

**EVALUATION OF CLINICAL PERFORMANCE TOOL
Advanced Medical Surgical Nursing- 2021**

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

Student:

Final Grade: ~~Satisfactory/Unsatisfactory~~

Semester: Spring

Date of Completion:

Faculty: Frances Brennan, MSN, RN; Amy M. Rockwell, MSN, RN
Carmen Patterson, MSN, RN; Brian Seitz, MSN, RN
Brittany Lombardi, MSN, RN

Faculty eSignature:

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. If the final performance code is unsatisfactory or needs improvement 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 or needs improvement 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:

- Clinical Assignments
- Completion of Patient Care
- Meditech Documentation
- Observation of Clinical Performance
- Evaluation of Clinical Performance Tool

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)

Onsite Clinical Debriefing
 Clinical Discussion Rubric
 Preceptor Feedback
 Nursing Care Plan Rubric
 Skills Lab Checklists/Competency Tool
 Lasater Clinical Judgment Rubric
 Virtual Simulation scenarios
 ABCDEF Bundle Grading Rubric
 Pathophysiology Grading Rubric

Initials	Faculty Name		
FB	Frances Brennan, MSN, RN		
CP	Carmen Patterson, MSN, RN		
AR	Amy Rockwell, MSN, RN		
BS	Brian Seitz, MSN, RN		
BL	Brittany Lombardi, MSN, RN		

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 needed 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, and flustered at times, expends excess energy within a delayed time

period, frequent verbal and occasional physical directive cues in addition to supportive cues, faculty feedback required in several areas of clinical written work.

Unsatisfactory (U):

Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded “U.” A “U” in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the “U,” the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA):

The clinical experience which would meet the competency was not available.

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

Objective

1. Engage in the coordination and delivery of nursing care measures to groups of patients and to patients with complex problems. (1,3,4,5,7,8)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Midterm	9	10	11	12	13	14	Make up	Final
Competencies:	S	S	S														
a. Manage complex patient care situations with evidence of preparation and organization. (Responding)	S	S	S														
b. Assess comprehensively as indicated by patient needs and circumstances. (Noticing)	S	S	S														
c. Respect patient and family perspectives, values, and diversity when planning, giving, and adapting care. (Responding)	S	S	S														
d. Evaluate patient's response to nursing interventions. (Reflecting)	S	S	S														
e. Interpret cardiac rhythm; determine rate and measurements. (Interpreting)	S	S	S														
f. Administer medications observing the six rights of medication administration. (Responding)	S	S	S														
g. Perform venipuncture skill with beginning dexterity and evidence of preparation. (Responding)	S	S	S NA														
h. Respond appropriately to equipment alarms; IV pumps, ECG monitors, ventilators, etc. (Responding)	S	S	S														

*End-of- Program Student Learning Outcomes

Faculty Initials	FB	FB	BL														
Clinical Location	4C	4C	4P														

Comments:

Week 2 (1a,d)- Great job providing care to a CHF patient this week, assessments and nursing interventions performed appropriately and in a timely manner for assigned patient. Great job using appropriate technique with blood draw of a triple lumen catheter. (1f)- Medication administration complete observing all rights of medication administration. Great job with administration of a topical medication, and IVP medication. FB

Week 3 (1f)- Great job with medication administration via OG tube, IV push, and IV infusion. You followed all appropriate procedures for each type of administration. FB

Week 4-1(a-f, h) Hannah, you did a great job taking care of your assigned patient this week while managing complex care situations. Your care was organized and you were well prepared for clinical on both days. Your head to toe assessments were thorough and well done. You did a great job monitoring your patient’s blood pressure closely as she was having very high readings requiring the administration of PRN blood pressure medications. You had excellent communication with the patient on both days, and respected her values. You also did a great job responding appropriately to equipment alarms. Your medication passes were very well done on both days, and you were able to administer PO, IM, IVP, and SubQ medications. You also did an excellent job with your EKG book interpreting cardiac rhythms and determining rate and measurements as well. BL

