

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

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

**Student:**

**Final Grade:** Satisfactory/Unsatisfactory

**Semester:** Spring

**Date of Completion:**

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

**Faculty eSignature:**

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

**DIRECTIONS FOR USE:**

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

**METHODS OF EVALUATION:**

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

**ABSENCE (Refer to Attendance Policy)**

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

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

## 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 Skin Integrity	Satisfactory/MD	NA	NA
1/29/2025	Decreased Cardiac Output	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>									<b>S</b>								
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	S	NA	S	S		NA	NA	
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	S	NA	S	S		NA	NA	
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	S	NA	S	S		NA	NA	
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S	S	NA	NA	<b>S</b>	NA	S	S	S		NA	NA	
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S	S	NA	NA	<b>S</b>	S	S	S	S		NA	NA	
	Indicate your clinical site as well as your patient's age and primary medical diagnosis in this box weekly.	Meditech, FSBS, IV Pump Sessions	Rehab; 92 F; Rhabdomyolosis	4N 77 M A-ftb w/ RVR & 77 M AMS,	3T: 78 F, respiratory failure with hypoxia	Rehab, 85 M CVA	NA	NA	<b>MIDTERM</b>	Wed -DH Thurs - IC	ECSC	3T: 79 M Acute exacc. CHF	3T: 73 M Abd. Ascites, acute lactic acidosis,		NA	NA	
Instructors Initials	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>NS</b>	<b>KA</b>	<b>SA</b>	<b>DW</b>	<b>MD</b>	<b>MD</b>	<b>DW</b>	<b>DW</b>	<b>KA</b>	<b>HS</b>				

\*\*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 4 1(a-h) – You did a great job this week making correlations between your assigned patient's disease processes and the nursing care required. On day one you cared for a patient admitted with afib with RVR after experiencing nausea/vomiting at home prior to admission. You correlated the symptoms he was experiencing, including the identified crackles in the posterior lung bases, with decreased cardiac output as a result of his rapid, irregular heart rate. You did well to review the diagnostic tests performed, including an EKG and BNP level. You identified the potential need for an echocardiogram to fully evaluate the heart function, nice job! You were able to discuss his prescribed medication of a Cardizem gtt and correlated this with his home prescription that was on hold. On day 2 you cared for a patient with altered mental status from underlying Parkinson's disease. His symptoms resulted in the need for an NG tube placement for nutrition and medications. You discussed the pharmacotherapy prescribed for his Parkinson's disease and the importance of administering these medications. Overall you did well discussing your patients, answering questions, and utilizing clinical judgment skills in understanding their disease processes. NS

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

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

Week 6 (1a-h)- 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 the medications that your patient was taking and how they impacted the plan of care. SA

Week 11 – 1a, b, c, d, e– You had the opportunity to care for a patient with shortness of breath and exacerbation of CHF. You did a nice job discussing on clinical your patient's disease process and what nursing was doing to help the patient. You were able to discuss symptoms we were monitoring and managing in your patient as well as pertinent labs for your patient diagnosis. You 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 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. You were also 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. Great job this week leading your team! KA

Week 12 (1a-e)- Great job this week! You had a very complex patient this week with a significant history, you were able to correlate the current issues along with the health history and associate the symptoms the patient was experiencing. You were able to identify the significance of the abnormal lab values as well as the treatment related to his ascites, and his acute kidney injury that he was experiencing. 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
<b>Competencies:</b>									S								
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	S	S	S	NA	NA		NA	NA	S	S		NA	NA	
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
d. Communicate physical assessment. (Responding)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	S	S	NA	NA	S	S	NA	S	S		NA	NA	
	MD	MD	MD	NS	KA	SA	DW	MD	MD	DW	DW	KA	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 Rehab Clinical Objective 2 A, D, & F: While you were on clinical you performed a satisfactory physical assessment, communicated abnormal assessments to myself and to the primary nurse, and you were able to satisfactorily document all information to Meditech documentation. MD

Week 4 2(a,e) – Great work with your assessments this week, noticing various deviations from normal. Your charting was very thorough and accurately depicted your assessment findings. Kudos to you for correctly identifying crackles upon auscultation during your focused assessment on day 1. You noticed a change in status compared to your initial assessment and promptly reported your findings. You did well to interpret these findings as potential fluid overload as a result of his decreased cardiac output, well done. On day 2, you analyzed appropriate assessment skills for a patient that was non-verbal and minimally responsive. You tailored your assessment based on the care required and gathered data through a variety of resources. Experience was gained in assessing an NG tube system, including tolerance of medications and fluids administered via the NG tube. NS

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

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

Week 6 (2a-f)- You did a nice job with your assessment as well as documenting it within the electronic medical record. SA

Week 11 – 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 11 – 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 11 – 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. You did a great job working with your team to ensure all documentation errors were corrected and updated in the EMR. KA

