

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

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

**Student:**

**Final Grade:** Satisfactory/Unsatisfactory

**Semester:** Spring

**Date of Completion:**

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

**Faculty eSignature:**

**Teaching Assistant:** Stacia Atkins, BSN, RN

**DIRECTIONS FOR USE:**

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

**METHODS OF EVALUATION:**

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

**ABSENCE (Refer to Attendance Policy)**

Date	Number of Hours	Comments	Make-up (/Date/Time)
2/6/25	7	Missed clinical	3/13/25 7hrs
2/10/25	1	Vsim Juan Carlos	2/10/2025 1hr
3/1/25	1	Simulation Scenario 1 Reflection Journal	3/11/25 1hr

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.

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

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
1/22-23/2025	Impaired Physical Mobility	Satisfactory/MD	NA	NA
2/22/2025	Impaired Bowel Elimination	S/NS	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.

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**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
<b>Competencies:</b>			S	NA	S	S	S	NA	S	S	S	S					
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	NA	S	S	S	NA	S	S	S	S					
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	NA	S	S	S	NA	S	S	S	S					
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	NA	S	S	S	NA	S	S	NA	NA					
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	NA	S	S	S	NA	S	S	NA	NA					
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	NA	S	S	S	NA	S	S	S	S					
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	NA	S	S	S	NA	S	S	NA	NA					
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S	S	S	NA	S	S	NA	NA					
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S	S	S	NA	S	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	5T/ Rehab & 57, Left acetabular fracture	ECSC	5T/Rehab, 87, Rib fractures involving the thorax	3T, 90, L-3 compress fracture	4N, 87, Generalized weakness/G.I. Bleed	NA	NA	5T 81, non-traumatic brain dysfunction,	3T, 71, stroke, CHF, COPD exacerbation	DH, IC					
Instructors Initials	KA	KA	MD	DW	SA	HS	NS	KA	KA	SA	KA						

\*\*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 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 5 (1a-h)-** You did a nice job reviewing all your medications before you administered them to the patient. You were able to discuss the reason why the patient was taking the medication as well as what we were monitoring the patient for. You also were able to discuss what information was needed to determine if the medication should be administered. SA

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. 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 all his medications that he was taking, especially the prn pain medications and how they impacted his plan of care. HS

Week 7 1(a-h) – Good work this week making correlations between your patient's health alterations and the nursing care required. You discussed the pathophysiology involved with her hematochezia. You discussed hemorrhoids and the recently prescribed dual anti-platelet therapy that could be causative factors. You correlated her signs and symptoms of increased weakness at home, bloody BM, elevated and irregular heart rate, and fatigue to her significant anemia. You discussed the importance of oxygen transport in relation to her low hemoglobin and identified signs to monitor for complications. You identified the rationale behind the planned colonoscopy procedure and discussed her low iron levels when reviewing her diagnostic results. Medications were reviewed and correlated to her current and past medical history. You discussed the potential for a blood transfusion and the importance of the colonoscopy to visualize the causative factor. Good job in our discussion and in developing your clinical judgement as portrayed in your care map submission this week. NS

Week 9 (1a-h)- Great job this week caring for your patient. Even though you did not get to do a medication administration, you were able to review the med list and discuss with the Team Leader all pertinent information on each. SA

Week 10 – 1a, b, c, e– You did a nice job discussing on clinical your patient's disease process related to the patient's exacerbation of COPD and CHF and what nursing was doing to help the patient. You were able to discuss symptoms we were monitoring and managing in your patient as well as pertinent labs for your patient diagnosis. You were able to discuss the different patients on your team and prioritize the patients according to their diagnosis and assessment. You utilized your knowledge and change in patient status to reprioritize the patients as the day went on. KA

Week 10 – 1d – You did a nice job reviewing all your medications before you administered them to the patient. You were able to discuss the reason why the patient was taking the medication as well as what we were monitoring the patient for. You also were able to discuss what information was needed to determine if the medication should be administered (i.e. blood pressure, pulse, potassium level). You were able to discuss the medications of all the patients on your team and was able to work with your team member to determine appropriateness of medication administration. KA

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

\*\*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)- A couple times I miss clicked and incorrectly documented. For example, documenting a capillary refill under an apical pulse. This can be fixed by slowing down when charting and taking my time. This is a good assessment of your skills and something that will improve with time. MD

Week 3 Rehab Clinical Objective 2 A & D: While you were on clinical you performed a satisfactory physical assessment and communicated abnormal assessments to myself and to the primary nurse. Great job! MD

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

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 7 2(a,e) – Good job with your assessments this week, noticing numerous deviations from normal. Specifically, you were able to assess an irregular and rapid heart rate related to her afib. NS