Objective

2. Formulate nursing care plans, correlations, or clinical reports that demonstrate patient-centered care, evidence-based practice, and clinical judgment. (1,2,3,4,5,8)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Midterm	9	10	11	12	13	14	Make up	Final
Competencies:	S	S	S NI														
a. Correlate relationships among disease process, patient’s history, patient symptoms, and present condition utilizing clinical judgment skills. CC (Noticing, Interpreting, Responding)																	
b. Monitor for potential risks and anticipate possible early complications. (Noticing, Interpreting, Responding)	S	S	S NI														
c. Recognize changes in patient status and take appropriate action. (Noticing, Interpreting, Responding)	S	S	S NI														
d. Formulate a prioritized nursing care plan utilizing clinical judgment skills. CC (Noticing, Interpreting, Responding, Reflecting)	NA	NA	S														
e. Incorporate the ABCDEF Standardized Bundle of interventions for assigned patient. CC (Noticing,	NA	S	NA														

*End-of- Program Student Learning Outcomes

Interpreting, Responding)																	
Faculty Initials	FB	FB	BL														

Comments:

Week 2 (2a)- Overall great job with correlating your assigned patient’s diagnosis with symptoms, history, medication, lab results, and diagnostic testing. See further comments in pathophysiology rubric below. FB
 Week 3 (2e)- Good job with completion of ABCDEF bundle. You provided assessments associated tools for each section on day 1 and day 2, but could have provided more detail on your assessment such as heart rate, O2 saturations, and respiratory rate. See details in ABCDEF rubric below. FB

Week 4-2(a,b,c) Hannah, these competencies were changed to an “NI” for this week because you had trouble putting all the pieces together with what was going on with your patient clinically. Your patient’s diagnosis was a NSTEMI, however, your only focus appeared to be on the fact she was brought to the hospital because of a fall. This was identified through conversation on Wednesday when you asked me to review your care plan that you had developed with a nursing diagnosis that was not related to cardiac, but instead mobility. You informed me that your patient did not have any defining characteristics to support a nursing diagnosis that was cardiac based, but we had already discussed specific examples together on Tuesday. Additionally, during debriefing on Wednesday, you were unable to identify any potential risks your patient may have related to her diagnosis and the fact that she had a recent heart catheterization. You stated that your patient was a fall risk, and other than that she was stable with no changes. I provided you guidance at this time asking you to consider the high blood pressures your patient was having intermittently, as well as thinking about the bleeding risk associated with the recent heart catheterization. As a nurse, it is very important that you understand your patients’ diagnoses, symptoms, history, and treatment in order to safely care for them. If you do not have an accurate understanding of all these components, the concern is that you will not be able to accurately prioritize assessments, monitor for potential risks, anticipate possible complications, recognize changes in patient status, and utilize your nursing judgment skills to take appropriate action. With that being said, the reality is that there will be times when you don’t always understand these components initially. However, you must take initiative in utilizing the resources you have to gain the understanding that you need to safely care for the patient. One of the best resources that you have is the patient’s chart and electronic medical record. Thoroughly reading through all the physician’s notes, labs, radiology, medications, etc. Utilizing your skyscape to look up any information that doesn’t make sense. Going forward, please be sure to make this a priority in order to provide the safest care possible to your patient. BL

Week 4-2(d) Overall, your care plan is very nicely done. However, it appears that the evaluation portion was not completed in its entirety. Although you have received enough points to be satisfactory, this will need to be revised with the completed evaluation section so it is a complete care plan. Please see the Care Plan Rubric at the end of this document for my feedback. BL

Objective

3. Plan leadership experiences with a mentor to impact team performance, patient safety, and quality indicators. (1,3,5,7,8)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Midterm	9	10	11	12	13	14	Make up	Final
Competencies:	S	S	S														
a. Critique communication barriers among team members. (Interpreting)																	
b. Participate in QI, core measures, monitoring standards and documentation. (Interpreting & Responding)	NA	NA	S														
c. Discuss strategies to achieve fiscal responsibility in clinical practice. (Responding)	S	S	S														
d. Clarify roles & accountability of team members related to delegation. (Noticing)	S	S	S														
e. Determine the priority patient from assigned patient population.	S	S	S NA														