Week 12 (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, especially identifying that the patient had not voided during your shift and recommending a bladder scan. You were also able to discuss your focused assessment and the reasoning behind your decision of focus for you patient. You did an excellent job documenting the pain assessment and all of the abnormal assessment findings that your patient had. 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
<b>Competencies:</b>									S								
a. Perform standard precautions. (Responding)	S		S	S	S	S	NA	NA	S	S	S	S			NA	NA	
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
d. Appropriately prioritizes nursing care. (Responding)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
e. Recognize the need for assistance. (Reflecting)			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S	S	S	NA	NA	S	S	NA	S	S		NA	NA	
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA	NA	S	NA	NA	S	NA	NA	NA	S		NA	NA	
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			NA	NA	S	S	NA	NA	S	NA	NA	NA	S		NA	NA	
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S	S	S	NA	NA	S	S	NA	S	S		NA	NA	
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S	S	NA	NA	S	NA	S	S	S		NA	NA	
	MD	MD	MD	NS	KA	SA	DW	MD	MD	DW	DW	KA	HS				

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

**Comments:**

Week 1 (30)- 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 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 4 3(b,c,d, j) – Great work with your nursing skills this week, gaining experience providing care to a patient with an NG tube. You demonstrated beginning knowledge and dexterity in assessing, flushing, and administering medications via the NG tube. You identified priority assessments, including noting the exit site at the nares and gastric residual volume. You were able to crush several medications and dilute with water to properly administer via the tube while also preventing complications. Appropriate aspiration precautions were in place throughout the care provided. You were a true team player in being willing to have your peers learn from your experience and help with medication administration, awesome job! NS

Week 5 – 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. Nice job! KA

Week 6 (3a-j)- You were able to prioritize your care for the day and adjust when necessary based on changes of the therapy schedule. You were available to help others when needed, and ask for assistance when needed. Excellent job stepping up to perform a straight catheterization procedure. You handled all steps appropriately and professionally. Awesome job! SA

Week 11 – 3b – You had the opportunity to bladder scan your patient this week. After bladder scanning the patient for 350mL of urine, you reported your finding to the nurse and were able to recognize the need for a urinary catheter based on the healthcare provider order. I know due to the confusion on who ordered the urinary catheter and this order not being placed in the system before we left you were unable to insert the urinary catheter however you did a nice job completing the steps up to that point and notifying the nurse of your findings. Nice job! KA

Week 12 (3 c, d, e)- You were able to prioritize your care for the day and adjust when necessary based on changes that occurred during the day. You were available to help others when needed, and ask for assistance when needed. On the second day your patient was tired and overwhelmed from all of the information that the providers had given him and his wife, so they requested he be left alone to nap. You were able to prioritize care so that he could try to get a nap in. You were able to monitor his urinary catheter on the second day. 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
<b>Competencies:</b>									<b>S</b>								
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	S	S	S	NA	NA		NA	NA	S	S		NA	NA	
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
m. Calculate medication doses accurately. (Responding)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			NA	S	S	NA	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
o. Regulate IV flow rate. (Responding)	S		NA	S	S	NA	NA	NA	<b>S</b>	NA	NA	NA	NA		NA	NA	
p. Flush saline lock. (Responding)			NA	S	S	NA	NA	NA	<b>S</b>	NA	NA	S	NA		NA	NA	
q. Monitor and/or discontinue an IV. (Noticing/Responding)			S	S	S	NA	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
r. Perform FSBS with appropriate interventions. (Responding)	S		NA	NA	NA	S	NA	NA	<b>S</b>	NA	NA	S	NA		NA	NA	
	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>NS</b>	<b>KA</b>	<b>SA</b>	<b>DW</b>	<b>MD</b>	<b>MD</b>	<b>DW</b>	<b>DW</b>	<b>KA</b>	<b>HS</b>				

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

Week 4 3(k-q) – You did a very nice job with medication administration this week. You were very thorough in discussing each medication, including the indication, side effects and nursing implications for each. It was evident that you were well-prepared for medication administration this week. You were able to identify the rights of administration and performed three safety checks. I appreciate your level of focus in pulling the medications from the pyxis machine, noting each medication and the expiration date verbally. Several PO medications were administered by mouth safely on day 1. On day 2, you experienced crushing medications and administering them via an NG tube. See comments on above objective related to NG care. On day 2, a decision was made to hold the MiraLAX due to excess amounts of fluid being administered via flushes. You made it a point to state the importance of editing the medication administration to reflect accurate timing of administration, well done! Additionally, you were able to gain experience working with IV medications, including the use of the IV spreadsheet for accurate intake information. You monitored IV sites well, observed for potential complications, and performed a saline flush with accurate technique. Overall a great week of medication administration experience! NS

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

Week 5 – 3n – You had the opportunity to administer an antibiotic slow IV push with your RN this week utilizing a prefilled syringe. You did a nice job priming your piggyback and connecting your patient to the medication for the first time. You performed all IV skills with beginning dexterity. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

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

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

Week 6 (3k-r)- Great job with medication administration this week. You were able to appropriately provide them per the patient’s swallow evaluation orders. You maintained professionalism and patience with the administration process and was successful with all administration. SA

Week 11 – 3k – You did a nice job administering your medications this week. You observed the rights of medication administration and was able to answer all questions about your medications. You had the opportunity to pass PO and IV medications this week. Remember when recapping your needles after pulling up from a vial to scoop the cap then secure it in place versus holding the cap and inserting the needle into it to prevent any chances of an accidental stick. With the needle. You performed the medication administration process with confidence and beginning dexterity. KA

