

**EVALUATION OF CLINICAL PERFORMANCE TOOL  
Nursing Foundations – 2018**

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

**Student:** Nicole Meier

**Semester:** Fall

**Faculty:** Frances Brennan, MSN, RN;  
 Dr. Michelle Bussard, PhD, RN, ACNS-BC, CNE; Nicole Lawrence, MSN, RN-BC, CNE;  
 Amy Rockwell, MSN, RN; Nick Simonovich, BSN, RN; Lara, Wilken, MSN, RN

**Final Grade:** Satisfactory

**Date of Completion:** December 5, 2018

**Faculty eSignature:** Fran Brennan MSN, 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 on the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a “S, NI, or U”. 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, the following week it must be addressed with a comment as to why it is no longer a “U”. If the student does not state why the “U” is corrected, then it will be another “U” until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. If the final performance code is unsatisfactory in any one of the competencies, a grade of unsatisfactory is given. If a pattern of unsatisfactory performance occurs after performing the competency satisfactorily, this also constitutes a grade of unsatisfactory. An unsatisfactory as a final score in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.

**METHODS OF EVALUATION:**

- Lasater Clinical Judgment Rubric
- Careplan Grading Rubric
- Documentation
- Skills Demonstration
- Administration of Medications
- Evaluation of Clinical Performance Tool
- Clinical Discussion Group Grading Rubric
- High-Fidelity Simulation
- Skills Lab Competency Tool
- Skills Lab Checklist
- Faculty Feedback

**ABSENCE (Refer to Attendance Policy)**

Date	Number of Hours	Comments	Make Up (Date/Time)
<b>Faculty’s Name</b>			<b>Initials</b>
	Frances Brennan		FB
	Dr. Michelle Bussard		MB
	Nicole Lawrence		NL
	Nicholas Simonovich		NS
	Amy Rockwell		AR
	Lara Wilken		LW

## 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/patients/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.**

Objective																		
1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>										S	S		S	S		S		S
a. Identify spiritual needs of patient (Noticing).										S	S		S	S		S		S
b. Identify cultural factors that influence healthcare (Noticing).										S	S		S	S		S		S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).			NA	S	NA	S		S		S	S		S	S		S		S
			NL	NS	NL	NS		NS		FB	FB		FB	FB		FB		FB
Clinical Location				3N		3T				3N	3N		3N	3N		4N		

**Comments**

Week 4 objective 1-Great job this week with coordinating care for your patient and determining his care needs. You understood that your patient needed to eat lunch, and were able to obtain his vital signs beforehand. Remember to enter your clinical location each week. NS

Week 9 (1d) – Nicole, you were very respectful of your patient's values and were attentive to the patient's needs. FB

\* End-of-Program Student Learning Outcomes

Objective																		
2. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>						S		S		S	S		S	S		S		S
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).						S		S		S	S		S	S		S		S
b. Use correct technique for vital sign measurement (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
c. Conduct a fall assessment and institute appropriate precautions (Responding).						S		S		S	S		S	S		S		S
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).										S	S		S	S		S		S
e. Collect the nutritional data of assigned patient (Noticing).										S	S		S	S		S		S
f. Demonstrates appropriate insertion & maintenance of NG tube (Responding).										NA	NA		NA	NA		S		S
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).													S	S		S		S
			NL	NS	NL	NS		NS		FB	FB		FB	FB		FB		FB

**Comments**

**Week 9 (2a) – Nicole** you did a good job performing a head to toe assessment and asked appropriate questions regarding the patient’s fistula and how to assess a fistula. **FB**  
**Week 15 (2f)- Nicole,** great technique used with removal of NG tube from your assigned patient. Great job with assessment and care provided to this patient as well. **FB**

\* End-of-Program Student Learning Outcomes

Objective																		
3. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>						NA		NA		S	S		S	S		S		S
a. Receive report at beginning of shift from assigned nurse (Noticing).						NA		NA		S	S		S	S		S		S
b. Hand off (report) pertinent, current information to the next provider of care (Responding).			NA	S NA	NA	NA		NA		S	S		S	S		S		S
c. Use appropriate medical terminology in verbal and written communication (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
d. Report promptly and accurately any change in the status of the patient (Responding).			NA	NI	NA	S		S		S	S		S	S		S		S
e. Communicate effectively with patients and families (Responding).			NA	NI	NA	S		S		S	S		S	S		S		S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
			NL	NS	NL	NS		NS		FB	FB		FB	FB		FB		FB

