	S	S							
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			S	N/A	S	S	S	N/A	S	S							
c. Report promptly and accurately any change in the status of the patient. (Responding)			N/A	N/A	S	S	N/A	N/A	S	S							
d. Maintain confidentiality of patient health and medical information. (Responding)			S	N/A	S	S	S	N/A	S	S							
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S NI	N/A	S	S	S	N/A	S	S	U						
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			N/A	N/A	S	S	N/A	N/A	S	S							
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			N/A	N/A	S	S	N/A	N/A	S	S							
	MD	MD	DW	DW	RH	HS	SA	MD	MD	HS							

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

Comments:

Week 3(4e)- According to the CDG Grading Rubric, you have earned a needs improvement for your Infection Control discussion this week. Your discussion included a response for each question, but was only backed by partial evidence. All posts must include an intext citation and the reference, but your post only included the reference. From this, I am unable to tell which information you were citing from the Lewis's Medical Surgical textbook. Additionally, in terms of APA formatting, I have a couple

suggestion: 1. The reference should include all of the author/editors last names and initials; 2. Only Lewis's and Assessment should be capitalized in the title, everything else should be lowercase. Please pay closer attention to these finer details in APA formatting. I am happy to help if you need assistance. The Purdue Owl website is also a great resource (<https://owl.purdue.edu>). Here is the corrected version of your reference: Harding, M., Kwong, J., Hagler, D., & Reinisch, C. (2023). *Lewis's medical-surgical nursing: Assessment and management of clinical problems* (12th ed.). Elsevier - Evolve. <https://pageburst.elsevier.com/books/9780323792332>. DW

Week 5: (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 6 (4e)- Nice job on your CDG this week! You successfully met all of the requirements on the rubric for your initial posting and the response to a peer. You answered all of the questions with a thorough explanation for each medication. You also provided an in-text citation and a reference for the initial and peer response. Nice job! HS

Week 9 (4e)- Nice job on your CDG this week! You were able to identify 4 SDOH that were specific to your patient, which included, physical activity, family, living situation, and mental health. You also did a nice job discussing how each one was pertinent to your patient. You successfully met all of the requirements on the rubric for your initial posting and the response to your peer. You also provided an in-text citation and a reference for the initial and peer response. Nice job! HS

Week 10 (4e) - This week I gave myself a "U" because I did not submit my CDG that was due on Friday at 2200 in a timely manner and I submitted it Saturday. This week I was disorganized and did not write down my week and when I need to do things like I usually do and this assignment got away from me. To ensure this does not happen again, I will be sure to make it a priority to set aside 10 minutes on Monday's to write down my week on my dry erase board to ensure I am completing assignments on time. JB

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)			N/A	N/A	S	S	N/A	N/A	S	S							
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			N/A	N/A	S	S NI	N/A	N/A	NI	S	S						
	MD	MD	DW	DW	RH	HS	SA	MD	MD	HS							

****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 5 – Rehab

a&b - I provided education on proper nutrition and fluid intake to my patient because he was refusing to eat adequately. He was very weak and confused after being admitted for a recent fall with head trauma. I explained the importance of eating and how adequate protein intake is crucial for healing, maintain energy and preventing further decline in health. I spoke with my patient several times in his room about trying to eat anything. I felt confident in telling him the importance of eating and staying hydrated for healing and strength because it is covered many times in several different chapters we have learned in class as well as my past research on Skyscape. **This is a great education topic for your patient and I am sure the family appreciated it as well since they were so worried about the patient's intake. RH**