Week 11 – 3n – You had the opportunity to practice drawing up two medications from a vials and administering them slow IV push to your patient. You performed all IV skills with beginning dexterity. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

Week 11 – 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 11 – 3q – You did a nice job monitoring your patient’s IV site this week and documenting your assessment in the EMR. Great job! KA

Week 11 – 3r – You demonstrated proper technique when completing FSBS on your patient. You utilized the information received from the monitor to determine the need for insulin utilizing the patient’s prescribed coverage scale. You were unable to administer the insulin due to the patient having emesis and not eating. You documented all information correctly in the EMR. KA

Week 12 (3k, l, m, n, q)- You did a nice job with medication administration this week! You were able to administer oral medications, an IV push medication, and a saline flush. 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. Great job! 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
<b>Competencies:</b>									<b>S</b>								
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S	S	NA	NA		S	S	S	S		NA	NA	
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			S	S	S	S	NA	NA	<b>S</b>	S	S	S	S		NA	NA	
c. Report promptly and accurately any change in the status of the patient. (Responding)			NI	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S	S	NA	NA	<b>S</b>	S	S	S	S		NA	NA	
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	S	S	NA	NA	<b>S</b>	S	S	S	S		NA	NA	
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			S	S	S	S	NA	NA	<b>S</b>	NA	NA	S	S		NA	NA	
	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>NS</b>	<b>KA</b>	<b>SA</b>	<b>DW</b>	<b>MD</b>	<b>MD</b>	<b>DW</b>	<b>DW</b>	<b>KA</b>	<b>HS</b>				

\*\*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 4C: I believe you document an NI for this objective due to documenting and finding crackles in the patient's lungs without prompt report to the primary nurse or myself. This is definitely something to work on and the patient did well throughout the day. MD

Week 3 Rehab Clinical Objective 4E: For clinical this week you provided a CDG that was satisfactory per the CDG rubric. In this CDG, you provided information on polyurethane foam dressings which applied to your patient for the week that was interesting and detailed. The reference and in-text citation you provided were appropriate with the exception of your peer response. In your peer response your reference was from 2019. Please be sure to use references that are less than 5 years old. Great job! MD

Week 4 4(e) – You did a great job with your CDG prompts this week. An appropriate article was identified and discussed related to your patient experience. All criteria were met for a satisfactory evaluation. See my comments on your posts for more details. One tip for future success with APA formatting: for your reference in your initial post, the title of the article should only include capital letters for the first word and any word following a colon (:). Inversely, the first letter of each word in the Journal title should be capitalized. Otherwise, formatting looked spot on! Let me know if you have any questions. NS

Week 4 4(a,b,c) – This week you were in constant communication with the faculty, assigned nurse, and members of the health care team. You used communication skills to provide updates to the assigned RN that were pertinent to the care required. You promptly reported your new findings of crackles upon auscultation in order to make the best decisions for your patient. You were also a great team member this week in providing a unique learning opportunity for your peers, communicating with them the care required throughout. NS

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

Week 5 – 4e – Michelle, you did a nice job choosing an appropriate EBP article and responding thoroughly to all the CDG questions this week. You made an initial post to the questions and responded to your classmate and added to the conversation on their article. You made sure to include in-text citation and reference in both of your posts. When in-text citing a direct quotation make sure to include the page number or the paragraph number if there are no page numbers. Keep up the excellent work! KA

Week 6 (4a-g)- Great job with your CDG this week! You were able to find all medications that pertained to your patient and discuss the relevance. You successfully met all of the requirements on the rubric for your initial posting and the response to a peer. Great job! SA

Week 9 (4e)- According to the CDG Grading Rubric, you have earned a Satisfactory for your Infection Control discussion. Your posts were detailed and thoughtful. Content was supported by reliable evidence. Additionally, your APA formatting was right on target. Keep up the great work! DW

Week 10 (4e)- According to the CDG Grading Rubric, you have earned an S for your participation in discussion this week. Your Erie County Senior Center post was thoughtful and supported by evidence. APA formatting is very close. The only couple of suggestions I have for the future is: 1. whenever possible, scholarly writing encourages the use of paraphrasing and avoiding direct quoting; with that said, if you use a direct quote, the in-text citation should include a page or paragraph number that the quote can be found. Paragraph numbers are only used when there are no page numbers. For example, (Cleveland Clinic, 2022, para 1). Otherwise, keep up the great work! DW

Week 11 – 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 provided your SBAR report for the patient you cared for this week when you were not the team leader. You were clear, concise, detailed, and organized with your SBAR report and communicated patient priorities and outstanding issues in the patient's plan of care. You did not need any prompts to provide an excellent report on the patient that painted a clear picture of what was going on with them. Terrific job! KA

Week 11 – 4e – Michelle, you did a nice job responding to the CDG questions related to your team leading experience this week. You were thoughtful and thorough with your responses. You included a reference and in-text citation with both your posts. When in-text citing a direct quotation remember to include a page number or a paragraph number if there are no page numbers in your citation. Thank you for sharing your thoughts. Terrific job! KA