**Comments**

Week 3 objective 3 (b) – This competency was changed to a “NA” this week because we did not have the opportunity to provide hand-off report. In the coming weeks you will get this experience and will be able to give hand-off report to the primary RN caring for your patient. NS

Week 3 (d,e) – These are areas that you will improve on with experience. Overall I thought you did a good job with communication! Your patient had a busy morning and was eager to go home, so unfortunately he was not as open to the communication activity. The more experience you have communicating with patients the easier it will become. NS

Week 9 (3 d, e)- You reported and reacted appropriately to a change in precautions that arose for your patient. You communicated appropriate changes to the staff nurse.  
Great job! FB

\* End-of-Program Student Learning Outcomes

Objective																		
4. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>						S		S		S	S		S	S		S		S
a. Document the head to toe assessment for assigned patient (Responding).								S		S	S		S	S		S		S
b. Document the patient response to nursing care provided (Responding).										S	S		S	S		S		S
c. Document according to policy (Responding).			NA	NI S	NA	S		S		S	S		S	S		S		S
d. Access medical information of assigned patient in Electronic Medical Record (Responding).		S	NA	S	NA	S		S		S	S		S	S		S		S
e. Show beginning skill in accessing patient education material on intranet (Responding).		S								NA	NA		NA	NA		NA		S
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).											S NI		S	S		S		S
		NS	NL	NS	NL	NS		NS		FB	FB		FB	FB		FB		FB

**Comments**

Week 2 – orientation to Meditech 6.1

Week 3 objective 4 (c) – Overall your documentation looked good! You will start to get more comfortable with Meditech each time you use the system. Keep up the hard work! NS

Week 9 (4 a, d) – Documentation was appropriate and accurate. You demonstrated the ability to find pertinent medical history on assigned patient. Great job! FB

Week 10 (4f)- Great job with CDG post and responding to two of your peers. You are receiving a NI (needs improvement) because you did not provide an in-text citation within your care plan, you provided a reference but nothing within the body of the care plan. Postings were submitted on time, using correct grammar, punctuation, and spelling. You provided supporting opinions with correct citations. You also need to copy and paste your care plan, do not post as a word document attachment. FB

Week 13 (4f)- Good job, instead of saying respiratory assessment is WNL, you should have reported on each portion of the respiratory assessment. Make sure to elaborate further on CDG questions. You provided meaningful thought provoking responses to 2 of your peers, good job! FB

Week 15 (4f)- Nicole, you provided very thought provoking responses to two of your peers. You also provided a great picture of your patient regarding pain issues. FB

\* End-of-Program Student Learning Outcomes

Objective																		
5. Exemplify psychomotor skills and nursing care safely using evidence-based practice. (3,4,5,7,8)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>			NA	S	NA	S		S		S	S		S	S		S		S
a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
b. Apply the principles of asepsis and standard precautions (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
c. Demonstrates appropriate skill with foley catheter insertion and removal (Responding).										NA	NA		NA	NA		NA		N/A
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
e. Organize time providing patient care efficiently and safely (Responding).			NA	NI	NA	S		S		S	S		S	S		S		S
f. Manages a patient in physical restraints according to hospital policy (Responding).										NA	NA		NA	NA		NA		S

g. Manages hygiene needs of assigned patient (Responding).										S	S		S	S		S		S
h. Demonstrate appropriate skill with wound care (Responding).										NA	NA		NA	NA		S		S
i. <b>Document the location of fire pull stations and fire extinguishers.**</b> (Interpreting).						S		S										S
			NL	NS	NL	NS		NS		FB	FB		FB	FB		FB		FB

Comments

**\*\*You must document the location of the pull station and extinguisher here for clinical #2 experience.**

**Week 6: There are 5 fire extinguishers, one across from the waiting room, two at each end near stairs, and one next to the nursing corridor. NS**