Week 9 (2a-f)- Nice job this week performing a thorough assessment. You successfully documented all information and communicated with your primary nurse appropriately. SA

Week 10 – 2a, d – You did a nice job thoroughly assessing your patient and notifying your nurse of any pertinent information. You were also able to work with your team to keep up on the assessment changes occurring with all patients on the team. KA

Week 10 – 2b – You completed your patient’s fall assessment and recognized the patient was a high fall risk. You ensured all measures for high fall risk were completed and documented appropriately in the EMR for your patient. KA

Week 10 – 2f – You utilized the EMR to research your patient and determine what care needed to be provided to your patient throughout the day. You also used the EMR to research all the patients on your team and to check your classmates charting for accuracy. KA

**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
<b>Competencies:</b>	S		S	S	S	S	S	NA	S	S	S						
a. Perform standard precautions. (Responding)	S		S	NA	S	S	S	NA	S	S	NA						
b. Demonstrate nursing measures skillfully and safely. (Responding)			S	NA	S	S	S	NA	S	S	NA						
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	NA	S	S	S	NA	S	S	NA						
d. Appropriately prioritizes nursing care. (Responding)			S	NA	S	S	S	NA	S	S	NA						
e. Recognize the need for assistance. (Reflecting)			S	NA	S	S	S	NA	S	S	NA						
f. Apply the principles of asepsis where indicated. (Responding)	S		S	NA	S	S	S	NA	S	S	S						
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	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	NA	NA	S	NA	NA	NA					
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	NA	S	S	S	NA	S	S	S						
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S	S	S	NA	S	S	NA						
	KA	KA	MD	DW	SA	HS	NS	KA	KA	SA	KA						

\*\*Evaluate these competencies for the offsite clinicals:

DH: 3a

IC: 3a, f, i

ECSC: 3a, j

Comments:

Week 3 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

Week 5 (3a-j)- Great job this week working with your patient and the therapy team. You observed all therapy sessions and appropriately prioritized all nursing care duties. SA

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. HS

Week 7 3(c,d) – Your time management was excellent this week. You were timely in your assessments, documented quickly, and were prepared for medication administration in a timely manner. You utilized your time well to provide patient care, review the patient’s chart, and identified education priorities. Great job! NS

Week 9 (3a-f, i-j)- Great job this week with prioritizing your assessment and adapting to the patient’s therapy schedule and complete documentation. SA

Week 10 – 3b – You did a great job managing your patient O2 which was being administered via nasal canula. You made sure to complete a focused respiratory assessment and vital sign assessment to ensure for effectiveness of the therapy. You also worked with the nurse to titrate the patient’s oxygen to ensure the pulse ox was maintained at the prescribed levels. You had the opportunity to care for a patient on a fluid restriction. You monitored your patient’s I&O and assisted the patient in staying within the restriction’s parameters. Nice job! KA

Week 10 – 3g – You did a nice job monitoring your patient’s Foley and providing peri care throughout your shift. You monitored the patient for any signs and symptoms of complications related to Foley placement. You documented the Foley in the EMR appropriately in your assessment. KA

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

\*\*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 (k)- I was hesitant and nervous during medication administration and need to work on being more confident in following through the steps. I can definitely understand your hesitancy for medication administration this week considering that this medication administration was the first for the semester. I do want to encourage you

that while the actual medication pass you were nervous and need confidence you were able to identify the rights of medication administration appropriately and provided a comprehensive analysis of the medications you were giving to your patient. You included the type of medication, side effects, and nursing implications for each medication and you were able to identify and practice the safe medication administration guidelines. MD

Week 5 (3k-m)- You did a nice job administering your medications this week. You observed the rights of medication administration and was able to answer all questions about your medications. You had the opportunity to pass PO and a topical patch medication this week. SA

Week 6 (3k, l, m, p)- You did a nice job with medication administration this week! You were able to administer PO medications, and SQ insulin. 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. (3q)- I changed this because you did complete and IV site assessment on your patient. (3r) You were able to complete a FSBS and determine the appropriate amount of insulin to be administered. HS

Week 7 (3k,l,m) – You did a wonderful job with medication administration this week. You were well-prepared to discuss the implications, side effects, and nursing considerations for each medication. You observed the rights of medication administration and promoted safety through the use of the BMV scanner. You gained insight into the importance of utilizing the safety checks and systems in place, as a medication was placed into the wrong pocket in the Pyxis machine and was identified when scanning the medication. You gained experience with several PO medications and administered a suppository using appropriate technique. All dosage calculations were performed accurately. NS

Week 9 (3l,q)- Unfortunately you did not get the opportunity to perform medication administration as the primary nurse had already completed this. You did however successfully discontinue and remove the patient's IV. You were able to document the removal appropriately and gain experience with this area. SA