Week 12 (4e)-Nice job on your CDG this week! You were satisfactory for initial CDG posting, and your peer response, you provided both an in-text citation and a reference for both posts. You discussed how you focused on promoting patient satisfaction during your patient's hospital stay. You also discussed the challenges that you

faced with obtaining an overall rating from your patient related to his overall hospital satisfaction, and how the hospital surroundings can impact an individual that is hospitalized. Lastly, you discussed the challenges that you faced with assisting your patient in his restorative care to increase his physical function. HS

**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>																	
<b>a. Describe a teaching need of your patient.** (Reflecting)</b>			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
<b>b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)</b>			S	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
	MD	MD	MD	NS	KA	SA	DW	MD	MD	DW	DW	KA	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 3**

5a) Education provided to pt regarding safety when changing positions from sitting to standing. Pt began to stand up from the toilet by pulling herself up using the walker. Education was given to pt to use the side rails of the bedside commode (that was being used as a toilet seat riser) to push herself up with rather than pulling herself up with the walker. This education was necessary for pt safety so the walker wouldn't roll out from underneath her and cause her to fall. **Wonderful! MD**

5b) I did not give any written materials to my pt. I utilized knowledge from nursing foundations and the mobility lab we did during the course. Pt stated she understood the importance of not using the walker to assist her when standing for her safety to prevent falls. Education was successful as pt was observed pushing up from bed, wheelchair, or toilet rather than pulling herself up with the walker during consecutive transfers. **I am glad you were able to use the knowledge you gained from nursing foundations and the mobility lab. However, please be sure to state at least where you could find information about this topic. We want to make sure you know what resources are out there for future practice. MD**

**Week 4**

5a) Education provided to patient to change positions slowly when going from laying down to sitting to standing. A-fib can cause dizziness. Although pt denied having any dizziness, I educated patient on standing slowly to prevent falls and to be cautious in case he would develop any dizziness.

5b) Skyscape utilized for symptoms of A-fib for pt education. **Very good! This was also especially important for your patient related to his recent nausea and vomiting which could have caused some dehydration. With some of the medications he is on (Xarelto) he is at high risk of complications if a fall occurred. Good topic of education for his safety and well-being! NS**

**Week 5**

5a) Education provided to pt regarding probiotic that she was taking. Patient is on multiple medications that can cause GI upset including diarrhea and C-diff. Patient educated on the benefits of a prebiotic and probiotic.

5b) Lexicomp utilized for patient education on probiotics and a print off was given to the patient. Some information included was the names of name brand OTC probiotics available, benefits, and side effects. **Great job providing her with this education. I know this is an area she was concerned with. KA**

#### Week 6

5a) I educated the patient on good oral hygiene practices. I also reminded patient to tuck chin when swallowing per speech therapist recommendations. The speech therapist gave the patient and his wife information on the exercises that they are doing with the patient that he can work on without the therapist present to build up muscle strength when swallowing.

5b) Dynamic Health utilized for information on good oral hygiene to prevent aspiration pneumonia. **Very important education and therapeutic interventions! SA**

#### Week 11

5a) My patient had been made NPO by the previous nurse on night shift due to risk for aspiration. The patient had asked me for something to drink. I told the patient that until speech therapy did a swallowing evaluation, I was not able to give him anything to eat or drink.

5b) I educated the patient on the risk of aspiration, and it can develop into pneumonia. Aspiration pneumonia information is available on Dynamic Health. **This was great education for your patient since this was a change in his status that affected diet. As the day went on and his diet was changed back to a regular diet did you have further discussion about this with him or did his fatigue affect your ability to provide further teaching? KA**

#### Week 12

5a) I provided education to my patient on a couple medications, and I also explained to him what I had heard the hospitalist tell him as to why she wanted to transfer him to Cleveland Clinic to see his specialist for his Myelofibrosis diagnosis rather than him waiting to see him at his outpatient appointment previously scheduled for next week. The first medication that I educated him on was his Protonix. I felt education on this medication was appropriate because he refused to take this when I gave him his morning medications on Wed. At the bedside during my med pass I gave him education on the medication immediately when he asked what the medicine was for when he refused it. I explained to him it was for heartburn and GERD. I went back in later and had given him a written patient education sheet on Protonix. On Thurs, he was ordered Sodium Bicarbonate IV push. I gave him education at the bedside that the Sodium Bicarbonate was prescribed to help correct his abnormal lab values due to metabolic acidosis. **Great job giving the patient information so that he was able to make an educated decision. HS**

5b) For information on Protonix, I utilized skyscape and Lexicomp from Firelands intranet page to print off patient education to give to the patient. For information about Sodium Bicarbonate, I used skyscape for information on that medication. **HS**

**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	S	S	NA	NA	NA	S	NA	NA	NA	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	S	S	S	NA	NA	S	NA	NA	S	S		NA	NA	
	MD	MD	MD	NS	KA	SA	DW	MD	MD	DW	DW	KA	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. See Care Map Grading Rubrics below.**