*End-of- Program Student Learning Outcomes

(Interpreting) (Patient Mngmt.)																	
Faculty Initials	FB	FB	BL														

Comments:

Week 2 (3a)- Good discussion on the effects of communication on a culture of safety in post conference. FB

Week 4-3(c) This week you did an excellent job utilizing the PAR system appropriately to charge out items that you needed to care for your patient. This is just one example of a way to ensure fiscal responsibility in clinical practice. BL

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Objective

4. 4. Plan for a future in the nursing profession by analyzing information concerning employment, licensure, ethical, and legal issues in nursing focusing on accountability and respecting patient autonomy. (1,2,4,5)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Midterm	9	10	11	12	13	14	Make up	Final
Competencies: a. Critique examples of legal or ethical issues observed in the clinical setting. (Interpreting)	S	S	S														
b. Engage with patients and families to make autonomous decisions regarding healthcare. (Responding)	S	S	S														
c. Exhibit professional behavior in appearance, responsibility, integrity and respect. (Responding)	S	S	S NI														
Faculty Initials	FB	FB	BL														

Comments:

Week 2 (4a)- Great job with discussion regarding legal and ethical issues observed in the clinical setting and how these issues can affect patient outcomes. FB

Week 4-4(c) Hannah, this week this competency was changed to an “NI” because there was a lack of responsibility due to not completely researching the patients chart and electronic medical record. BL

Objective

5. Construct methods for self-reflection and critiquing healthcare systems, processes, practices and regulations on a weekly basis. (7,8)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Mid term	9	10	11	12	13	14	Make up	Final
Competencies:	S	S	S														
a. Reflect on your overall performance in the clinical area for the week. (Responding)																	
b. Demonstrate initiative in seeking new learning opportunities. (Responding)	S	S	S NI														
c. Describe factors that create a culture of safety (error reporting, communication, & standardization, etc). (Interpreting)	S	S	S														
d. Perform Standard/Standard Plus Precautions. (Responding)	S	S	S														
e. Practice use of	S	S	S														

*End-of- Program Student Learning Outcomes

standardized EBP tools that support safety and quality. (Responding)																	
f. Utilize faculty feedback to improve clinical performance. (Responding & Reflecting)	S	S	S U														
Faculty Initials	FB	FB	BL														

Comments:

Week 2 (5c,e)- Great job with observation and describing factors that create a culture of safety and how that affects the patient. Good use of EBP while performing care to your assigned patient. FB

Week 3: I am very pleased with the clinical experience I got in the ICU. It is not my jam, but I was able to see and perform a variety of skills in which I have never done in the clinical setting. The nurses and Fran really engaged with us, and gave us many learning opportunities while on the floor.

Hannah, I am glad you had a good experience, ICU is not for everyone but I am sure you will find your place in the nursing profession. FB

Week 4-5(b) This competency has been changed to an “NI” for this week due to inadequate research of your patient’s chart, electronic medical record, and Skyscape in order to learn more about her diagnosis. Additionally, I would like you to work on taking more initiative when it comes to caring for your patient and completing certain tasks. For example, I asked you to obtain your patient’s FSBS on both Tuesday and Wednesday, and instead the PCT did it. Delegation is encouraged when appropriate, however, when you are only assigned to care for one patient on clinical it is expected that you are doing all the care to gain as much experience as possible. On Wednesday, you did complete your patient’s wound dressings independently and you did a great job! Make it a goal to seek out every learning opportunity that is available when you are on clinical. This is what is going to allow you to gain as much as experience as possible. BL