Week 6 – 3T

a&b – My patient this week seemed to be confused or unaware of some of her medication and why she was taking it. My patient stated she usually takes pills at home to help manage her diabetes and in the hospital she had 2 different types of insulin pens. My clinical instructor made a good point to her about why that may have been. In the hospital setting, people can decline faster or have more issues because they are trying to heal and the pens work faster than pills do. When her son came in to visit, he found me in the hallway and asked me if we were giving her anything for her cough. He stated he asked her and she said she was not sure but she thought she gave her a pill for it. I explained to him that she was prescribed guaifenesin which helps thin the mucus to help with the cough. I also told him that I explained to her as well that maintaining fluids was important to help as well as deep breathing and coughing to help break that mucus up. I was familiar with this certain type of medication as it was a medication we had just covered in respiratory pharmacology at the beginning of the semester. I felt confident in educating not only my patient but her family as well. **Nice job educating your patient! (5b)- This was changed to an NI because you did not list a specific resource that was used when educating the patient, such as Lexicomp or ATI. HS**

Week 9 – 3T

a&b – My patient this week was admitted for pneumonia and had a non-productive wet cough. He was on 4L of O2 via nasal cannula and seemed to be having a hard time clearing what sounded to be thick secretions. While listening to his lungs, they were very diminished but also coarse crackles and rhonchi that could be heard. My patient had a hard time understanding that he needed to cough and help clear up those secretions. He also had extreme weakness and found it difficult to hold things up to his mouth, such as water to make sure to get fluids to also help with clearing and thinning those secretions. I noticed there was no incentive spirometer in the room, so I went and got him one and showed him how to use it and explained the benefit from it. My prior research on Skyscape under Impaired Gas Exchange mentioned the importance of maintaining a clear airway when unable to clear secretions. This included frequent position changes and deep breathing and coughing, all of which I discussed and demonstrated with my patient to try and help improve his airway. **Great job! HS**

Week 10 – 5T

a&b – My patient this week was admitted for functional decline due to an L1 compression fracture. He was having a difficult time with pain and even wanting to get up and ambulate. When conducting his pain assessments they seemed to always be an “8 or a 9” on a pain scale of 1-10. However, when he did have his PT, he seemed to really want to try and walk and even did a whole flight of stairs but after he was done with his PT, he seemed to just be done for the day and not wanting to do anything else because he was in too much pain or was just tired. My research in Skyscape helped me explain to my patient the importance of getting up and ambulating for not only trying to regain that strength and stability but to also help with his constipation that he was also really struggling with. I also explained to him the importance of drinking water and how it will help with constipation.

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)			N/A	N/A	S	S	N/A	N/A	S	S	N/A						
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)			N/A	N/A	S	S	N/A	N/A	S	S	S						
	MD	MD	DW	DW	RH	HS	SA	MD	MD	HS							

****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:

Week 5 – Rehab

6b – The patient’s limited mobility, emotional state, and lack of appetite suggest a decline in overall well being. While the patient was confused at times, he also seemed depressed and disconnected perhaps from his lack of independence and not understanding where he was at most times. I would say a major SDOH would be his family and support. While he seemed to have family visiting, they seemed to be frustrated with his lack of progress and not wanting to eat. Addressing the importance of both physical and emotional needs to the family play a crucial role in healing for the patient. This could also improve his outlook and recovery. My patient did much better today with PT/OT and I think because he seemed in a better mood, which allowed him to want to do more and then with the continued encouragement from staff he seemed to want to do more ambulating and willing to learn and want to help improve his overall wellbeing. **Sometimes the negative things patients overhear from their loved ones is not motivating so it can impose an emotional toll on them. I am glad your patient seemed to be in better spirits on Thursday and was able to participate in therapy more than the day before. RH**

WEEK 6 – 3T

6b – My patient this week seemed to have a lot of family support, which is important in many aspects. She had several visitors and I even had a discussion with her son about how she was doing and her progress. She seemed to love talking about her family and her grandkids and she even mentioned her granddaughter coming in and doing her hair for her. I believe this is very important in the healing process for the patient to have continued support and encouragement from family. **That is an excellent**

example! A good support system will be very important for her once she is discharged from the hospital in many different ways such as getting her to appointments and assisting her in managing her medications. HS