**Comments:**

Week 3

6b) A social determinant of health that could influence my pt’s health care is lack of family support. She stated she had a granddaughter who recently moved to Kentucky and a grandson who lives in Republic. She said that she has not spoke with them since she has been in the hospital. She also stated she only had one daughter, but she passed away in 2022. **Absolutely true! MD**

**Week 3 Rehab Clinical Objective 6A: This week you were able to develop a satisfactory care map based on impaired skin integrity. Please see rubric for additional comments! MD**

Week 4

6b) A social determinant of health for my pt on day 2 was that he lives at the OVH. Living in a nursing home can affect the quality of care that a patient receives and the patient’s are at higher risk for being exposed to communicable diseases from other residents, staff, and visitors that they may come into contact with. **Good thoughts! Living in an extended care facility has both positive and negative consequences related to SDOH. On one hand, they are certainly at risk for communicable diseases and deteriorating health. On the other hand, they also have health care support around the clock when compared to a home environment. NS**

**Week 4 6(a) – Satisfactory completion of nursing care map related to the priority nursing problem of decreased cardiac output. See the attached grading rubric for more details. NS**

Week 5

6b) A SDOH for my patient would be stress. She denied any depression at this time, but said she did feel depressed recently because of her health. She was able to talk to someone about her feelings and that helped. She is a former smoker and if she started smoking due to others smoking around her then that could be a SDOH as well. She has COPD and cigarette smoke is a major risk factor for COPD. **Great thoughts. She also had a strong support system which is a SDOH that positively reflects on your patient's overall management of her health. KA**

Week 6

6b) A SDOH for my patient would be his discharge plans to go to Admirals Pointe upon completion of the therapy at FRMC. This will benefit his health because his wife works at Admirals Pointe. With his limitations for mobility, speech, and swallowing, it would not be safe for him to be home by himself while she is at work. While at Admiral's Pointe he will get 24-hour care and assistance. This also does not put the demands and stress of the needed care on his wife which could make him feel like he is a burden to her. **SA**

Week 11

6b) A SDOH for this patient is that he lives alone, and his daughter lives out of state. She is very involved with him by talking to him on the phone daily, but he is not compliant with his care at home. I don't think that he would like an assisted living facility as he might feel like he is losing his independence. I think he would benefit from having a home health nurse that would check in on him more frequently. The home health nurse could help educate him and come up with a plan to assist him in being more compliant with his care at home. Also, he said that his daughter had told him to go to the ER sooner than he did, but at that time he didn't feel it was necessary. A home health nurse would be a great reference for him to utilize when his CHF symptoms are worsening so he could get treatment sooner from his PCP which would allow him to possibly avoid needing to be hospitalized. **These are all great thoughts on ways to assist with this living situation. What are your thoughts on services such as life alert for him? KA**

Week 12

6b) A SDOH for my patient is that he lives with his wife. His wife is very supportive and assists him as needed. When PT was working with him, he told the therapist to tell the doctor he was able to go home. She told him that right now he physically is not strong enough to do so. His response to her was that his wife would be there to help him and that she could take care of his needs at home. His wife was there at his bedside Thurs when all the doctors were coming in to talk to him. This is beneficial because he was confused about all the information that was thrown at him at once. His wife was there to hear the doctors for herself and was able to ask questions she might have rather than having to rely on the patient to remember everything. She helped make the decision to have him transferred to Cleveland Clinic. Also, his home health nurse was at the bedside during this time. She knows the patient better than hospital staff and could help explain things to the patient and his wife in a way that they understand better or if they have questions after the doctor leaves the room, she could possibly help answer them since she heard what was said. **Great example! I understand that the patient's wife assists with his care, however I wonder if she would have issues getting him in and out of the car and getting him to his appointment in Cleveland. There are several SDOH that could impact his care. HS**

**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. <b>Reflect on an area of strength. ** (Reflecting)</b>	S		S	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
b. <b>Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)</b>	S		S NI	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		S	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		S	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
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	NA	NA	S	S	S	S	S		NA	NA	
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	S		S	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		S	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
h. Actively engage in self-reflection. (Reflecting)	S		S	S	S	S	NA	NA	S	S	S	S	S		NA	NA	
	MD	MD	MD	NS	KA	SA	DW	MD	MD	DW	DW	KA	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) An area of strength that I have is accurately taking a fingerstick, labeling glucometer supplies appropriately and running a QC check on the glucometer properly. Great! MD

7b) An area to improve on is charting on an IV. A goal that I have is to study the definitions of descriptive terms such as extravasation and its appearance when assessing an IV site. **Great goal! MD**

#### Week 3

7a) An area of strength that I had was noticing my pt had an irregular pulse on day 2, which was a change compared to day 1 when her pulse was regular. Instructor notified immediately. Bedside nurse was then notified. Patient has a hx of A-fib and is on an anticoagulant medication because of this diagnosis. **This was an excellent finding during your morning assessment! MD**

7b) An area for improvement was that on day one I charted that I heard crackles when listening to my pt lung sounds. To improve (my goal), I need to have pt cough to see if secretions can be cleared before documentation of abnormal sounds and to notify the instructor and bedside nurse immediately of the abnormal finding. **This is a great goal! Unfortunately, you did not state how you will work on this goal for future clinical experiences. Please be sure to write how you will obtain this goal each week. MD**