Week 10 – 3k – You did a nice job administering your medications this week. You observed the rights of medication administration and was able to answer all questions about your medications. Remember to review all medications thoroughly with the patient before administering. This will help ensure accuracy and allow the patient time to refuse any prescribed medications if they choose to. You had the opportunity to pass PO, transdermal, and IV medications this week. You performed the medication administration process with beginning dexterity. You will gain confidence in your medication administration process the more you practice. Continue to seek out opportunities to administer a variety of different types of medications. KA

Week 10 – 3n – You had the opportunity to practice drawing up medication from a vial and administering it slow IV push to your patient. You did a nice job priming your piggy back using primary tubing and connecting your patient to the medication. You performed all IV skills with beginning dexterity. You will improve your dexterity with continued practice. You did a nice job seeking our clarification and assistance to ensure you were doing the process correctly. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

Week 10 – 3p – You did a nice job flushing your patient's IV this week and ensuring patency of the IV line. You were able to document this appropriately in the EMR. KA

Week 10 – 3q – You did a nice job monitoring your patient's IV site this week and documenting your assessment in the EMR. Great job! KA

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

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

**Comments:**

Week 3 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 healthcare provider led exercises for patient's with hip fractures that was interesting and detailed for the patient you worked with in clinical. The reference and in-text citation you provided were well written using APA formatting. Great job! MD

Week 4 (4e)- According to the CDG Grading Rubric, you have earned a satisfactory for your Erie County Senior Center discussion this week. Your discussion was thorough and backed by evidence from RNotes. Great job overall with APA formatting; just a couple thoughts for future improvement: 1. When you cite a direct quote from a resource, the in-text citation should include a page or paragraph number that the quote can be found; for example, (Myers, 2023, para 1). A paragraph number is only used when the resource does not have page number, such as an electronic resource like RNotes. Keep in mind that there is an APA Formatting Examples document in the Clinical Resources on Edvance360 and online resources to help you (ex. Purdue Owl website- I really like this one! [https://owl.purdue.edu/owl/research\\_and\\_citation/apa\\_style/apa\\_formatting\\_and\\_style\\_guide/general\\_format.html](https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/general_format.html)). I am always happy to help you if some of these resources are unclear to you. DW

Week 5 (4a-g)- You did a nice job choosing an EBP article pertinent to your patient and responding to all the CDG questions on it. You thoughtfully responded to the questions as well as to your classmate. You included an in-text citation and reference in both your posts. Keep up the great work! SA

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 7 (4e) – Nice work with your CDG this week focused on education. Descriptive details were provided. See my comments on your posts for further details. All criteria were met for a satisfactory evaluation. NS

Week 9 (4a-g)- Great job communicating with your patient and all information with the primary nurse. I did change one competency to “NA” as you were not required to do the CDG this week as this was a make up clinical. SA

Week 10 – 4b – You completed the SBAR worksheet and provided your RN with handoff communication related to your patient utilizing the SBAR you developed. You made sure all pertinent information and changes in patient status were communicated to your nurse during hand-off report. You also presented your SBAR during debriefing and provided an accurate report to your classmates and faculty. You provided a concise and detailed SBAR that was mostly organized on your patient. Your soft-spoken voice can occasionally make it a little difficult to hear all information which can potentially cause an issue with clarity of message. You missed a few important areas such as pain and the patient’s diagnostics studies, but was easily able to answer questions when prompted. Overall nice job! KA

Week 10 – 4e – Nevaeh, you did a nice job responding to all CDG questions on your team leading experience this week. Your responses were clear and thoughtful. You included an in-text citation and reference in both your initial response and your response to your peer. You did a great job sharing your experience and adding to the conversation. Keep up the nice work! KA

## 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
<b>Competencies:</b>			S	NA	S	S	S	NA	S	S	S	NA					
<b>a. Describe a teaching need of your patient.** (Reflecting)</b>			S	NA	S	S	S	NA	S	S	S	NA					
<b>b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)</b>			S NI	NA	S	S	S	NA	S	S	S	NA					
	KA	KA	MD	DW	SA	HS	NS	KA	KA	SA	KA						

**\*\*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(a & b)- Education related to preventing respiratory complications due to having impaired physical mobility (This is done by deep breathing exercises, such as a deep breath through the nose, holding it for 2-3 seconds, then exhaling completely through the mouth, followed by a strong cough) was provided to my patient through discussion and demonstration. This was necessary to reduce the risk of the patient developing atelectasis due to physical inactivity. The teach-back/ show-back method was used. **This is great information to provide your patient, however, where did you obtain this information? It is important to include this to identify what resources you have available to you as a nurse! MD**

