LOS ANGELES HARBOR COLLEGE
WEEKLY CLINICAL EVALUATION for NURSING 339
Long Term Care

Student:	Clinical Instructor:	Agencies:	Date:

Evaluation Criteria

- **Satisfactory**: Clinical performance demonstrates continued growth towards course competencies. Behaviors are consistent, safe, and performed at expected learner level described in the student competency behavior descriptors for satisfactory performance.
- **Needs Improvement:** Behaviors manifested have potential for causing harm. Student requires excessive prompting and direction to perform safely and at expected learner level.
- **Unsatisfactory:** Behaviors performed are unsafe. Omits student behaviors required to achieve course competencies. Student behaviors lack knowledge base and skill competencies expected (see unsatisfactory behavior descriptors).

(*)-Represents Critical Competency Behaviors:
Competency Behaviors must be met in order to pass the clinical component of this course. "Unsatisfactory" daily ratings will be given for the following behaviors:

- An "Unsatisfactory" rating in any critical behavior (delineated by an "*").

- Three or more "Needs Improvement" ratings in any area on one day of clinic or 1 "Unsatisfactory" rating in a non-critical behavior and 1 "Needs Improvement" in 1 clinic day

The Student must demonstrate a "Satisfactory" level of **performance for 75% of the clinical rotation** in order to pass the course. One "Unsatisfactory" clinical week will result in a clinic failure.

COMPETENCIES/PERFORMANCE CRITERIA

I. APPLY THE NURSING PROCESS USING THE ROY ADAPTATION MODEL IN CARING FOR INDIVIDUALS AND GROUPS ACROSS THE LIFESPAN AND IN VARIOUS DEVELOPMENTAL STAGES.

1. Collects comprehensive assessment data that includes the geriatric patient's values, preferences, expressed needs, and developmental, emotional, cultural, religious, and spiritual influences.
2. Creates a nursing history and assessment on a geriatric patient that categorize ineffective behaviors that affect adaptation in the four modes: physiological, self-concept, role function, and interdependence. *
3. Identifies stimuli based on ineffective behaviors identified in the first level assessment.
4. Analyzes assessment data to propose nursing diagnoses and formulates expected outcomes based on patient values, preferences, and expressed needs.
5. Develops a plan of care that prescribes strategies and alternatives to achieve expected outcomes coordinating with the patient and interprofessional team as needed.
6. Implement identified plan for the geriatric patient. *
7. Evaluate progress toward attainment of outcomes and modify plan of care as needed. *

WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				

LOS ANGELES HARBOR COLLEGE
WEEKLY CLINICAL EVALUATION for NURSING 339
Long Term Care

II. PRACTICE PROFESSIONAL BEHAVIORS

1. Constructs one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving identity as a nurse committed to evidence-based practice, caring, advocacy, and safe, quality care for diverse geriatric patients within a family and community context.
2. Integrates the Code of Ethics, Standards of Practice, and policies and procedures of Los Angeles Harbor College, the nursing program, and the clinical agencies into practice.
3. Codifies appropriate behaviors, e.g. prompt and timely arrival to class and clinic; adherence to uniform standards; attendance, honesty; and attitude.
4. Accepts accountability and responsibility for own actions. *
5. Advocates for geriatric patients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings.
6. Evaluates own performance correctly and thoughtfully on WCET form.

WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				

III. DEMONSTRATE CLINICAL DECISION MAKING THAT IS ACCURATE AND SAFE.

1. Analyze and demonstrate critical thinking in making clinical decisions, e.g. information regarding medical history, assessment, diagnostic tests, laboratory values, and medications to develop an individualized plan of care for the geriatric patient.
2. Differentiate stimuli of effective and ineffective behaviors.
3. Categorize and document all relevant information and use appropriate geriatric resources and reasoning for clinical decision-making.

WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				

IV. PROVIDE SAFE, PATIENT-CENTERED CARE.

1. Demonstrate understanding of the pathophysiology and pharmacotherapy for geriatric-related conditions.
2. Examine learning needs, develop teaching plans, implement teaching and evaluate effectiveness.
3. Respect and encourage individual expression of geriatric patient values, preferences, and expressed needs.
4. Provide geriatric patient-centered care with sensitivity and respect for developmental stage, values, customs, religion, ethnicity, and culture.
5. Assess for pain and implement interventions for treatment in light of geriatric patient values, preferences, and expressed needs.
6. Performs nursing skills competently and safely according to college or agency policy, e.g. follow rights of medication administration.
7. Adheres to current National Patient Safety Guidelines.
8. Demonstrates strategies to prevent and reduce harm.

WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				

V. FUNCTION EFFECTIVELY WITHIN NURSING AND INTER-PROFESSIONAL TEAMS UTILIZING EFFECTIVE COMMUNICAITON STRATEGIES.

1. Function competently within scope of practice as a member of the health care team and describe the scopes of practice and roles of health care team members (e.g. geriatrician, geriatric nurse practitioner, nurse manager, clinical social worker, recreation therapist, music therapist, spiritual practitioner, unit secretary, and so forth).
2. Utilize therapeutic communication techniques with interdisciplinary team members to assist geriatric patient, family, and significant others to cope with alterations of health and achieve goals.
3. Follow communication practices that minimize risks associated with handoffs among providers across transitions of care (ISBARR).
4. Reports ineffective behaviors, accurate, pertinent information, and geriatric patient concerns in a timely manner to staff and/or instructor. *

WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				

INCORPORATE EVIDENCE-BASED PRACTICES, WHICH SUPPORT CLINICAL REASONING.				
Analyze evidence-based practice to include the components of research evidence, clinical expertise, and geriatric patient/family values. Compare and contrast efficient and effective search strategies to locate reliable sources of evidence that will provide the ability to make judgments in practice, substantiated with evidence, that integrate nursing science in the provision of safe, quality care and promote health of patients within a family and community context. Systematize the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and other new insights to improve the quality of care for geriatric patients, families, and communities.				
WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				
IDENTIFY AREAS FOR IMPROVEMENT IN QUALITY AND SAFETY OF HEALTH CARE SYSTEMS.				
Analyze a variety of sources of information to review outcomes of care and identify potential areas for improvement. Differentiate nursing and other health professions as parts of systems of care that affect outcomes for geriatric patients, families, and communities. Completes care safely, cost effectively, organized and timely to improve the quality of care. Integrates measurable outcomes on care plans to evaluate care.				
WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				
VIII. UTILIZE TECHNOLOGY TO RESEARCH PATIENT INFORMATION, COMMUNICATE WITH INTERPROFESSIONAL TEAMS, MANAGE KNOWLEDGE, MITIGATE ERROR, AND SUPPORT DECISION-MAKING.				
Demonstrate successful navigation and documentation within the electronic health record in the clinical setting. Examine appropriate resources, collected electronically or other means to communicate with the inter-professional teams and solve geriatric problems. Maintains geriatric patient confidentiality and security of all health records.				
WEEK/DATE	1		2	
Evaluator	Student	Instructor	Student	Instructor
Satisfactory				
Needs Improvement				
Unsatisfactory				
N/A				

WEEKLY CLINICAL EVALUATION for NURSING 339
Long Term Care

STUDENT:	SEMESTER:

Student comments week 1:

Student comments week 2:

Instructor comments week 1

Instructor comments week 2:

Week/Date Week 1 Date:	**Unsatisfactory** (Instructor initials)	**Satisfactory** (Instructor initials)	**FINAL CLINIC GRADE FOR Skilled Nursing** **SATISFACTORY _____**
Week 2 Date:			**UNSATISFACTORY _____**

Care Plan #1 Score _____/30	*Care Plan #2 Score _____/30*

Student's Signature:	*Date:*

Instructor's Signature:	*Date:*

Competency	Satisfactory (Moving toward independent level. Performing as expected for this level)	Unsatisfactory (Dependent level, significant concerns for safety)
I. **APPLY THE NURSING PROCESS USING THE ROY ADAPTATION MODEL IN CARING FOR INDIVIDUALS AND GROUPS ACROSS THE LIFESPAN AND DEVELOPMENTAL STAGES.**	Utilizing appropriate guidelines, resources, & assessment techniques, demonstrates steps of the nursing process. Identifies adaptive & ineffective behaviors in all four modes. Includes subjective & objective data. Identifies stimuli for ineffective behaviors, includes patient values, preferences, expressed-needs, growth & developmental stage, culture, spiritual, adaption levels, & economic factors, as they relate to the patient. Differentiates pathophysiological and biological changes of aging. H&A forms contain 95% of pertinent data (e.g. lab, diagnostic tests, mode assessment data, BMI, general assessment - < 2 areas needing minor corrections or additions). Identifies $\geq$ 2 prime Nursing diagnoses (ND). Identifies $\geq$ 3 pertinent manipulatable stimuli for each ND. Care plans reflect priority nursing diagnosis. Goal stated are appropriate for patient. Has $\geq$ 3 outcomes measurable & with realistic critical times. Identifies 90% of therapeutic nursing interventions (NI) related to stated outcomes. Gives rationale for each NI. Evaluates progress towards outcomes & revises NI PRN. Receives $\geq$ 75% of points awarded on each CP. Completes a nursing assessment with no more than 2 areas needing minor additions/corrections. All major ineffective behaviors are highlighted on H & A. Documentation reflects assessment findings. All ineffective behaviors, significant events and variances have focus notes with appropriate data, action, and response.	Does not utilize appropriate guidelines or resources. Submits work late. Does not utilize appropriate assessment techniques. History and Assessment contains less than 75% of pertinent data. Does not relate patient values, preferences, expressed-needs, growth & developmental stage, culture, spiritual, adaption levels, & economic factors when indicated. Inaccurate data obtained. Failure to identify all significant related subjective and objective data for selected nursing diagnosis. Fails to demonstrate understanding of the link between stimuli and supporting behaviors. Cannot verbalize stimuli for patient behaviors with major cues. Care plan not individualized. Fails to demonstrate the ability to prioritize nursing diagnoses. Outcomes are not measurable or lack of realistic critical time for 3 or more outcomes. Nursing interventions do not have related rationales. Missing 3 or more key interventions on plan of care. Does not evaluate outcomes or revise nursing interventions as indicated. Score < 75% on care plan. Fails to perform necessary interventions to promote positive outcomes for patients. Care plan not individualized to patient.