#### Week 4

7a) An area of strength that I had was safely administering medications to a pt via NG tube. **This was a great learning experience! As you noticed, when a patient has several medications to be crushed and administered, time management plays an important role. Also, you were able to use good clinical judgement in decision making regarding his medication administration. I thought you did a great job demonstrating knowledge of NG tubes and had good dexterity in your approach caring for it. NS**

7b) An area of weakness that I had was finding pedal pulses in my pt. He had some slight edema in his feet and venous insufficiency resulting in the patient having multiple toe amputations in the past. I will practice finding pedal pulse on family before my next clinical. **Practice makes perfect! I always struggled with finding pedal pulses as well, especially when edema was present. As we discussed in clinical, sometimes you can find a doppler, locate the pulse via the doppler, then move your fingers over the identified spot to enhance your confidence. I think your play to practice on family members is a great way to get more comfortable! Keep up the hard work! NS**

#### Week 5

7a) An area of strength that I had was improving on my skills for hanging an IV medication and starting the pump to the correct rate. I have noticed that each time that I set up the pump I need less assistance from the instructor(s). **Nice job! You were able to successfully prime the tubing and hang the antibiotic two on your patient on clinical. KA**

7b) An area of weakness that I had was that there was a change in my patient's Vancomycin dosage strength so a second IV had to be given. To improve, I will verify if a Vanco trough has been drawn and resulted before administering the IV Vancomycin. **Great catch and recognizing this is an important lab to gather data on. It caused the patient to need to get 2 bags of vanco to receive the correct dose versus 1 but this would be great to check at the beginning of your shift to ensure whether it is time to be drawn or not. KA**

#### Week 6

7a) An area of strength that I had was attempting to straight cath a patient in clinical. This was my first time doing this skill in the clinical setting. Although I was not able to successfully obtain the needed sample, I was able to perform the steps of the skill successfully.

7b) An area for improvement is to feel more confident in inserting a catheter. To build up confidence I will review steps of the skill prior to clinical. **You did a great job on your attempts! The more practice you get, the more confidence you will gain and those attempts will not be so stressful. Thank you for jumping in to help on someone that was not your patient. SA**

**MIDTERM- Great job in the first half of the semester Michelle! Keep working on practicing all of the skills you have learned! MD**

#### Week 9

7a) An area of strength was knowing the proper isolation and PPE required for the different infection types seen throughout the clinical that I was assigned to. **Excellent! DW**

7b) An area of improvement is to learn more about the infectious diseases that I have less commonly seen while on clinical sites and their isolation requirements. To do this, I will review the list of frequently isolated organisms. During this clinical I learned why RSV is contact isolation and not droplet although it is a respiratory

illness. I also learned that the CDC does not require isolation for adult patients with RSV unless they are an immunocompromised patient. **Great reflection and goal development here! Keep up the good work! DW**

#### Week 10

7a) An area of strength was that we developed an activity that all seniors were able to participate in. We adapted throughout the activity to find ways for everyone to get a chance to win a prize. Also, the activity that we developed required physical activity and cognitive stimulation which benefited both their physical and mental health. **Excellent! DW**

7b) An area for improvement would have been to find alternative ways to have them answer questions. A lot of them didn't raise their hands and then at times it was hard to see who raised their hand first because of the seating arrangements. To improve, I can research independently and ask activity directors at the senior center or nursing homes for suggestions of ways that work better for older adults rather than having them raise their hands. Some older adults may not have fast reflexes or take longer to think of the answer which would give them a disadvantage. **Lesson learned! DW**

#### Week 11

7a) A area of strength that I had was to notice that my patient was not feeling well and acted in a timely manner to notify his bedside nurse who was able to obtain an order for Zofran for the patient. **You did a great job acting fast and advocating for your patient this week. He truly benefited from all the care you provided to him even though his status kept changing. KA**

7b) A area for improvement is that when I gave the patient his morning medications, he had 12 oral medications, I should have proactively given him some crackers with the medications. His Synthroid must be given on an empty stomach. Instead of giving him all the medications at once, due to his previous NPO status and vomiting, I could have given the Synthroid alone. After 30 minutes I then could have given him some crackers before giving him the rest of his pills to prevent his nausea from returning. To improve, I will ask the patient if they typically get nauseous from taking their medications and offer some crackers with them if not contraindicated. **Great thoughts on how to help this situation in the future. We learn from each situation and the care we provide. Great self-reflection on how you can improve on your medication administration process that can help all patients in a similar situation. KA**