Week 5(a & b)- Education related to improving lung function and preventing complications how having decreased physical mobility (This was done by encouraging and explaining the importance of the incentive spirometer. The patient should inhale slowly through the mouth piece, then hold their breath for 3-5 seconds, and finally exhale slowly removing their mouth from the mouth piece) was provided to my patient through discussion. This is necessary to improve lung functions and prevent complications such as atelectasis. This information was found through Skyscape, and the teach-back method was used. **Nice intervention for lung function improvement. Skyscape is a nice resource tool and the teach back method confirms patient understanding. Great job! SA**

Week 6(a and b)- Education related to proper blood glucose level testing (This was done by encouraging the finger to be poked on the side of the finger instead of directly on the pad on the finger. The site should rotate as well) was provided to the patient through discussion. This is necessary to prevent complications such as infection and to prevent necessary pain to the patient. This information was found through Skyscape, and the teach-back method was used. **Nice job! HS**

Week 7(a & b)- Education related to recognizing symptoms of anemia and how it increases the risk of falling (This was done by explaining some of the symptoms of anemia like fatigue, SOB, and dizziness. As well as making sure if she experienced any dizziness when getting up that she sits back down in order not to fall.) was provided to that patient through discussion. This is necessary in order to prevent falls, which could create more injuries that lead to further complications. This information was found through Skyscape and the teach-back method was used. **Very good! Safety is a high priority in the hospital setting. Good job using your clinical judgment to correlate the**

symptoms she was experiencing as a result of the anemia and providing education so that she understood her risks when ambulating. Good use of clinical judgment to provide this education and ensure she had a good understanding. NS

Week 9(a & b)- Education related to making sure the patient continues taking their prescribed medication, especially their anticonvulsant, Levetiracetam, as directed (This was done by explaining how stopping or skipping doses can cause very serious problems and even worse symptoms) to the patient through discussion. This was necessary in order to prevent worsening symptoms or other problems. This information was found through Skyscape and the teach-back method was used. Nice job discussing medication adherence and safety with an anticonvulsant med. This is incredibly important for those with history of seizures or at risk for. SA

Week 10 (a &b)- Education related to making sure the patient continues adhering to their prescribed medication (This was done by talking with the patient and explaining how important it is to continue taking the medications he was prescribed as directed, and how not adhering to this might greatly affect his healing process) was provided to the patient through discussion. This was necessary to help this patient receive a better outcome. This information was found through Skyscape and the teach-back method was used. This would be good information for your patient to receive. KA

**Objective**

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

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

**\*\*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(6.b)- My patient had a hip fracture that impaired his physical ability to do activities of daily living. While he is recovering and gaining back his ability to do things, he will be limited from certain things he normally could do. He will find it difficult, for example, to drive. This could severely effect his employment, which could eventually lead to financial strain on the patient. **Absolutely! MD**

**Week 3 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 5 (b)- My patient had rib fractures that impaired her ability to do activities of daily living. She would find it hard to continue doing the things she had previously done every day, such as feed her cat. Before her injury she had lived only, but now she will have someone coming to her house in order to help her with these tasks. She will pay this person which could lead to financial strain on the patient. **Great point of view! SA**

Week 6(b)- My patient had an L-3 fracture that severely impacted his mobility and his abilities of daily living. He would find it hard to do the necessary tasks he needed for every day life. He needed assists when moving, and experienced pain from just turning over in bed. He would more than likely have to pay someone for help assisting him, which as the potential to put financial and emotional strain on the patient. **Nice job, you have identified some important SDOH factors for the patient. He may have limited resources in a few different areas. We did not see any visitors while you cared for him, and financial concerns may also be a factor for him as well once he is discharged from the hospital. HS**

Week 7 (b)- My patient had generalized weakness and a G.I. bleed that had a big impact of her mobility and her ability to perform activities of daily living. She was also at times confused and couldn't tell me why she was at the hospital. These factors could make it hard for her to care for herself without assistance. She might have to rely on her family, which could lead to an emotional strain on this patient. She also was recently discharged from the hospital and a few weeks later was sent back which could lead to financial strain. **Good thoughts! NS**

**Week 7 6(a) – Satisfactory submission of a care map on the top priority problem of impaired bowel elimination. See the attached grading rubric for comments. NS**

Week 9 (b)- My patient had non-traumatic brain dysfunction, seizures, and a brain tumor which had a big effect on his mobility. He was also a little confused at times. Both the confusion and mobility can affect his ability to do activities of daily living. This can also put emotional strain on this patient because he isn't able to do as much as he uses to. **Great job recognizing your patients needs and how they can be a barrier to their future care. What are some things you can provide and discuss to aid as a positive reinforcement towards his outlook on his current state? SA**