Week 9 – 3T

6b – I would say a Social Determinant of Health for my patient this week would be disabilities. My patient was almost entirely immobile and did not have any interest in doing much of anything at times, including wanting to reposition, but once I explained the importance of it he was willing to readjust. I also feel because he was hearing impaired and had hearing aids, this made it harder for him to hear and communicate with others effectively. I made sure to stand closer to him and speak up so he could understand me and used hand gestures to help him better understand what I was trying to communicate to him. He also had glaucoma, so I was sure to stand in front of him when talking or showing him things. **Your patient had several challenges that he is faced with. I would agree, he has several disabilities impacting his care. HS**
Your care map was satisfactory for week 9. See care map rubric below. HS

Week 10 – 5T

6b – This week my patient's SCDH would lack of family support and maybe a bit of depression. My patient seemed to be disassociated with people and did not mention any family or friends or seem to want to talk about much other than politics and the news. Lack of family support can contribute to feeling lonely or depressed. I tried to engage in conversation with him about things but he would give short answers and he seemed not interested. He was however very polite when I would get him things or do things for him. I think him being in pain contributed to a lot of him not wanting to make conversation.

See Care Map Grading Rubrics below.

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

**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:

Week 1 7a –

This first 2 weeks there was a lot of new skills and information. I felt confident in watching the videos and then applying them during lab. I liked interacting with the IV pump and in lab being more hands on with the IV bags and lines. **There were tons of new skills! You did a great job! MD**

7b – One skill I felt I struggled with was IV math. I will continue to practice IV math once a week until I become more confident. I will utilize the resource tab located in Edvance for practice sheets. **This is a great goal! Let us know if you need any help! MD**

WEEK 3 7A –

I was really excited to be able to see what Infection Control does as well as Digestive Health this week. I feel my strength this week was jumping in and offering to help at Digestive Health. The RN's there were extremely helpful and offered us things to do. I was able to assist with spiking IV bags for several pre op patients. I was able to see several IVs put in and even a few glucose checks with the meter. **DW**

7b – I would say one area of improvement for this week was not being really familiar with the hospital. I am not aware of where all the different units/floors are and more so what the different floors are involved with. I was not aware of what 4P was or really even how to get to 4C or 4P (even though I have been to 4N). I did learn a lot being with Infection Control. It gave me the opportunity to walk around and check all the floors several times. However, when I have clinical now each week, before I leave, I will make sure I find each floor and each unit in a timely manner to help familiarize myself with my surroundings. **This will be extremely helpful to be comfortable in your surroundings. You never know when you may need to get to a different part of the hospital quickly. Great idea! DW**

Week 3 (7f)- Jessica, though you received an S for this competency, I would like to encourage you to review all directions for all assignments more closely moving forward. Assignments that are not submitted in the correct format or in the correct location may not be accepted for credit in the future. The infection control scavenger hunt was submitted in handwritten form but was corrected upon request and submitted in typed form. This will just be a lesson learned and I have no doubt you will get the hang of it moving forward. Thank you! **DW**

Week 5 – Rehab

7a – My area of strength this week was feeling confident with the patient and going into the room and doing everything I needed to do in a timely manner, such as vitals, head to toe, patient rounds, fall risk etc. Rehab was a new experience and I felt very comfortable there. I am less nervous when interacting with patients and if I am unsure of something or need help, I am not afraid to ask. **You did a great job clustering your care and caring for your patient this week. Your patient was more hands on than other patients on the floor, but you did well caring for them and ensuring all tasks were done for the day. RH**

7b- An area of improvement this week was medications. While I have only had the opportunity to pass meds twice now, I am still learning to get comfortable with them. I am more nervous on not being familiar with what the medications are and what they are used for, and how to pronounce them. To improve this skill, I will be sure to look up my patients medication in a timely manner and research them and practice saying the medication and what they are for prior to administering them with a peer. I also want to be more comfortable in the MAR and better understand how to read the medication and when the medication is due. To get more comfortable with this, at each clinical I will go through my patients MAR several times and review how to view this information to prepare me for future med passes. **This semester you will have more opportunities to perform medication administration than last semester and practice always helps calm the nerves. Being more familiar with medications is a great goal to have for the semester! RH**