Week 4-5(f) Unfortunately, this competency was changed to a “U” for this week due to inadequate research of your patient’s chart, electronic medical record, and Skyscape after you were asked to do so in order to obtain the information necessary to understand your patient’s diagnosis. Because you did not utilize faculty feedback, you came to clinical on Wednesday with a care plan that was not appropriate for your patient’s admitting diagnosis. This resulted in you becoming frustrated and stressed when you were instructed that it would need to be revised. Additionally, I asked you to identify what your patient’s troponin level was on admission on a couple different occasions, and you were unable to tell me. Please be sure to address this “U” on your tool next week. BL

Objective

6. Engage with members of the healthcare team, patients, families, faculty, and peers through written, verbal and nonverbal methods, and by utilizing computer technology. (1,2,6,7,8)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Midterm	9	10	11	12	13	14	Make up	Final
Competencies: a. Establish collaborative partnerships with patients, families, and coworkers. (Responding)	S	S	S														
b. Teach patients and families based on readiness to learn and discharge learning needs. (Interpreting & Responding)	S	NA S	S														

*End-of- Program Student Learning Outcomes

c. Collaborate with members of the healthcare team, patients, and families to achieve optimal patient outcomes. (Responding)	S	S	S													
d. Deliver effective and concise hand-off reports. (Responding)	NA	NA	NA													
e. Document interventions and medication administration correctly in the electronic medical record. (Responding)	S	S	S NI													
f. Consistently and appropriately posts in clinical discussion groups. (Responding and Reflecting)	S	S	S NI													
Faculty Initials	FB	FB	BL													

Comments:

Week 2 (6e)- Great job with documentation of nursing interventions within meditech. Documentation was accurate and in a timely manner. (6f)-CDG was on time meeting all requirements per the grading rubric. FB

Week 3 (6a,b,c)- Although your patient’s status limited your ability to perform teaching, you identified in discussion and through ABCDEF bundle documentation the education needs for discharge of your assigned patient. Therefore, this competency was changed to a “S”. You discussed the ways collaboration with family, patients, and other healthcare team members is optimal for positive patient outcomes. FB

Week 4-6(e) This competency has been changed to an “NI” for this week because you needed to be reminded several times on both Tuesday and Wednesday to complete documentation for certain interventions (Pain Assessment, Feeding Method, IV Assessment). While reviewing documentation, I was finding that you were omitting charting on some of the interventions if the nurse already completed it before you. Even if the nurse has already documented on the interventions for a certain time, you are still required to document too. You are acting as the nurse while in clinical, and it’s important that you are getting as much experience with documenting as possible. You all received a “Meditech Intervention List” handout in your clinical folder with a list of all the

interventions you are expected to document while on clinical. Please be sure to have that with you going forward so you are aware of everything that needs to be documented. With that being said, your documentation was done very nicely and accurately, and you did do a great job taking my feedback related to your documentation and fixing it when asked. BL

Week 4-6(f) Hannah, unfortunately I had to change this competency to an “NI” for this week because you did not complete the evaluation portion of your care plan in its entirety. Please revise your care plan with the completed evaluation portion by 2/11/21 at 0800. If you have any questions, please do not hesitate to ask. BL

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Objective

7. Devise methods utilized by nursing to develop the profession, advance the knowledge base, ensure accountability, and improve the outcomes of care delivery.
(1,3,4,6,7,8)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Midterm	9	10	11	12	13	14	Make up	Final
Competencies: a. Value the need for continuous improvement in clinical practice based on evidence. (Responding)	S	S	S														
b. Accountable for investigating evidence-based practice to improve patient outcomes. (Responding)	S	S	S														

*End-of- Program Student Learning Outcomes

c. Comply with the FRMCSN “Student Code of Conduct Policy.” (Responding)	S	S	S													
e. Incorporate the core values of caring, diversity, excellence, integrity, and “ACE”-attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S	S	S U													
Faculty Initials	FB	FB	BL													

Comments:

Week 3 (7a)- Good job with the implementation of the evidence-based bundle to improve patient outcomes for a ventilated patient. FB