Week 10 (b)- My patient had stroke which resulted in a slurring of speech, facial droop, and weakness. Both days that I was there he had to be put on oxygen continuously, which he previously did not have to do. These can all effect his self-esteem and put severe emotional strain on this patient and effect his mental health. Luckily it seemed like he had a pretty good support system in his family. **Family support is a positive SDOH your patient had. What do you think about your patient nutritional status while in the hospital? KA**

**Objective**

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

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

\*\*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(a.) One area of strength would be strong attention to detail in order to correctly following procedures taught in skills lab. This is a great skill to have in nursing.  
KA

Week 1 (b.) One area of improvement might be improving my skill in dosage calculation. I will review that correct formulas and will practice by completing 10 dosage calculations before the next test. **Great idea! Practice makes perfect. There are a variety of practice problems in the IV Math folder in the resource section of the MSN course on edvance360. KA**

Week 3(a.) One area of strength would be providing interventions for the patient such as demonstrating deep breathing exercises. **Absolutely! MD**

Week (b.) One area of improvement would be gaining more confidence in medication administration. I will review the steps 5 times before my next clinical week in order to gain more confidence. **This is a great goal! I cannot wait to see how you grow in medication administration throughout the semester! MD**

Week 4 (a.) One area of strength would be my ability to properly assist the seniors when it came to their mobility. For example, helping them sit down and serving them so they did not have to get up. **I'm sure they greatly appreciated it, especially the older adults that require the use of a walker to be mobile. Keep up the great work! DW**

Week 4 (b.) One area of weakness would be finding the right volume to talk in when talking to the seniors. For example, one or two times my voice was too quiet and I had to repeat myself. This can be improved by practicing speaking louder 5 times before my next clinical. **Nevaeh, I can totally relate to this as someone that historically and naturally has a soft-spoken voice. The good news is that you can work on it and improve over time. Make a conscious effort to project your voice when interacting with others...in all realms of your life. Additionally, when interacting with someone that is hard of hearing, a deeper voice is more easily heard. High pitch is not always effective. Keep this in mind for the future. You've got this! DW**

Week 5(a) One area of strength would be assisting my patient to and from here therapy sessions. **You had a great experience getting to attend your patients therapy sessions. This also allowed you to reflect the importance of prioritizing your patients medications and needs to accommodate their busy schedule. SA**

Week 5(b) One area of improvement would be in improving my clinical judgement. This can be done by reviewing case studies 5 times before my next clinical. **SA**

Week 5 (f) I missed clinical time 2/6/25 and will make it up 3/13/25/. **Thank you for recognizing this as professionalism. I changed this back to a satisfactory grade as we understand that life happens and weather can prohibit our time and your safety is of utmost importance! SA**

Week 6(a)- One area of strength was communication with the patient. **Great job! Effective communication is key when providing care to our patients. HS**

Week 6 (b)- One area of weakness would be not fully completing a pain assessment. I didn't follow up by asking the patient if there was anything that he needed for the pain or if he needed additional pain medication. To fix this I will go over and practice pain assessments 3 times before my next clinical. **That sounds like a good plan. HS**

Week 7 (a)- One area of strength was talking with the patient. **Good! It looks like communication was your identified strength last week. Try to think of something different each week that you can highlight as a strength. For example, this week you had the opportunity to administer a suppository medication for the first time. While this isn't something overly exciting, it is a new skill that you performed effectively. NS**

Week 7 (b)- One area of improvement would be building confidence in clinical decision making. I will do this by reflecting on patient's conditions and what nursing interventions would be needed. I will do this 5 times before my next clinical. **Good! I thought you did well using your knowledge and clinical judgment in our discussions. You demonstrated an understanding of her risks and potential complications. This can be hard when on the spot in unfamiliar situations, but I thought you handled the week well. Great plan for improvement! Keep up the hard work. NS**

Midterm – **Nevaeh, you did a nice job during the first half of the semester. You have had the opportunity to care for a variety of patients and work on the majority of your clinical competencies. Please let the faculty you are working with during the second half of the semester know that you have not had the opportunity to work with a patient with a Foley so they can help you seek out this opportunity to work on this competency. Also let them know you are seeking out opportunities to administer IV therapy, IV piggybacks, IV push medications, and flush an IV saline lock so they can help you locate opportunities to complete these skills before the end of the semester. You have also satisfactorily completed both of your required care maps for the semester before midterm. Nice job! Continue the hard work into the second semester and finish strong. KA**

Week 9 (a)-One area of strength was communicating with the patient. **You did a very nice job at actively listening to your patient! SA**

Week 9 (b) One area of improvement would be being more organized and having better time management. I will do this by writing out a "to-do" list to help me organize before each clinical. I will also look at case studies and prioritization the information given to me in them 5 times before my next clinical. **This is a good plan. When**

working on the Rehab unit, a nurse must be adaptable to the ever changing therapy schedule. One suggestion would be when getting organized, to prepare and prioritize their needs prior to therapy, that way you can always return to other duties when they return and you have time to readjust some to the duties that are not as immediate.SA

Week 10 (a)- One area of strength was collaborating well with other students during my team lead experience. You did a nice job leading your team and ensuring they had everything they need. KA

Week 10 (b)- One area of improvement would be improving my dexterity and hands on skills during IV infusions. I will do this by practicing IV medication administration and going over the steps 7 times before my next clinical. This is definitely a skill you will strengthen with time and practice. Let me know if you would like the lab open to practice. KA

Week 11(a)- One area of strength would be knowing the correct PPE needed for certain isolation precautions.