#### Week 12

7a) An area of strength that I had was able to correlate his lab values, symptoms, and treatments together. On my first day with him his kidney function had started to decline from the previous day. They had him on continuous fluids to try to fix the problem. I had noticed that he hadn't produced any urine output within the 5 hours that I was caring for him. I asked about bladder scanning him but also knew that it might not be accurate due to his ascites. I bladder scanned him for >400 mL and then he used the urinal and had 100 mL output. Unfortunately, his kidneys continued to decline. When I came back the next day the fluids had stopped, he had a foley catheter placed, and he was on a Lasix drip. He also was prescribed Midodrine and needed O<sub>2</sub>, both of which were new orders since the day before when I cared for him. I had noticed that previous nurses did not get a daily weight on him for due to his bed scale not working. With his diagnosis I recognized that his weight is an important piece of information needed to monitor his condition. I took the bed extender off the bed and obtained his weight. He had a 3.1 kg (6.82 lb.) weight gain despite having 4,500 mL of fluid removed 2 days prior. His breathing pattern had also changed. On day 2 he was using accessory muscles when breathing which he wasn't doing the day before. That is because the excess fluid is affecting his respiratory system to work harder. **Great job correlating all of those findings! Great job being proactive and communicating with the nurse to bladder scan. Excellent job identifying that the patient didn't have a daily weight completed, and obtaining his weight. HS**

7b) An area for improvement that I have is that I need to ask the patient if they are symptomatic with vitals. My patient typically has a BP on the lower side. He normally has a systolic in the 100s, but I got a reading in the 90s. The patient didn't appear to be any different and it wasn't much of a difference from his normal reading, so I didn't initially ask him if he felt dizzy. To remember to do this, I will review signs and symptoms of hypotension and ask future patients if they are experiencing any of the manifestations of hypotension when they have low blood pressure regardless of their BP normally runs low or not. **Great job! HS**

Student Name: Michelle Porcher		Course Objective: Impaired Skin Integrity					
Date or Clinical Week: Week 3 1/22-23/2025							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	3	All criteria met. MD
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	All criteria met. MD
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	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.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement\*

< 23 points = Unsatisfactory\*

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

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

**Faculty/Teaching Assistant Comments:**

**Total Points: 45/45 Satisfactory MD**

**Faculty/Teaching Assistant Initials: MD**

Student Name: Michelle Porcher		Course Objective: 6					
Date or Clinical Week: Week 4							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	3	A thorough list of nine abnormal assessment findings were listed, including specific patient data identified in the clinical experience. Eleven abnormal labs/diagnostics were listed based on findings from the EHR. A quick comment on the chest CT findings – the potential infiltrate that was identified on the CT could be directly related to your identified priority problem of decreased cardiac output. This can lead to what’s called pulmonary edema which is caused by fluid build up in the lungs due to the heart not effectively pumping blood out to the rest of the body. This is probably why you heard crackles in the lower bases (just some food for thought). A thorough list of risk factors were identified based on current and past medical history.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	An exceptionally detailed list of priority nursing problems were listed, with the appropriate priority problem identified as decreased cardiac output resulting from his Afib with RVR diagnosis. Based on the identified priority problem, a goal statement that is realistic for the patient situation was identified to display hemodynamic stability. Most findings from the noticing section were appropriately highlighted as they relate to the decreased cardiac output. As mentioned above, you could highlight the CT scan findings are supportive. Otherwise, well done! Based on the priority problem of decreased cardiac output, three high priority potential complications were listed with specific signs and symptoms to monitor for listed.
	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	
Respon	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	A detailed list of 17 nursing interventions were included, each prioritized appropriately with assessments taking highest priority. Each listed intervention included a frequency and appropriate
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

<b>ding</b>	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	rationale. Specific interventions related to medications provided individualized prescriptions and provider orders. I would consider including an intervention related to encouraging slow position changes, implementing fall precautions, etc. These can be related to his decreased cardiac output leading to orthostatic hypotension. Depending on the patient, they may also be on a fluid or diet restriction (not in your case).
	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
	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	Each abnormal assessment findings and applicable labs/diagnostics were updated in the evaluation section. Based on the findings, it was appropriately determined to continue the plan of care.
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <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*</p> <p><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: Michelle, you did a great job demonstrating your clinical judgement skills in the development of a nursing care map for the priority problem of decreased cardiac output. This is a more complex priority problem based on where you are at in the program. I was impressed with your thought process and ability to make correlations throughout this care map. Very well done! You have now successfully completed both required care map submissions with a satisfactory evaluation. Great job with your time management this semester! Let me know if you have any questions. NS</b></p>	<p><b>Total Points: 45/45 - Satisfactory</b></p> <hr/> <p><b>Faculty/Teaching Assistant Initials: NS</b></p>
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Firelands Regional Medical Center School of Nursing  
**Medical Surgical Nursing 2025**  
**Skills Lab Competency Tool**

Student name: Michelle Porcher								
<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>
Performance Codes: <b>S:</b> Satisfactory <b>U:</b> Unsatisfactory	<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)*
	<b>Date:</b> 1/7/25	<b>Date:</b> 1/7/25	<b>Date:</b> 1/9/25	<b>Date:</b> 1/9/25	<b>Date:</b> 1/10/25	<b>Date:</b> 1/16/25	<b>Date:</b> 1/15/25	<b>Date:</b> 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>MD</b>	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>MD</b>	<b>DW</b>
<b>Remediation: 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 1/9/25. 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