**Week 9 (5 b, d, g) – Nicole you practiced great precaution awareness, doing appropriate PPE when these precautions changed from standard to contact precautions. You managed the care of your patient appropriately and provided hygiene. Keep up the great work! FB**

\* End-of-Program Student Learning Outcomes

Objective																		
6. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>																		
a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).											S NI		<del>H</del> S	S		S		S
b. Development of clinical judgment in high-fidelity simulation scenarios. (Noticing, Interpreting, Responding, Reflecting)												S	S	NA				S
c. Simulation Remediation (if needed)																		
											FB	FB	FB	FB		FB		FB

**Comments** Week 10 (6a)- See care plan grading rubric for comments and suggestions regarding care plan. FB

Week 11 (6b) Your simulation team demonstrated development of clinical judgment by noticing patient data, interpreting the findings, and responding with appropriate nursing interventions. Additionally, your simulation group engaged in effective reflection by discussing both strengths and weaknesses as well as the desire for continuous improvement. Well done with your first simulation scenario! NL/AR/NS

Week 12 (6b) Your simulation team demonstrated development of clinical judgment by noticing patient data, interpreting the findings, and responding with appropriate nursing interventions. Additionally, your simulation group engaged in effective reflection by discussing both strengths and weaknesses as well as the desire for continuous improvement. Well done! NL/FB

<p><b>Objective # 6:</b> Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*</p>	
<p><b>**Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating</b></p>	<p>Total Points Comments</p>
<p>Nursing Diagnosis: (3 points total)          Problem Statement (1) (1)          Etiology (1) (0.5)          Defining Characteristics (1) (1)</p>	<p>Total Points 2.5          Comments The etiology for your patient should have including the history of high blood pressure, high cholesterol, and high blood sugars.</p>
<p>Goal and Outcome (6 points total)          Goal Statement (1 point) (1)          Outcome:          Specific (1) (1)          Measurable (1) (0)          Attainable (1) (1)          Realistic (1) (1)          Time Frame (1) (0)</p>	<p>Total Points 4          Comments: Outcomes need to follow the SMART acronym, how will you measure fatigue, dizziness, SOB, heart palpitations. You need to specify such as Patient displays no signs of SOB with a SPO2 of &gt; 92% on room air. Patient states he/she has no dizziness. Do not use no, decreased, improved, increased because these are not measurable.</p>
<p>Nursing Interventions: (8 points total)          Prioritized (1) (0.5)          What (1) (1)          How Often (1) (1)          When (1) (1)          Individualized (1) (1)          Realistic (1)          Rationale (1)          All pertinent interventions listed (1)</p>	<p>Total Points 7          Comments: Cardiovascular assessments should be a priority, followed by vital signs, heart rhythm, medication administration, and education.</p>
<p>Evaluation: (5 points total)          Date (1) (1)          Goal Met/partially/unmet (1) (1)          Defining characteristics (1) (0.5)          Plan to continue/terminate (1) (0)          Signature (1) (0)</p>	<p>Total Points 2.5          Comments: Defining characteristics are not specific, use the nursing care plan guide to assist you. No plan to continue, or terminate plan of care was included. There was also no signature provided.          Make sure to use the nursing care plan guidelines provided in resources on edvance360 as well as the CDG guidelines provided. FB</p>
<p>Total possible points = 22          18-22 = Satisfactory care plan          17-13 = Needs improvement care plan          &lt;13 = Unsatisfactory care plan</p>	<p>Total Points for entire Care plan = 16          Comments: Needs improvement care plan. Make sure to read through comments and suggestions and if you have questions do not hesitate to ask for help. Reflecting</p>