Week 11(b)-One area of improvement would be knowing more about which specific diseases and the precautions that would be needed. I will do this by reviewing the back of my isolation card and looking at other isolated organisms 5 times before my next clinical.

Student Name: <b>Nevaeh Walton</b>		Course Objective: <b>Impaired Physical Mobility</b>					
Date or Clinical Week: <b>1/22-23/2025</b>							
Criteria		3	2	1	0	Points Earned	Comments
<b>Noticing</b>	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	
<b>Interpreting</b>	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	
<b>Responding</b>	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 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	
<b>Reflecting</b>	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"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	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.

<p>Total Possible Points= 45 points  45-35 points = Satisfactory  34-23 points = Needs Improvement*  &lt; 23 points = Unsatisfactory*  <b>*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.</b></p> <p><b>***Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. ***</b></p> <p><b>Faculty/Teaching Assistant Comments:</b></p>	<p><b>Total Points: 45/45 Satisfactory MD</b></p> <hr/> <p><b>Faculty/Teaching Assistant Initials: MD</b></p>
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Student Name: <b>Nevaeh Walton</b>		Course Objective: <b>6</b>					
Date or Clinical Week: <b>Week 7</b>							
Criteria		3	2	1	0	Points Earned	Comments
<b>Noticing</b>	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	Seven abnormal assessment findings were listed based on the care provided during the clinical experience. Consider including the irregularity with her heart rate in addition to the rapid rate (afib). Also, consider including her high fall risk score, as her weakness from anemia can lead to complications.  Three abnormal diagnostic findings were listed. Points were deducted due to several abnormal lab and diagnostic values being omitted. For your consideration, she had an elevated PT level of 17.0, chloride level of 116, decreased calcium of 8.5, iron of 18, iron saturation of 5.8. She also had an abdominal CT that showed bile duct stent and hepatic cysts. Lastly, she had a stool sample collected that showed positive occult blood. These would be important diagnostics to include in the care map.  8 risk factors were identified, based on her current and past medical history.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	1	
	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	
<b>Interpreting</b>	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	A thorough list of nursing priorities were identified. Based on the noticing section and patient care provided, it was appropriately determined that impaired bowel elimination was the priority problem based on her admission for hematochezia.  An appropriate and realistic goal was identified.  Due to the omission of important lab values, not all relevant data was highlighted in support of the priority problem. See my comments above for examples.  Three priority potential complications
	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	2	
	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	

							were identified with specific signs and symptoms to monitor for each.
<b>Responding</b>	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	<p>A list of 11 nursing interventions were provided. Most interventions listed focus on assessing the patient. I encourage you to think of additional interventions that the nurse can do to help the priority problem. For example, you administered a suppository medication aimed at treating her internal hemorrhoids. She was also scheduled for a colonoscopy procedure, so we would want to include the education and preparation for this procedure, including medications prescribed for bowel preparation.</p> <p>Each listed intervention is prioritized appropriately with assessments taking highest priority.</p> <p>Be sure to include specific medication prescriptions that are individualized for your patient that you administered.</p>
	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	2	

	Criteria	3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Appropriate rationale provided for each listed intervention.
<b>Reflecting</b>	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	<p>A list of re-assessment findings for each abnormal findings listed in the noticing section was provided to evaluate the effectiveness of the plan of care. Based on the recent findings, it was appropriately determined to continue the plan of care.</p>
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	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: Nevaeh, nice work with your care map on the priority problem of impaired bowel elimination. Be sure to review the comments provided and let me know if you have any questions!**