Week 9

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

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

<b><u>Simulation Evaluation</u></b>	<b>Student Name: Michelle Porcher</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:  <b>S:</b> Satisfactory  <b>U:</b> Unsatisfactory								
	<b>Date:</b> 1/27/25	<b>Date:</b> 2/10/25	<b>Date:</b> 2/24/25	<b>Date:</b> 2/26/25	<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	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>				
Faculty/Teaching Assistant Initials	<b>RH</b>	<b>KA</b>	<b>MD</b>	<b>MD</b>				
<b>Remediation:</b> Date/Evaluation/Initials	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>				

\* 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): Lee (M) Porcher (A)

GROUP #: 2

SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory

OBSERVATION DATE/TIME(S): 2/26/25 1015-1215

CLINICAL JUDGMENT COMPONENTS	<u>OBSERVATION NOTES</u>
<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>Full vital signs assessment. Notice low oxygen levels, elevated heart rate.</p> <p>Pain assessment: location, rating, radiation, tingling/numbness.</p> <p>Respiratory assessment third. Identify crackles in lung sounds.</p> <p>Circulatory assessment done after identifying pain location and redness on right leg. Notice pulses present. Notice edema +1.</p> <p>Reassess pain and vitals assessment after pain medication administration.</p> <p>In debriefing, it was noted that patient was non-compliant with medications at home (aspirin and blood thinner for history of a fib)</p> <p>Does not ask about preferred pronouns</p>
<p><b>INTERPRETING: (1) *</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>Prioritize vitals and pain assessment of patient. Prioritize cardiovascular and respiratory when patient complains of shortness of breath.</p> <p>Prioritize oxygen administration due to oxygen levels. Stay in room until oxygen levels stabilize.</p> <p>Made sense of dosage calculation for morphine.</p> <p>ABG interpretation as respiratory alkalosis with hypoxia.</p> <p>Makes sense of enoxaparin dosage calculation.</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>Identify self upon entering room. Verify patient name/DOB. Does not address pronouns or patient preferred name.</p> <p>Elevate head of bed when report shortness of breath.</p> <p>Educate on pursed lip breathing to assist with SOB feeling.</p> <p>Call healthcare provider. SBAR organized. Receive new orders for patient. Does not read any orders back for verification. Always read back verbal orders for verification.</p> <p>Educate/keep patient updated on plan of care and what is happening.</p>

	<p>Morphine administration: verify name/DOB, verify allergies. Scan patient and medications. Identify need for waste. Use of incorrect needle size (uses subq needle size). Correct administration and use of needle safety.</p> <p>Call healthcare provider with updates on lab results and radiology results. Receive new orders for enoxaparin. Does not read back orders for verification.</p> <p>Education provided to patient on incentive spirometer (how to use, how often to use), SCD use and compliance, empathize with patient for fear of falling but continues to educate on importance of participating in therapy and moving around more. Includes education on why “just lying in bed” is not the best way to heal and what complications could occur if patient does not move.</p> <p>Call healthcare provider back for clarification on enoxaparin order. Did not read order back for verification.</p> <p>Enoxaparin administration: educate on what medication is for and why it is necessary. Performs all checks. Correct dosage calculation</p>
<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>	<p>Group led discussion regarding priority assessments and focused assessments. For first half, team members identified that priority assessment should have been pain and should have focused more on the identification of the 6Ps rather than returning to the head to toe assessment. Group members stated that if they would have identified the 6 Ps sooner they could have made the connection to compartment syndrome faster. This realization also led to discussion about interventions done for the first half of the scenario and group members identified that their nursing interventions (continuing to elevate leg, maintaining ice therapy) were incorrect due to the compartment syndrome presentation. Discussion about how to change approach to the scenario and what could have been done differently in the first half was done by all members of the group, including the observers.</p> <p>Group led discussion for second half of scenario continued with identifying the priority assessment and how the anticipated priority assessment (surgical site) changed due to patient report of pain when entering the room (changed to respiratory/cardiovascular and non-surgical leg). Group identified that patient reporting the change of pain site and shortness of breath allowed them to change their approach and call the healthcare provider to get new orders. Group identified that they did not readback orders to healthcare provider at all during various phone calls. Discussion of why this is important and who would be accountable for the incorrect or incomplete orders in real life.</p> <p>Group identified that there was no confrontation with nurse regarding lack of use of proper pronouns for patient and that they also did not ask for the patient’s preferred pronouns. Discussion lead to how to ask these questions and how it makes the patient feel.</p>
<p><b>SUMMARY COMMENTS: * = Course Objectives</b></p> <p>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</p> <p>E= Exemplary</p>	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Makes limited efforts to seek</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>additional information from the patient and family; often seems not to know what information to seek and/or pursues unrelated information.</p> <p>Interpreting: Focuses on the most relevant and important data useful for explaining the patient's condition. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient's data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success.</p> <p>Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. Shows some communication ability (e.g., giving directions); communication with patients, families, and team members is only partly successful; displays caring but not competence. 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>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.</p>
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**EVALUATION OF CLINICAL PERFORMANCE TOOL**  
**Medical Surgical Nursing – 2025**

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

I was given the opportunity to review my final clinical ratings in each course competency. I was given the opportunity to ask questions about my clinical performance. I have the following comments to make about my clinical performance/final clinical evaluation:

Student eSignature and Date:

11/21/24