Week 4-7(e) This competency was changed to a “U” as it relates to attitude and enthusiasm. Unfortunately, on Wednesday you displayed a negative attitude towards myself when I was offering you feedback on your care plan that you presented me to review and assist you with. You became very frustrated and short with me. I asked you to come with me to the kitchenette area so I could assist you with doing some research on Skyscape, and your overall demeanor appeared very annoyed and bothered. Although you may not have been trying to come off this way, be mindful of your non-verbal communication because it can unintentionally speak differently. As your clinical instructor, it is my job to educate and guide you in order for you to become a safe and competent nurse. I want nothing more than for you to be successful, and that is why I offer the feedback that I do. Hannah, you are always very kind, compassionate, and caring in the presence of all your patients. You have all the qualities it takes to be a great RN, and I know you will be! I’ve enjoyed watching you grow over the past two years. Please take all the feedback that I have offered you this week and set some goals for the weeks to come. I know you can do it! Remember to address this “U” on your tool for next week. BL

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

*End-of- Program Student Learning Outcomes

Skills Lab Evaluation Tool
AMS
2021

Skills Lab Competency Evaluation	Lab Skills									
	Critical Care Meditech Document (1,2,3,4,5,6)*	Physician Orders (1,2,3,4,5,6)*	Prioritization/Delegation (1,2,3,4,5,6)*	Resuscitation (1,3,6,7)*	IV Start (1,3,4,6)*	Blood Admin/IV Pumps (1,2,3,4,5,6)*	Central Line/Blood Draw/Ports/IV Push (1,2,3,4,6)*	Head to Toe Assessment (1,2,6)*	ECG/Telemetry Placement s/CT (1,6)*	ECG Measurements (1.2,4.5,6)*
	Date: 1/5/2021	Date: 1/5/2021	Date: 1/5/2021	Date: 1/5/2021	Date: 1/7/2021	Date: 1/7/2021	Date: 1/8/2021	Date: 1/8/2021	Date: 1/8/2021	Date: 1/8/2021
Performance Codes: S: Satisfactory U: Unsatisfactory										
Evaluation:	S	S	S	S	S	S	S	S	S	S
Faculty Initials	FB	FB	FB	FB	FB	FB	FB	FB	FB	FB
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

***Course Objectives**

Comments:

Meditech Documentation: Satisfactory participation of assessment documentation including physical re-assessment, safety and fall assessment, RN mechanical ventilator assessment, IV location assessment, and documentation editing. Great job! FB

Physician Orders: Satisfactory completion of physician's order lab utilizing SBAR communication and taking orders over the phone. Good job! BL/BS

Prioritization/Delegation: You have successfully completed the prioritization and delegation skills lab. You satisfactorily prioritized care for multiple patients using multiple methods (e.g. Maslow's hierarchy of needs, ABC, and ABCD methods). You were able to appropriately delegate nursing tasks for your assigned patients. You actively participated in the group discussion on delegation of nursing tasks and your team shared several important factors to consider when delegating, including scope of practice and skill level of the delegate,

nursing laws, facility policy, and condition of the patient. Great job! CP

Resuscitation: Satisfactory participation in the practice of Hands-Only CPR, discussion regarding use of and ventilation with bag- valve mask/Ambu bag, and review of crash cart and Code Blue team duties and documentation. AR

IV Start: Satisfactory participation in the IV Start lab, including practice with technique, initiation and discontinuation of IV site, and placement of IV dressing. AR/BS/CP/BL

Blood Admin/IV Pumps: Satisfactory completion of practice with blood administration safety checks activity. Great job with IV pump practice, the use of the medication library, and pump set up of primary and secondary IV medication infusion. FB

Central Line Dressing Change/IV Push: Satisfactory central line dressing change using proper technique, as well as line flushing. Great job with preparation of mixing a medication with normal saline and administering as an IV push through the central line. FB

Ports/Blood Draw: You were satisfactory in accessing an Infusaport device, demonstrated proper technique for CVAD cap change and satisfactorily demonstrated how to draw blood from a CVAD per hospital policy. Nice work! CP

Head to Toe Assessment: You are satisfactory for the head-to-toe assessment competency. Nice Job! BL/BS