**Total Points: 40/45 – Satisfactory**

**Faculty/Teaching Assistant Initials: NS**

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

Student name: Nevaeh Walton								
<b>Skills Lab Competency Evaluation</b>	<b>Lab Skills</b>							
	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 2</b>	<b>Week 2</b>	<b>Week 9</b>
	<b>Insulin</b> (2,3,5,7)*	<b>Assessment</b> (2,3,4,5,7)*	<b>IV Math Application</b> (3,7)*	<b>Lab Day</b> (1,2,3,4,5,6,7)*	<b>IV Skills</b> (2,3,5,7)*	<b>Trach</b> (1,2,3,4,5,6,7)*	<b>EBP</b> (3,7)*	<b>Lab Day</b> (1,2,3,4,5,6,7)*
Performance Codes:  S: Satisfactory  U:Unsatisfactory	<b>Date:</b> 1/7/25	<b>Date:</b> 1/7/25	<b>Date:</b> 1/8 or 1/9/25	<b>Date:</b> 1/8 or 1/9/25	<b>Date:</b> 1/10/25	<b>Date:</b> 1/15 or 1/16/25	<b>Date:</b> 1/15 or 1/16/25	<b>Date:</b> 3/10 or 3/11/25
Evaluation:	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>
Faculty/Teaching Assistant Initials	<b>KA</b>	<b>KA</b>	<b>KA</b>	<b>KA</b>	<b>KA</b>	<b>KA</b>	<b>KA</b>	<b>SA</b>
<b>Remediation:</b> <b>Date/Evaluation/Initials</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>

\*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 January 8, 2025. KA/DW/HS/SA

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

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

**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

Week 9

(Lab Day- Skills Review)- You satisfactorily participated in lab by practicing IV pump and NG tube. KA

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

<b><u>Simulation Evaluation</u></b>	<b>Student Name: Nevaeh Walton</b>							
	<b>vSim- Vincent Brody</b> (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	<b>vSim- Juan Carlos</b> (Pharmacology) (*1, 2, 3, 4, 5, 6)	<b>vSim- Marilyn Hughes</b> (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	<b>Simulation #1</b> (Musculoskeletal & Resp) (*1, 2, 3, 4, 5, 6, 7)	<b>Simulation #2</b> (GI & Endocrine) (*1, 2, 3, 4, 5, 6, 7)	<b>vSim- Stan Checketts</b> (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	<b>vSim- Harry Hadley</b> (Pharmacology) (*1, 2, 3, 4, 5, 6)	<b>vSim- Yoa Li</b> (Pharmacology) (*1, 2, 3, 4, 5, 6)
Performance Codes:  S: Satisfactory  U: Unsatisfactory								
	<b>Date:</b> 1/27/25	<b>Date:</b> 2/10/25	<b>Date:</b> 2/24/25	<b>Date:</b> 2/26 or 2/27/25	<b>Date:</b> 4/9 or 4/10/25	<b>Date:</b> 4/14/25	<b>Date:</b> 4/24/25	<b>Date:</b> 4/25/25
Evaluation	S	U	S	U				
Faculty/Teaching Assistant Initials	MD	SA	KA	KA				
<b>Remediation:</b> Date/Evaluation/Initials	NA	2/10/2025 S/HS	NA	3/11/25 S/ SA				

\* Course Objectives

**Comments:**

vSim Juan Carlos- this was due 2/10/25 at 0800. Unfortunately, you did not turn in the vSim in on time. Once you submit your vSim, it will be satisfactory. Please have completed by 2/14/2025 1500. Let me know if you have any questions. SA

2/10/2025-Juan Carlos- was completed satisfactorily. HS

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 You have received a U for this simulation related to your nurse’s note in your reflection journal being too similar to the example nurse’s note provided. Once you have satisfactorily rewrote your nurse’s note and resubmitted it to your dropbox by March 11, 2025 at 1500 you will be marked as satisfactory for simulation remediation. If you have any questions please let me know. KA  
Reflection journal successfully made up. SA

# Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Colleen Camp (A) Nevaeh Walton (M)

GROUP #: 2

SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory

OBSERVATION DATE/TIME(S): 2/26/2025 1015-1215

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
<p><b>NOTICING: (2) *</b></p> <ul style="list-style-type: none"> <li>• Focused Observation:            E        A        D        B</li> <li>• Recognizing Deviations from Expected Patterns:            E        A        D        B</li> <li>• Information Seeking:            E        A        D        B</li> </ul>	<p><b><u>Focused Observation</u></b></p> <p>Focused obtaining VS (Bp, HR, RR, Spo2)</p> <p>Focused assessment of left leg</p> <p>Focused assessment of right leg color, pulse, temp</p> <p>Used proper patient pronouns</p> <p>Assessed respiratory status but did not listen to lung sounds</p> <p><b><u>Recognizing</u></b></p> <p>Recognized elevated BP and HR</p> <p>Assesses dressing to be dry and intact</p> <p>Recognizes improved color of left foot</p> <p>Recognizes redness to right lower leg and pain</p> <p>Recognizes right pedal pulse weak</p> <p>Recognizes patient short of breath and complaints of chest pain</p> <p><b><u>Information Seeking</u></b></p> <p>Sought information related to history of elevated BP</p> <p>Assesses patients' allergies</p> <p>Sought additional information related to pain in right leg</p> <p>Assessing pedal pulse to right foot</p> <p>Sought information related to chest pain 8/10</p> <p>Obtaining SpO2 after complaints of chest pain</p> <p>Reassessed breathing after applying oxygen</p> <p>Regarding chest pain prior to medicating</p>
<p><b>INTERPRETING: (1) *</b></p>	<p><b><u>Prioritizing Data</u></b></p>