**Week 10:**



<p><b>Objective # 6:</b> Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*</p>	
<p><b>**Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating</b></p>	<p>Total Points Comments</p>
<p>Nursing Diagnosis: (3 points)          Problem Statement (1)          Etiology (1)          Defining Characteristics (1)</p> <p><del>Student Name: Nicole Meier</del></p>	<p>Total Points <b>3</b>          Comments: <b>Nursing diagnosis is appropriate for assigned patient, and problem statement is NANDA approved. A better etiology would have been insufficient knowledge to avoid exposure to pathogens. A heart rate of 80 is WNL listed in defining characteristics.</b>  <del>Clinical Date: 11/8/2018</del></p>
<p>Goal and Outcome (6 points total)          Goal Statement (1 point)          Outcome:          Specific (1)          Measurable (1)          Attainable (1)          Realistic (1)          Time Frame (1)</p>	<p>Total Points <b>5.5</b>          Comments: <b>Goal statement is generalized and problem directly relates to NANDA problem. Most outcomes follow the SMART acronym. One of the outcomes is unrealistic because the normal heart rate is 60-100 bpm. Suggestion: include refusal of hygiene care as defining characteristic and under outcomes hygiene care performed daily and as needed.</b></p>
<p>Nursing Interventions: (8 points total)          Prioritized (1)          What (1)          How Often (1)          When (1)          Individualized (1)          Realistic (1)          Rationale (1)          All pertinent interventions listed (1)</p>	<p>Total Points <b>7.5</b>          Comments: <b>Nursing interventions are appropriate and additional interventions should include hygiene care.</b></p>
<p>Evaluation: (5 points total)          Date (1)          Goal Met/partially/unmet (1)          Defining characteristics (1)          Plan to continue/terminate (1)          Signature (1)</p>	<p>Total Points <b>5</b>          Comments: <b>Evaluation directly reflects all content included in defining characteristics of goal and outcome statement.</b></p>
<p>Total possible points = 22          18-22 = Satisfactory care plan          17-14 = Needs improvement care plan          Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting          &lt;13 = Unsatisfactory care plan</p>	<p>Total Points for entire Care plan = <b>21</b>          Comments: <b>Satisfactory care plan.</b></p>

**Week 12:**

Nursing Care Plans Grading Rubric  
 Nursing Foundations  
 2018

<p><b>Objective # 6:</b> Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*</p>	
<p><b>**Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating</b></p>	<p>Total Points Comments</p>
<p>Nursing Diagnosis: (3 points)          Problem Statement (1)          Etiology (1)          Defining Characteristics (1)</p>	<p>Total Points 3          Comments: Great job, nursing diagnosis appropriate for assigned patient. Problem statement and etiology are relevant. Defining characteristics are supportive of nursing diagnosis.</p>
<p>Goal and Outcome (6 points total)          Goal Statement (1 point)          Outcome:          Specific (1)          Measurable (1)          Attainable (1)          Realistic (1) (0.5)          Time Frame (1)</p>	<p>Total Points 5.5          Comments: Goal statement and outcomes are relevant to NANDA problem. Make sure all outcomes are realistic, ex. Patient will have urinary output <math>\geq 720</math> mL in a 24 hour period. (normal is approximately 30 mL per hour).</p>
<p>Nursing Interventions: (8 points total)          Prioritized (1)          What (1)          How Often (1) (0.5)          When (1) (0.5)          Individualized (1)          Realistic (1)          Rationale (1)          All pertinent interventions listed (1)</p>	<p>Total Points 7          Comments: Nursing interventions are prioritized, individualized, realistic, and pertinent to patient. Remember to state how often for all interventions, including those geared towards education.</p>
<p>Evaluation: (5 points total)          Date (1)          Goal Met/partially/unmet (1)          Defining characteristics (1)          Plan to continue/terminate (1)          Signature (1)</p>	<p>Total Points 5          Comments: Great job, evaluation addresses all objectives appropriately.</p>
<p>Total possible points = 22          18-22 = Satisfactory care plan          13-17 = Needs improvement care plan          &lt;13 = Unsatisfactory care plan</p>	<p>Total Points for entire Care plan = 20.5          Comments: Satisfactory care plan</p>

Week 13:

<p><b>Objective # 6:</b> Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*</p>	
<p><b>**Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating</b></p>	<p>Total Points Comments</p>
<p>Nursing Diagnosis: (3 points)          Problem Statement (1)          Etiology (1)          Defining Characteristics (1)</p>	<p>Total Points 3          Comments <b>Great job with appropriate nursing diagnosis for assigned patient. Defining characteristics support the disease process and nursing diagnosis.</b></p>
<p>Goal and Outcome (6 points total)          Goal Statement (1 point)          Outcome:          Specific (1)          Measurable (1)          Attainable (1)          Realistic (1)          Time Frame (1)</p>	<p>Total Points 6          Comments:  <b>Goal statement is generalized and outcomes follow the SMART acronym.</b></p>
<p>Nursing Interventions: (8 points total)          Prioritized (1)          What (1)          How Often (1)          When (1)          Individualized (1)          Realistic (1)          Rationale (1)          All pertinent interventions listed (1) <b>(0.5)</b></p>	<p>Total Points 7.5          Comments: <b>Nursing interventions are prioritized appropriately there were a couple of interventions that should be added: Educate on the use of non-pharmacological pain management such as guided imagery, distraction activities etc. Encourage rest periods.</b></p>
<p>Evaluation: (5 points total)          Date (1)          Goal Met/partially/unmet (1)          Defining characteristics (1) <b>(0.5)</b>          Plan to continue/terminate (1)          Signature (1)</p>	<p>Total Points 4.5          Comments:  <b>Evaluation includes defining characteristics of goal statement. A BP of 135/80 is within normal limits and might be appropriate for you patient.</b></p>
<p>Total possible points = 22          18-22 = Satisfactory care plan          17-14 = Needs improvement care plan          &lt;13 = Unsatisfactory care plan</p>	<p>Total Points for entire Care plan = <b>21</b>          Comments: <b>Great job! Satisfactory care plan. FB</b></p>
<p>Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting</p>	

**Week 15:**

Objective																		
7. Convert basic pharmacology principles into safe medication administration. (3,5,6,7)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>														S		S		S
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).														S		S		S
b. Recognize patient drug allergies (Interpreting).														S		S		S
c. Practice the 6 rights and 3 checks prior to medication administration (Responding).														S		S		S
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).														NI		S		S
e. Check the patient record for time of last dose before giving a prn dose (Interpreting).														NA		NA		N/A
f. Assess the patient response to prn medications (Responding).														NA		S		S
g. Document medication administration appropriately (Responding).													S	S		S		S
													FB	FB		FB		FB

**Comments**

Wk. 12 7(G): You are satisfactory for attending the BMV clinical lab, meeting the requirements for practicing electronic medication administration. Great job! LW/NS

Week 13- Great job with first medication administration, you were prepared, follow all six medication administration rights and documented appropriately. Remember to have a little more conversation with your nurse regarding the medication administration for a patient that is unable to communicate with you. FB

\* End-of-Program Student Learning Outcomes

Objective																		
8. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*																		
Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Mid-Term	Week 8	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14	Week 15	Make-Up	Final
<b>Competencies:</b>			S	S	NA	S		S		S	S		S	S		S		S
a. Reflect on areas of strength** (Reflecting)			NA					S										S
b. Reflect on areas for self-growth with a plan for improvement.** (Reflecting)			S	S	NA	S		S		S	S		S	S		S		S
c. Incorporate instructor feedback for improvement and growth (Reflecting).			NA	S	NA	S		S		S	S		S	S		S		S
d. Follow the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care" (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).			NA	S	NA	S		S		S	S		S	S		S		S
g. Comply with patient's Bill of Rights (Responding).			NA	S	NA	S		S		S	S		S	S		S		S

h.	Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).			NA	S	NA	S		S	S		S	S		S		S
i.	Actively engage in self-reflection. (Reflecting)			NA	S	NA	S		S	S		S	S		S		S
				NL	NS	NL	NS		NS	FB	FB		FB	FB		FB	FB

**\*\* Must have different written example each week of clinical/lab. You must explain your plan for how you will improve. Example, "I am having a hard time with manual BP. I will get a BP cuff from Dawn and practice manual BP's with at least three members of my family this week." Please ensure that you answer this section in-depth with your plan of action.**