ECG/Telemetry Placements/CT: Satisfactory participation with review of monitoring tutorial and placement of ECG/Telemetry patches and leads; satisfactory participation in review of Chest Tube/Atrium tutorial. BL/BS

ECG Measurements: Satisfactory participation in and practice of ECG measurements during the ECG Measurements Lab. You accurately measured and interpreted a 6-second rhythm strip for Normal Sinus Rhythm. Great job! AR

Nursing Care Plan Grading Tool
AMSN
2021

Student Name: **Hannah Schoen**

Clinical Date: **1/26/21-1/27/21**

<p>Objective # 2: Formulate nursing care plans, correlations, or clinical reports that demonstrate patient-centered care, evidence-based practice, and clinical judgment. (1,2,3,4,5,8)* Specific to course</p>	<p>Nursing Diagnosis: Decreased Cardiac Tissue Perfusion R/T Poor Diet</p>
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<p>**Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating</p>	<p>Total Points Comments</p>
<p>Nursing Diagnosis: (3 points) Problem Statement (1)-1 Etiology (1)-1 Defining Characteristics (1)-1</p>	<p>Total Points: 3 Comments: Great job! Nursing diagnosis is appropriate for your assigned patient, and all defining characteristics are specific. BL</p>
<p>Goal and Outcome (6 points total) Goal Statement (1 point)-1 Outcome: Specific (1)-1 Measurable (1)-1 Attainable (1)-1 Realistic (1)-1 Time Frame (1)-1</p>	<p>Total Points: 6 Comments: Great job! Your goal statement is written correctly, and your outcome statements are all SMART! BL</p>
<p>Nursing Interventions: (8 points total) Prioritized (1)-1 What (1)-1 How Often (1)-1 When (1)-1 Individualized (1)-1 Realistic (1)-1 Rationale (1)-0.5 All pertinent interventions listed (1)-1</p>	<p>Total Points: 7.5 Comments: Overall, very nice job with your nursing interventions. All pertinent nursing interventions were included and prioritized appropriately. Some of your rationales could have used a little more detail. BL</p>
<p>Evaluation: (5 points total) Date (1)-1 Goal Met/partially/unmet (1)-0 Defining characteristics (1)-0 Plan to continue/terminate/modify (1)-1 Signature (1)-1</p>	<p>Total Points: 3 Comments: It appears as if your evaluation section was not completed in its entirety. There were no defining characteristics present, therefore, it is not appropriate to state "Goals partially met" when there is no evidence to support this. BL</p>
<p>Total possible points = 22 18-22 = Satisfactory care plan 14-17 = Needs improvement care plan <13 = Unsatisfactory care plan</p>	<p>Total Points for entire Care plan = 19.5/22 Comments: Although you have received enough points to be satisfactory, this will need to be revised with the completed evaluation section so it is a complete care plan. Please make these revisions by 2/11/21 at 0800. Faculty/TA initials __BL__</p>

Firelands Regional Medical Center School of Nursing
Advanced Medical Surgical Nursing 2021
Simulation Evaluations

<u>vSim Evaluation</u>	Rachael Heidebrink (Pharmacology) (1, 2, 6, 7)*	Junetta Cooper (Pharmacology) (1, 2, 6, 7)*	Mary Richards (Pharmacology) (1, 2, 6, 7)*	Lloyd Bennett (Medical-Surgical) (1, 2, 6, 7)*	Kenneth Bronson (Medical-Surgical) (1, 2, 6, 7)*	Carl Shapiro (Pharmacology) (1, 2, 6, 7)*
	Date: 2/9/2021	Date: 2/26/2021	Date: 3/12/2021	Date: 3/19/2021	Date: 3/25/2021	Date: 4/22/2021
Evaluation						
Faculty Initials						
Remediation: Date/Evaluation/Initials						

* Course Objectives

*End-of- Program Student Learning Outcomes

ABCDEF Bundle Grading Rubric
 Firelands Regional Medical Center School of Nursing
 Advanced Medical Surgical Nursing
 2021

Student Name:

Clinical Date:

<p>1. (A) Assess Prevent and Manage Pain (5 points total)</p> <ul style="list-style-type: none"> • Results of subjective and objective comprehensive pain assessment are explained including the clinical tool results and validation of pain (1) • Comparison results/trending (1) (0) • Explanation of what the patient is receiving for pain management, and whether or not it is working (1) • Non-pharmacological interventions discussed for pain management (1) • Underlying cause/reason/diagnosis for patient’s pain is discussed (1) 	<p>Total Points: 5 Comments: Great use of pain tools with explanation provided. The comparison trending was lacking such as trending vital signs or previous pain documentation.</p>
<p>2. (B) Both Spontaneous Awakening Trials and Spontaneous Breathing Trials (7 points total)</p> <ul style="list-style-type: none"> • Patient’s subjective and objective comprehensive respiratory assessment explained (1) (0.5) 	<p>Total Points: 6 Comments: Great job with providing a patient history and discussion of spontaneous awakening and breathing trials. All subjective</p>

<ul style="list-style-type: none"> • Background history provided on patient’s respiratory status (1) • Explanation provided of patient’s cardiac status (1) (0.5) • Safety screening assessments for SAT and SBT discussed (1) • Spontaneous Awakening Trials and Breathing Trials tried on patient discussed (1) • Explanation of sedation medication titrations based on results (1) • All diagnostic pulmonary results discussed (1) 	<p>and objective data was not provided such as patient respiratory rate, and O2 saturations. You also did not provide details of cardiac status such as heart rate and heart sounds.</p>
<p>3. (C) Choice of Analgesia and Sedation (6 points total)</p> <ul style="list-style-type: none"> • Comprehensive neurological assessment completed and results discussed (1) (0.5) • RASS results discussed (1) • Medications patient is receiving for anxiety, agitation, and sedation discussed. Medications that may cause anxiety, agitation, and sedation discussed (2) • Other reasons for patient’s change in mentation status or sedation identified and explained (1) • Trending/changes in patient’s status since admission to unit reviewed and discussed (1) 	<p>Total Points: 5.5 Comments: The neurological assessment did not include patient ability to comprehend indicated by the ability of the patient to answer yes/no questions. All other areas were included in neurological assessment.</p>
<p>4. (D) Delirium: Assess, Prevent, and Manage (6 points total)</p> <ul style="list-style-type: none"> • Delirium assessment completed on patient (RASS and CAM-ICU tools) and results discussed (2) • Patient’s assessment since admission trended/reviewed and changes discussed (1) • Medications and conditions that place the patient at risk for delirium are identified and explained (2) (0) • Family’s feelings and observations about patient’s confusion, mentation, and agitation discussed now and prior to admission (1) 	<p>Total Points: 4 Comments: Good discussion related to delirium tools and results provided. No discussion related to medications the patient was receiving was presented.</p>

<p>5. (E) Early Mobility and Exercise (6 points total)</p> <ul style="list-style-type: none"> • Patient’s strength and mobility assessed and discussed (1) • Patient’s cardiac status explained (1) • Exercise Safety Screening results discussed. What mobility/exercise was the patient able to complete and how did they tolerate it? (2) • Explanation of interdisciplinary team and family involvement in patient’s mobility and exercise (1) • Problems/diagnoses/results hindering patient’s mobility and exercise identified and explained (1) 	<p>Total Points: 6 Comments: Strength and current mobility discussed. Safety screen results presented.</p>
<p>6. (F) Family Engagement and Empowerment (6 points total)</p> <ul style="list-style-type: none"> • Family/significant others concerns, wishes, participation, and involvement in patient’s care identified and discussed (2) • Rapport and communication between patient, family, and health care providers discussed (2) • Long term care needs, educational needs, emotional support, discharge needs, and community resources needed for patient/family identified and discussed (2) 	<p>Total Points: 6 Comments: Family communication provided.</p>
<p>Total possible points = 36 32-36 = Satisfactory 27-31 = Needs improvement <27 = Unsatisfactory</p>	<p>Total= 32.5 Satisfactory completion of ABCDEF bundle. FB</p>