<ul style="list-style-type: none"> <li>• Prioritizing Data: E A D B</li> <li>• Making Sense of Data: E A D B</li> </ul>	<p>Prioritizes focused assessment</p> <p>Prioritizes pain medication</p> <p>Prioritizes calling provider after identifying potential DVT/PE</p> <p>Prioritizes calling provider test results</p> <p><b><u>Making Sense</u></b></p> <p>Educating patient on importance of getting out of bed now that she has a PE</p> <p>Patient not getting out of bed and not wearing SCD's may have lead to blood clot (DVT, leading to PE)</p> <p>Correctly interpreted ABG's as Respiratory Alkalosis partially compensated</p> <p>Explaining to patient significance of enoxaparin and side effects and subcutaneous route of medication</p>
<p><b>RESPONDING: (2,3,4,5,6) *</b></p> <ul style="list-style-type: none"> <li>• Calm, Confident Manner: E A D B</li> <li>• Clear Communication: E A D B</li> <li>• Well-Planned Intervention/ Flexibility: E A D B</li> <li>• Being Skillful: E A D B</li> </ul>	<p><b><u>Communication</u></b></p> <p>Educated patient on taking deep breaths</p> <p>Team work with med nurse while leaving the room to call provider</p> <p>SBAR with provider regarding right leg pain and shortness of breath and chest pain</p> <p>Excellent job with reading back orders and clarified order details with provider regarding enoxaparin route</p> <p>Nice communication with patient regarding new orders for labs and CT scan explained the possibility of a blood clot</p> <p>SBAR missing background when calling provider back with provider regarding ABG's respiratory alkalosis and other lab values</p> <p>Good communication with the patient regarding the CT results and the new orders</p> <p><b><u>Intervention</u></b></p> <p>Need to apply oxygen after chest pain and spo2 level</p> <p>Called lab to notify of stat orders</p> <p>Called CT to notify of stat CT order</p> <p>Reassessed Spo2 level</p> <p>Incorrect dosage of morphine administered. 3ml total which would be 6mg dose. The medication was supplied at 2mg/ml</p> <p>Left the morphine sitting at bedside while leaving the room</p> <p>Needle size incorrect for IM morphine administration</p> <p>Initiated fall precautions</p> <p>Re-assessed SPo2 and lung sounds</p> <p>Re-assessed Spo2 and patient's chest pain</p>

	Administered SQ enoxaparin correct dose given (confused stated to waste .5ml to be wasted. Total dose to be administered would be 1ml per the dosage calc it would be 0.95ml (which you cannot measure that amount on the syringe)
<p><b>REFLECTING: (7) *</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis:        E        A        D        B</li> <li>• Commitment to Improvement: E        A        D        B</li> </ul>	A nice discussion occurred regarding the scenario. The group was able to independently evaluate and analyze personal clinical performance. They were able to demonstrate commitment to ongoing improvement, and discuss strengths and weaknesses. Students were able to summarize the scenario and the fact that the patient had a postoperative complication resulting in a DVT then a PE. They were able to state how they organized their interventions and the plan of care. The students were able to review the correct size needle to be used for an IM injection. They were able to discuss the things that went well during the scenario as well as areas to improve upon into the future.
<p><b>SUMMARY COMMENTS: * = Course Objectives</b></p> <p><b>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</b></p> <p><b>E= Exemplary</b></p> <p><b>A= Accomplished</b></p> <p><b>D= Developing</b></p> <p><b>B= Beginning</b></p> <p><b>Scenario Objectives:</b></p> <ol style="list-style-type: none"> <li>1. Select focused physical assessment priorities based on individual patient needs. (2)*</li> <li>2. Implement appropriate nursing interventions based on patient’s assessment. (1,3,6)*</li> <li>3. Communicate appropriately with the patient, family, team members, and healthcare providers incorporating elements of clinical judgment and conflict resolution. (4,7)*</li> <li>4. Provide patient-centered care with consideration to cultural, ethnic, and social diversity. (2,3,6)*</li> <li>5. Provide appropriate patient education based on diagnosis. (5)*</li> </ol> <p>* Course Objectives</p>	<p><b>Lasater Clinical Judgement Rubric Comments:</b></p> <p><b>Noticing:</b> Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads.</p> <p><b>Interpreting:</b> 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><b>Responding:</b> 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. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Is hesitant or ineffective in using nursing skills.</p> <p><b>Reflecting:</b> 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>

**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