- A) Areas of strength for me this week were doing manual BP, taking temperatures, and interpreting the values of the pulse oximeter.
- B) I struggled slightly with taking pulse and respirations one after the other and being able to remember both numbers. I will practice on friends and family until remembering both numbers becomes easier for me. **The clinical tool is only for evaluating clinical experiences, not skills lab. I changed competency 8a and 8b to "NA" for you as you were not in clinical in week 3. Please let me know if you have any questions. NL**
- A) Week 4: An area of strength for me this week was recognizing when the values for BP and temperature strayed from the normal and checking patient's history to see if either were normal for the patient. **Great job! You used correct technique for obtaining vital signs and noticed the BP and temperature reading. You interpreted these readings as abnormal, and responded by navigating through the patient's chart and trending his vital signs. Your patient's blood pressure had been running the same throughout his admission in the hospital so you understood it was not abnormal for him. With his temperature being low, we can start to think of interventions that can be done to respond to his low temperature. Simple interventions such as turning the temperature up in his room or offering a warm blanket can be helpful. Good job with your first clinical experience this week! NS**
- B) Week 4: When walking into the patient's room I failed to ask for both forms of identification. I will practice role playing with several family members or fellow students by next clinical to ensure I remember to do so each time regardless of the situation I walk into. **This is a good area that you can work on for self-growth. With this being your first encounter with a patient, nerves and anxiety are expected and can lead to forgetfulness. In the future, remember to take a deep breath before entering the room and remember the concepts learned in lab and be sure to identify your patient for their safety. Great plan for improvement! Role playing is a good way to help remind yourself of all the concepts you have learned. NS**
- A) Week 6: An area of strength for me this week was communicating with the patient. I informed them of what I was doing and asked any questions the patient had to the best of my ability. **Nicole, you seemed very comfortable and confident with your care and communication with your patient this week. Communicating with your patient with family members in the room can be difficult, but it is important that you show confidence to ensure the patient and their family that they are receiving the best care that you can provide. I think you did a great job this week and communicated effectively! NS**
- B) Week 6: When doing the head to toe assessment I almost forgot a few steps, such as capillary refill and edema. To make sure this doesn't happen and that I am more comfortable with the steps, I will practice with family or friends while they follow the task list so if I miss anything I can be corrected. In doing this I hope to become more comfortable with the process, I will do this before the next clinical. **Great recognition of an area for self-growth. This was your first head to toe assessment on a patient, and it can be difficult to remember the process of a full assessment while also interpreting and responding to your findings. With continued hard work and practice, this will become much easier for you and I think you will find yourself improving each week! NS**

Midterm: Nicole, congratulations on completing your first half of nursing foundations! You have shown improvement each week in the clinical setting, and this was evident with your confidence that you portrayed. At this point in the semester, I think you are doing very well in clinical. You have recognized areas in need of improvement and have put in the dedication and hard work to make the improvements. You are satisfactory in each of the competencies thus far. Keep up all the hard work! NS

- A) Week 9: An area of strength for me this week was providing hygiene for my patient, I helped to provide a bag bath, changing linens, and changing a dirty gown. **Great job providing hygiene care for your patient, it is so important and can make a patient feel refreshed and ultimately better. FB**

- B) Week 9: When doing the head to toe assessment, I remembered the steps however I need to work on individualizing it to the patient, when given an abnormal situation I wasn't sure how to handle it. To improve on this I will have family or friends give me abnormal scenarios and go through steps and ways to work around the situation. This will be done by the next clinical. **Sounds like a great plan, you must always be prepared for the unexpected. You never know what you might encounter while caring for patients. You appeared to handle the situation appropriately. FB**
- A) Week 10: An area of strength for me this week was making sure to provide privacy for my patient. There were people coming and going but I made sure the curtain was always closed once the other people left. **Great job this is so important to help respect the patient. FB**
- B) Week 10: An area of weakness for me this week was when clinical was over, I failed to remove my patient from my list. To ensure this doesn't happen again I will make sure during lab or personal time on Meditech I remove the patient from my list so when I get to clinical I don't forget. I will do this by the next clinical. **Good idea. FB**
- A) Week 12: An area of strength for me this week was properly administering a flu shot. **Great job with flu shot administration, good technique followed. FB**
- B) Week 12: An area of weakness for me this week was in the three checks for administering a medication. I failed to ask for the name and date of birth until prompted to do so. I will spend time practicing with the materials given to me during BMV lab including asking for name and date of birth. This will be done by next clinical. **Great idea, practice will increase your confidence and retention of knowledge. FB**
- A) Week 13: An area of strength for me this week was properly emptying a catheter bag and measuring the output. **Great job!**
- B) Week 13: An area of weakness for me this week was not taking the time to ease my patient's anxiety about his procedure. I will work on taking time to talk to people, patient or not, if they are in emotional distress. This will be done by the next clinical. **FB**
- A) Week 15: An area of strength was doing a dressing change on a wound. **Great job with dressing change. FB**
- B) Week 15: An area of weakness was I did not stay busy once I had all the information I needed and my patient was taken care of. I will work on this by answering call lights whether it's my patient or not and helping my fellow classmates if they need it. This will be done next time I have clinical. **That's a great idea, you can learn a lot by answering call lights, this will enhance your learning experience and help you grow. FB**