Week 6 – 3T

7a- My area of strength this week was answering call lights and helping fellow students or PCT's. I used to be a little apprehensive when getting call lights because I was not as confident in my skills and was worried I would not know what to do in situations. I have come to realize that you never know what you are going to get when you walk into any patients room, even the patient you were assigned. I also look at it as a learning opportunity. The more I do, the more I am going to learn and if I need help, I will ask. **Very true! Great job! HS**

7b – An area of improvement would be reviewing the medications with the patient before administering if they are not familiar with them. My patient was confused on what she was taking and why at times and I felt I could of made an effort to review them better with her. She had asked what she was taking, (which was her docusate) and I was not sure at the time and had to look it up for her. She also expressed to her son that she was not sure if she was taking anything for her cough. I felt I could of done a better job explaining these medications to my patient. This will also help me as a nurse get more familiar with medications as well by explaining them and going over them with the patient if they seem confused. **You have not listed a specific plan on how you will improve on this. HS**

Week 7 – Erie County Senior Center

7a – My area of strength this week was going above and beyond to help a female at the senior center. There was a female who had just got done at the doctor and she had a bandage that fell off and needed help putting it back on. The director was giving her a new bandage and had mentioned we were nursing students and if she would like some help. I was happy to help assist her and I was glad she felt comfortable enough to allow me to help because this bandage was on her chest. **That is so kind of you to help!**
SA

7b – I would say my area of improvement this week would be time management. I forgot how quickly my clinical at senior center was approaching and when I got started on the project of making the balloon swatters (just a few days prior) I realized this idea we had of using the cardboard was not going to work like we wanted too. I then got the idea to just purchase plastic fly swatters on amazon. They were supposed to be here Monday but were delayed because of the weather and that put a little stress on me because I then had to come up with a plan b. Luckily they came in time and it all worked out. However, to fix this type of situation so it does not happen again, I will make sure now to look at my schedule the week before and write on my dry erase board of when things are due and upcoming things that need done so I do not forget anything and I am not rushing last minute and creating extra stress because I will be more prepared. **That is a great plan to look ahead. This will help in the long run with your time management skills as well as prioritization skills when working as a nurse!** SA

MIDTERM-Great job this first half of the semester Jess! Be sure to keep being proactive in practicing skills and gearing up for the last part of Med/Surg nursing!
MD

Week 9 – 3T

7a – For my area of strength this week, I think I have two things I would like to reflect on. First, I found myself more involved in the patient's chart and really trying to understand what medications my patient was on and why. There were a few medications he was on and I found myself really reading through the charts and doctor's notes to figure out why. My patient was also on three different eye drops and that was good to be able to experience since I feel you don't see that too often within the clinical setting. My second reflection and area of strength was being able to observe things in the room and/or with my patient that needed addressed. We could not locate his hearing aid charger and I was able to locate it on the desk by the computer but it was bunched up and blended in with the other wires. I also found that his IV did not have a green cap on it, so I placed one on. My patient also seemed to be experiencing dry mouth and his nasal passage appeared to be dry and cracked from the nasal cannula, so I suggested to the nurse that perhaps humidifying might be beneficial and she showed me how to hook one up. Side note: I also did a one on one feeding with my patient, that was a new experience for me and I felt confident in doing so and I felt it gave me a little bit better of a connection with my patient because we got to talk a little more. **Great job this week!** HS