II. DISPLAY PROFESSIONAL BEHAVIOR FOR NURSING PRACTICE.	Notifies instructor and unit of any absences or tardiness before start of duty. Presents to the clinical setting in a punctual manner, dressed appropriately, with name badge, and all prep/paperwork completed. Worksheet updated and complete by 0730. Is familiar with and brings clinic guide to clinic. Participates in clinical conference. Completes all work in a timely manner and presents to pre and post conference on time. Researches and adheres to agency guidelines and school policies. Conducts self in an honest and ethical manner within the legal limits and scope of practice of a student nurse. Treats staff, patients, instructors, and peers respectfully and with dignity. Engages in self-reflection to accurately identify performance areas for personal and professional growth. Takes responsibility for behaviors and outcomes of actions. Assigns self to a variety of patients to enhance and hone skills. Works within the scope of student nurse.	Any tardiness or absence without notification of instructor or unit. Prep/paperwork not complete. Worksheet not updated by 0900. Clinic guide not brought to clinic or is unfamiliar with content. Does not comply with instructor's request/instructions. Does not correct behaviors after being discussed by instructor. Is dishonest, disrespectful or argumentative with patient, staff, or instructor. Completion of patient care necessitates that the student is late for post conference or works past the shift. Leaves unit without reporting to primary nurse or instructor. Assignments submitted > 1 day late, or < 2 weekly assignments submitted late. Consistent use of unapproved abbreviations. Non-compliance with the college dress code. Fails to identify personal responsibility in less than desirable clinical outcomes. Works outside the scope of student nurse.
III. DEMONSTRATE CLINICAL DECISION MAKING THAT IS ACCURATE AND SAFE.	Clinical preps and care plans are supported by evidence-based nursing theory. Utilizes agency care maps, critical pathways as guides to patient care. Able to Identifies priorities in clinical care. Recognizes pertinent laboratory values, ineffective physiological responses, and abnormal diagnostic tests. Provides nursing interventions to promote positive health outcomes.	Does not prioritize care given. Does not ask questions when unsure of patient status or appropriate interventions. Unable to present patient case study in clinical conference with pertinent data nor propose nursing diagnoses. Does not know results of pertinent diagnostic tests or laboratory values. Does not recognize or report adverse medication side effects.

| IV. PROVIDES SAFE, PATIENT-CENTERED CARE. | Recognizes physiologic and psychosocial responses and needs. Provides interventions and support to meet those identified needs. Can articulate etiology for patient behaviors. Identifies and complies with National Patient Safety Goals for Long Term Care. Two or less minor cues from instructor during all previously learned procedures. Recognizes and corrects break in sterile technique. Follows agency policy in assessing and documenting use of restraints. Monitors and documents I&O, vital signs, NFT/drainage tubes and suctioning. Immediately reports and patient behavior that is critical or unsafe to the charge nurse or clinical supervisor. Seeks assistance or mentorship when needed. Able to relate knowledge of the mechanism of action, indication, dosage range, therapeutic effect, laboratory values, side effects and nursing actions related to all medications. Notifies instructor before performance of any medication administration or procedures. Asks for assistance when unsure. Follows the 8 rights of medication administration. Follows facility policy for unit codes, fall precautions and hand washing/universal precautions. Assesses developmental stage, values, customs, religion, ethnicity and culture in all care given. | Fails to adhere to National Patient Safety Goals for Long Term Care. Cannot answer instructor's questions regarding significant patient information, medication and plan of care. Needs major prompt or instructor intervening to safely perform interventions. Does not ask questions when unsure of patient status or appropriate interventions. Does not prioritize care given. Has not researched pathophysiology of patient behaviors before care given. Does not know results of diagnostic reports/relevant laboratory results. Does not follow standard precautions or facility policies concerning patient safety (fall precautions, hand washing, universal precautions). Does not recognize or report significant change in patient condition. Administers medication or performs procedures without instructor notification. Does not notify instructor of errors. Violates one or more of the 8 rights of medication administration. No use of patient identifier when providing care. Does not perform nursing interventions. Unaware of break in sterile technique. Commit actions that cause or have the potential to cause significant harm to a patient. |