	Lab Skills											
	(2,3,5,8)*Week 2	(2,3,4,5,8)*Week 3	(2,3,4,5,8)*Week 4	(2,3,4,5,8)*Week 5	(1,2,3,4,5,8)*Week 6	(2,3,4,5,8)*Week 7	(2,3,4,5,8)*Week 8	(2,3,4,5,8)*Week 9	(2,3,4,5,6,8)*Week 10	1,2,3,4,5,6,7,8)*Week 11	(2,3,5,6,8)*Week 12	
	Date: 8/30/18	Date: 9/6/1/8	Date: 9/13/18	Date: 9/20/18	Date: 9/27/18	Date: 10/4/18	Date: 10/9/18	Date: 10/18/18	Date: 10/25/18	Date: 11/1/18	Date: 11/8/18	
Evaluation:	S	S	S	S	S	S	S	S	S	S	S	
Faculty Initials	LW	AR	LW	LW	LW	AR	LW	AR	LW	LW	AR	
<b>Remediation: Date/Evaluation/Initials</b>	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
<b>Remediation: Date/Evaluation/Initials</b>	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	

Firelands  
Regional  
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Center  
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Nursing  
Nursing

\*Course Objectives

Foundations 2018  
Skills Lab Competency Tool

Nicole Meier

Comments:

Week 2 (Hand Hygiene; Vital Signs; PPE):

During lab this week you were able to satisfactorily demonstrate:

- Proper application and removal of personal protective equipment.
- Appropriate hand hygiene utilizing hand sanitizer and soap/water with two attempts.
- Beginner skills level during guided practice with measurement of temperature (oral, axillary, & rectal), radial & brachial pulses, respirations, and oxygen saturation. Vital signs skills will be observed 1:1 with faculty during Week 3. Keep up the good work! □ LW

Week 3 (Vital Signs): You were satisfactory during your 1:1 observation related to vital signs. Great job!

You obtained an oral temperature, radial pulse, respiratory rate, pulse oximetry reading, and 2 accurate BP measurements (BP #1- reading 112/60-setting 116/58; BP #2- reading 160/92- setting 160/92). You were able to accurately verbalize the procedure for axillary and rectal temperatures, and orthostatic vital signs. The apical pulse will be assessed with the Basic Head to Toe Assessment. Meditech documentation related to vital signs was completed. You did a great job with role playing and communication, and provided thorough information throughout your observation. You were able to remind yourself to raise the side rail and lower the bed prior to leaving the bedside. Keep up the great work! AR

Week 4 (Assessment): Satisfactory with head to toe assessment guided practice, hand-off report activity, and Micromedex online activity. You will be observed 1:1 for Head to Toe Assessment competency during Week 5. LW

Week 5 (Assessment; Mobility): You were satisfactory during your initial 1:1 observation for assessment. You did well entering the patient's room, you were very thoughtful and professional with your patient communication. Additionally, you performed everything necessary related to hand hygiene and privacy. Throughout the assessment you were very thorough when focusing on each body system; you asked the patient all the necessary questions. You obtained consent for the assessment due to concern for the patient's headache. You continually reassessed the headache throughout the assessment, you were very kind. You took your time and remained organized. You required only one prompt, to assess the patient's capillary refill in their upper extremities. Overall you did an excellent job! Keep up the good work! □ LW  
You were satisfactory by actively participating in the mobility lab. LW

Meditech Documentation: Overall you did an excellent job with documentation! You had no errors with the vital signs, patient rounds or pain interventions! You did a great job overall documenting the physical re-assessment intervention, only missing information in one area! Under the respiratory section you were to document no for the chest tube section and you left this area blank. Other than that you did not miss a single thing! If you have any questions regarding this feel free to ask, we are always here to help. You are off to a great start! Keep up the good work! □ LW