7b- My area for improvement this week would be becoming more comfortable with the IV pump but more specifically hanging secondary bags that need primary tubing because the patient did not have a continuous line already hooked up. I felt this was probably the second time I have had to talk myself through why I needed primary tubing for say an antibiotic even though it is a much smaller bag and usually hung as a secondary line. Once I get in the patient's room and figure it out it kind of starts to come to me but there is always some apprehension. I also need to work on knowing the steps of how to prime the tubing without being wasteful of the medication. I also need to remember to fill the chamber. To correct and improve this skill, I will watch the videos on Edvance 360 for how to prime the tubing and how to use the IV pump each week before my clinical to ensure I am prepared and have a full understanding on how to improve on this skill. **This will become easier with each additional experience you have administering an IV piggyback medication.** HS

Week 10 – 5T

7a – My area of strength this week was administering medications. I felt very confident this week in making sure I was verifying the medications with the order, as well as drawing up IM injections and subcutaneous injections. While I still get nervous before administering an IM or a subcutaneous injection, I was thankful for the practice and I know the more I do it, the better I will feel about it.

7b – My area of improvement this week would be making sure to not leave medication in the room and leaving. My patient was getting oxycodone which is an opioid and controlled substance. When I brought the medication into the room, I asked if my patient needed more water before he took his pills and he did. I set down the medication and went to grab the water. When I returned the medication was gone. My instructor took them and we talked about how important it is to not leave medication laying around. While I was disappointed in myself for letting that happen, it was a good lesson to have learned. To make sure this does not happen again, I will be sure to ask if the patient needs anything before I leave the room to get the medication, so when I return with the medication I will have everything or if I do have to leave the room after I already have the medication, I will take it with me or ask someone else to grab me whatever it is I need so I am not leaving the medication unattended.

Student Name: Jessica				Course Objective:			
Date or Clinical Week: MSN week 5							
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. RH
	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	7. good list of potential compliations, detailed signs and symptoms to look for! RH
	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	All interventions are individualized to patient.
	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	
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete	3	

Reference

An in-text citation and reference are required.

The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.

The care map will be graded “unsatisfactory” if both in-text citation and reference are not included.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

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

Faculty/Teaching Assistant Comments:

Total Points: 45/45

Faculty/Teaching Assistant Initials: RH

Student Name: Jessica Bower				Course Objective: 6			
Date or Clinical Week: Week 9							
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 provided a thorough list of abnormal assessment findings, lab findings, and risk factors specific to the patient. HS
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	You included an extensive list of nursing priorities and selected the appropriate priority problem. You stated an appropriate goal for the problem. You highlighted the relevant data that supported the priority problem. The only thing you could also highlight would be the chest x-ray because that would also relate to the priority problem of impaired gas exchange. You provided several potential complications and listed the signs and symptoms to monitor the patient for. HS
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	You provided a very thorough list of nursing interventions pertaining specifically to the priority problem, they are prioritized, include a frequency, a rationale, and are individualized to the patient. HS
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	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 reassessed all of the highlighted assessment findings for the priority problem. You determined that the plan of care should be continued. HS
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete	3	

Reference

An in-text citation and reference are required.

The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.

The care map will be graded “unsatisfactory” if both in-text citation and reference are not included.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

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

Faculty/Teaching Assistant Comments:

Jessica,

Great job on your nursing care map! You identified all of the abnormal findings for your patient which then lead you to identifying nursing priorities and then selecting the top priority problem. You identified nursing interventions specific to the patient. Lastly, you re-evaluated your abnormal findings and determined the plan of care should be continued. You were able to paint a clear picture of the patient and establish a plan of care to follow. HS

Total Points:45/45

Faculty/Teaching Assistant Initials:

HS

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

Student name: Jessica Bower								
Skills Lab Competency Evaluation Performance Codes: S: Satisfactory U: Unsatisfactory	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	
Faculty/Teaching Assistant Initials	MD	MD	MD	MD	MD	MD	MD	
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. MD

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> Performance Codes: S: Satisfactory U: Unsatisfactory	Student Name: Jessica Bower							
	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: 2/26/25	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	DW	RH	SA	MD				
Remediation: Date/Evaluation/Initials	NA	N/A	N/A	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. MD

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): J. Bower (M) S. Linder (A)

GROUP #: 1

SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory

OBSERVATION DATE/TIME(S): 2/26/25 0800-1000

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (2) * • Focused Observation: E A D B	Asked about pronouns during report, asked about patient history during report. Asked patient about preferred name. Full vital sign assessment (temp, BP, pulse, oxygen, resp).