Pathophysiology Grading Rubric
Firelands Regional Medical Center School of Nursing
Advanced Medical Surgical Nursing
2021

*End-of- Program Student Learning Outcomes

Student Name: **Hannah Schoen**

Clinical Date: **1/12-13-2021**

<p>1. Provide a description of your patient including current diagnosis and past medical history. (2 points total)</p> <ul style="list-style-type: none">• Current Diagnosis (1)• Past Medical History (1)	<p>Total Points: 2 Comments:</p>
<p>2. Describe the pathophysiology of your patient's current diagnosis. (1 point total)</p> <ul style="list-style-type: none">• Pathophysiology-what is happening in the body at the cellular level (1)	<p>Total Points: 1 Comments:</p>
<p>3. Correlate the patient's current diagnosis with presenting signs and symptoms. (3 points total)</p> <ul style="list-style-type: none">• All patient's signs and symptoms included (1)• Explanation of what signs and symptoms are typically expected with this current diagnosis (Do these differ from what your patient presented with?) (1)• Explanation of how all patient's signs and symptoms correlate with current diagnosis. (1)	<p>Total Points: 2 Comments: The decrease in O2 saturations, abnormal ABG's, and high BNP lab should be included for signs of CHF. You also did not mention what you would expect to see as far as signs and symptoms of CHF.</p>
<p>4. Correlate the patient's current diagnosis with all related labs. (4 points total)</p> <ul style="list-style-type: none">• All patient's relevant lab result values included (1)• Rationale provided for each lab test performed (1)• Explanation provided of what a normal lab result should be in the absence of current diagnosis (1)• Explanation of how each of the patient's relevant lab result values correlate with current diagnosis (1)	<p>Total Points: 3 Comments: Great job correlating all related lab data to diagnosis. The BNP is a blood test that measures protein levels known as brain natriuretic peptide (BNP). These levels when reported as high indicate heart failure.</p>

<p>5. Correlate the patient’s current diagnosis with all related diagnostic tests. (4 points total)</p> <ul style="list-style-type: none"> • All patient’s relevant diagnostic tests and results included (1) • Rationale provided for each diagnostic test performed (1) • Explanation provided of what a normal diagnostic test result would be in the absence of current diagnosis (1) • Explanation of how each of the patient’s relevant diagnostic test results correlate with current diagnosis (1) 	<p>Total Points: 4 Comments: Great job correlating all diagnostic testing with patient’s current diagnosis.</p>
<p>6. Correlate the patient’s current diagnosis with all related medications. (3 points total)</p> <ul style="list-style-type: none"> • All related medications included (1) • Rationale provided for the use of each medication (1) • Explanation of how each of the patient’s relevant medications correlate with current diagnosis (1) 	<p>Total Points: 3 Comments: All pertinent medications related to patient’s diagnosis were provided with rationale and appropriate explanation.</p>
<p>7. Correlate the patient’s current diagnosis with all pertinent past medical history. (2 points total)</p> <ul style="list-style-type: none"> • All pertinent past medical history included (1) • Explanation of how patient’s pertinent past medical history correlates with current diagnosis (1) 	<p>Total Points: 2 Comments: Great job correlating all medical history to present diagnosis</p>
<p>8. Describe nursing interventions related to current diagnosis. (1 point total)</p> <ul style="list-style-type: none"> • All nursing interventions provided for patient explained and rationales provided (1) 	<p>Total Points: 0.5 Comments: Good job with nursing interventions, should also include administration of medications assisting with excretion of excess fluid, and mobility to assist with fluid movement and increase in respiratory status.</p>

Total possible points = 20 17-20 = Satisfactory 14-16 = Needs improvement <13 = Unsatisfactory	Total points: 17.5 Satisfactory completion of pathophysiology report. FB
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**EVALUATION OF CLINICAL PERFORMANCE TOOL
Advanced Medical Surgical Nursing- 2021**

**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:

ar 12/28/2020