Week 6 (Personal Hygiene Skills): Satisfactory with personal hygiene, making an occupied bed, shaving, oral care, hearing aide care, application of ace wraps, TED Hose, and SCD's, and clinical readiness scenario during guided practice, along with Meditech 6.1 Test Hospital documentation. Keep up the good work! LW

Week 7 (NG Skills: Insertion, Irrigation, and Removal; Mobility; Sterile Gloves): Mobility & Sterile Gloves Lab: You were Satisfactory by adequately performing in the mobility & sterile gloves lab. AR

Great job in the lab this week! You were satisfactory with the following skills: Nasogastric Tube Insertion, Irrigation, and Removal. No prompts were given. You were able to verbalize what you would do if the patient began to cough or choke during insertion, that you would verify tube placement by aspiration and confirming the cm marking, the difference between irrigation and flushing, and the different techniques for verifying tube placement. You participated in the PO intake, NG output, and Feeding stations, along with the assigned documentation in Meditech. It is obvious that you came well prepared; keep up the great work in the lab! AR

Week 8 (Foley Skills: Insertion, Removal; Sterile Gloves): You are satisfactory this week demonstrating great skill in your understanding and performance of Foley Skills. You managed to put on your sterile gloves with great ease and success. During the 1:1 Foley Catheter insertion you were very professional, focused, organized and kind to the patient. You did an excellent job creating and maintaining a sterile field throughout the insertion process, you were able to verbalize how far you would insert on both a female and male patient and you required no prompts during the skill of insertion. Great job! During the removal of the catheter you did not miss a single step! You also verbalized the correct method for performing peri-care! It is very apparent you were prepared for this lab! Overall, excellent job! Keep up the good work! □ LW

Week 9 (Dressing Change: Dry Sterile, Sterile Wet to Dry; Documentation Lab): You have satisfactorily demonstrated competency in the skill of wound assessment and care (wet to dry dressing change). You required one prompt related to pouring the sterile saline over the packing prior to placing your sterile gloves. Your communication was great! You provided adequate patient instruction and ensured patient comfort. Nice job! AR

Documentation Lab- You are satisfactory in that you actively participated in a hands-on review of practice documentation related to vital signs, physical assessment, pain assessment, patient rounds, TED hose/ACE wraps/SCDs, feeding, I&Os, urinary catheter management, and nurses notes. AR

Week 10 (Safety; Infection Control; Prioritization; Tube Feeding; Weight; Pressure Ulcer Prevention; Soft Restraints; Doppler BP; Care Plan Development): Satisfactory participation with the following stations: Prioritization, Tube Feeding, Patient Weight, Restraints, Doppler BP, Meditech documentation, and Patient Scenario involving Safety, Infection Control, and Care Plan Development. Keep up the good work! LW

Week 11 (Case Scenarios; Care Plan Development; Medication Lab; Open Lab):

11/1/18 Skills Lab:

Satisfactory participation in the following: Patient Scenario's involving discharge planning and focused assessment, and Care Plan Development. Keep up the good work! LW

10/31/18: Medication Lab:

Satisfactory participation and performance of the following skills in the medication lab: Oral, IM, SQ, and ID medication administration; performance of IM and ID injections on fellow student; performance of SQ injection on practice sponge; use of and drawing medication out of ampule and vial. □ LW

Week 12 (Respiratory Equipment; SAM II; Care Plan Development):

Satisfactory participation with the following: SAM II sounds review, respiratory equipment review, and care plan development. You have satisfactorily completed the lab portion of Nursing Foundations. Great job in the lab this semester!! Keep up the great work!! AR

\* End-of-Program Student Learning Outcomes

**EVALUATION OF CLINICAL PERFORMANCE TOOL  
Nursing Foundations – 2018**

**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 & Date: \_\_\_\_\_Nicole Meier\_\_\_\_\_12/5/18

/scholar\_extra2/e360/apps/v8/releases/1568405689/public/upload/firelands/media/dropbox/63268-FINALTOOLMeierclinicaltool.docx  
MB/DJ/AR/FB//df/6/2018