V. FUNCTION EFFECTIVELY WITHIN NURSING AND INTERPROFESSIONAL TEAMS UTILIZING EFFECTIVE COMMUNICAITON STRATEGIES.	Able to relate knowledge of the different roles of the members of the health care team and communicate with appropriate member to meet patient needs. Completes process recordings with less than 2 errors per recording. Consistently recognizes blocking techniques and provides therapeutic alternates each occurrence. Demonstrates a non-judgmental acceptance of views differing from own. Assess and reports clinical condition as needed consistently throughout shift. Able to demonstrate SBAR communication in association with patient handoffs. Documents objective facts in accordance with agency policies using approved abbreviations and DAR/AIE/ or SOAPE format. Checks with instructor when unsure of documentation. Utilizes interpreter as needed to impart information to patient and family. Participates in pre and post clinical conference including discussion of case studies. Introduces self and works with ancillary staff and follows up on care provided.	Does not utilize communication channels with members of the healthcare team as indicated by patient needs. Consistently unable to identify therapeutic or blocking techniques on the process recording form as evidenced by greater than 4 mistakes per assignment beyond week 3. Displays a judgmental attitude toward patients or other members of the health care team. Makes judgmental or inappropriate comments. Does not assess or report detrimental change in condition to instructor or assigned nurse. Unable to relate pertinent information in SBAR format. Unable to document according to hospital required format. Gives or documents inaccurate information to instructor, staff, patient or family. Does not utilize or recognize need to utilize interpreter for communication. Does coordinate care with aid or ancillary staff. Does not participate in clinical conference with prompts from instructor.
VI. INCORPORATE EVIDENCE-BASED PRACTICES TO SUPPORT CLINICAL REASONING.	Demonstrates ability to research appropriate evidence-base practices through accurate completion of prep/pathophysiology care sheet assignments with omission of less than two main areas of importance. Able to verbalize and incorporate reliable evidence-based data when planning and providing patient care. Utilizes agency care maps, critical pathways, core measures, and bundles as guides to patient care.	Cannot locate resources for obtaining evidence-based data to provide for patient care. Missing greater than 3 areas of evidence-based data that drive appropriate clinical reasoning for care given to patients on the pathophysiology sheet. Cannot describe evidence-based guidelines for care given in the clinical setting.

VII. IDENTIFY AREAS FOR IMPROVEMENT IN QUALITY AND SAFETY OF HEALTHCARE SYSTEMS.	Able to identify individual measures that move the system to improved quality and safety. Addresses personal biases and stereotypes in clinical conference. Utilizes quality and safety measures in place at the clinical agency. Weekly comments/journal entries reflect self-evaluation and clinical behaviors with a plan for improvement.	Unable to verbalize or demonstrate system based thinking. Cannot verbalize potential quality or safety issues in the clinical setting. Does not recognize personal biases or stigma in the mentally ill population. Does not follow protocols of safety and quality at the clinical agency. Does not correctly evaluate self for second week during clinical rotation. Does not reflect upon how to correct or improve upon major weaknesses.
VIII. UTILIZE TECHNOLOGY TO RESEARCH PATIENT INFORMATION AND COMMUNICATE WITH INTERPROFESSIONAL TEAMS, MANAGE KNOWLEDGE, MITIGATE ERROR, AND SUPPORT DECISION MAKING.	Completes all hospital-required training for access to electronic medical records (EMR). Maintains integrity of personal passwords. Demonstrates the ability to navigate and document in the EMR per agency protocol. Able to utilize EMR based resources to promote communication, manage knowledge, mitigate error and support decision-making. Strictly maintains patient confidentiality and reports any breach observed.	Unable to navigate or document within the EMR after the second week without major prompting from clinical instructor. Shares personal passwords to electronic medical record system with others. Unaware of mechanisms within the EMR that promote communication, manage knowledge, mitigate error and support decision-making. Breach of patient confidentiality in oral, written or social media form.