- Recognizing Deviations from Expected Patterns: E A D B - Information Seeking: E A D B	Asks information related to normal vital signs for patient when obtaining vitals. Asks information about home medications and compliancy with medications. Focused pain assessment. Numerical rating, location, description of pain, radiation to another area. Notice 6 Ps (pressure, paresthesia, pulse, pain, paralysis, pallor). Begin neuro assessment after pain assessment Notice the informed consent is not signed and asks patient about it. Brings consent into room for patient to review with them. Does not have patient sign it but does say that provider will be in to discuss procedure and have them sign it with the provider. Reassess pain and 6 Ps. Notice no change in assessment findings.
INTERPRETING: (1) * - Prioritizing Data: E A D B - Making Sense of Data: E A D B	Prioritized vital signs when entering room then moved to pain assessment. Prioritized looking at painful area. Does remove sock to visualize foot. Initially removes ice but does replace ice prior to leaving room. Does not remove pillow. Recognize need to contact healthcare provider due to assessment findings. Remove ice and pillow after calling healthcare provider and relates to compartment syndrome interventions. Prioritized fluids over pain medications. Made sense of antibiotic prior to surgery and asks for any additional “hold” orders related to medications prior to surgery. Made sense of dosage calculation of morphine order.
RESPONDING: (2,3,4,5,6) * - 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	Attempt to clarify pronouns and conflict resolution with off shift reporting nurse. Remained professional throughout report even though nurse giving report was not. Remained calm. Identify self, ask patient name/DOB, ask about pronoun preference and name preference. Call to healthcare provider in regards to patient assessment findings. SBAR organized but missing some information (did not include full abnormal assessment findings). Hanging IV fluids: check all rights prior to initiating fluids. Confirm

	patency of IV with flush prior to starting. Prime tubing prior to starting IV pump. NPO order status maintained. Call significant other to update on patient condition, remains calm and answers questions. Call healthcare provider in regards to no change in assessment findings and about informed consent. Use of CUS statement when communicating. Call OR for report. SBAR organized. Morphine administration: verify name/DOB, allergies, scan patient and medications, identify need for witness waste, use of correct needle size, correct dosage calculation for medication administration. Waste prior to putting needle on so you are not walking around with an open needle. Make sure needle is inserted to hub. Provide education on compartment syndrome to patient and reason as to why surgery was moved up. Hang antibiotic: puts primary bag below secondary bag, clamp tubing prior to priming line, hooks up to primary line correctly (above pump), does not program pump for antibiotic but rather tries to calculate drip rate. Does realize that pump needs programed and programs pump correctly. Continue to update patient on what is going on and plan of care.
REFLECTING: (7) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Group led discussion regarding the patient scenario. Students began with description of patient and what initial priority assessment would be as well as how priority assessment changed upon starting assessment on patient (group 1 focus was pain and 6Ps, second group was non-surgical leg circulation and respiratory/cardiovascular). Discussion about risk factors for developing DVT/PE and what education was provided to patient regarding this (lack of movement, refuse SCD, non-compliant with therapy). Discussion about compartment syndrome and what interventions were necessary when compartment syndrome was identified (pillow/elevation/ice). Discussion regarding ABG interpretation and how came to that conclusion. Each member of group stated strength and area of improvement for simulation. Group also discussed use of proper pronouns for patient and how report with nurse was inappropriate and unprofessional. Options to handle the situation included reporting it to the charge nurse or director in order for that nurse to not have that

	patient assignment again.
SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: 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)* * Course Objectives	Lasater Clinical Judgement Rubric Comments: Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Focuses on the most relevant and important data useful for explaining the patient’s condition. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.

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:

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11/21/24