**Student Exemplar:**

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| **Noticing** | **Interpreting** | **Responding** | **Reflecting** |
| What happened? | What does this mean to you as a nurse?Listen to every concern the patient has, regardless of seriousness it may help lead to a proper diagnosis and treatment. | What can nurses do?Nurses could improve their communication strategies to help patients’ well-being overall. Better documentation is needed as well to help patient road to recovery. Advocate for patient.  | How would the nurse know the issue/problem is improving?Better communication and patient satisfaction. Interoperability.Positive patient outcomes. |
| Lack of communication, doctors were not able to communicate with one another.  | What does this mean to the patient?Patient has to go through a rough pathway consisting of suffering and pain. Also made patient feel worse since she trusted the physicians to care for her but was let down. | What can health care teams do? Communicate better.What can other organizations/government do?Organizations could create ways to improve staff communication. Policy regarding interoperability  | How would the nurse know the issue/problem is NOT improving?Poor communication. Systems do not talk to each other. poor patient outcomes. Poor patient satisfaction. |
| The patients’ concerns were not heard.  | What does this mean to the family?The family has to experience mourning and accept their loved one’s death. Knowing that death of the patient could cause some negative thought about hospital environments. May cause the family to feel uneasy.  |  |  |
| The patient died. | What does this mean to the community? Bad patient and health outcomes. | What can the family do?Family meeting. Initiate a rapid response. |  |
|  |  | How should the plan be prioritized?Communication, listening, addressing could all be used to take in mind the patients’ needs and give a proper course of treatment.  |  |

**Grading:**

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| **Criteria**   | **Exceeds**   | **Meets**   | **Please resubmit**   |
| Recognizes nursing’s essential role in improving healthcare quality and safety    | Identifies two examples of how nurses can improve healthcare and safety (i.e., advocacy **and** policy development  | Identifies one example of how nurses can improve healthcare and safety (i.e., advocacy **or** policy development)  | Does not identify how nurses can improve healthcare and safety  |
| Examines common barriers to active involvement of patients in their own health care processes   | Identifies two barriers to active involvement of patients in their own health care processes (i.e., trust **and** communication)  | Identifies one barrier to active involvement of patients in their own health care processes (i.e., trust **or** communication)  | Does not identify barriers to active involvement of patients in their own health care processes    |
| Values active partnership with patients and families in planning, implementing, and evaluating care   | Acknowledges two behaviors that contribute to active partnership with patients and families (i.e., respect/listening **and** teamwork)   | Acknowledges one behavior that contribute to active partnership with patients and families (i.e., respect/listening **or** teamwork)  | Does not acknowledge behaviors that contribute to active partnership with patients and families   |
| Values the influence of system solutions in achieving effective team functioning  | Acknowledges two ways in which system solutions contribute to effective team functioning (i.e., interoperable technology **and** patient advocates)  | Acknowledges one way in which system solutions contribute to effective team functioning (i.e., interoperable technology **and** patient advocates  | Does not acknowledge that system solutions contribute to effective team functioning  |
| Communicates observations or concerns related to hazards and errors to patients, families and the health care team  | Identifies two observations or concerns that contributed to the patient’s health outcome (i.e., listening **and** interoperability)  | Identifies one observation or concern that contributed to the patient’s health outcome (i.e., listening **or** interoperability)   | Does not identify observations or concerns that contributed to the patient’s health outcome  |
| Describes examples of how technology and information management are related to the quality and safety of patient care  | Identifies two examples of how technology and information management are related to quality and safety (i.e., interoperability **and** communication)  | Identifies one example of how technology and information management are related to quality and safety (i.e., interoperability **or** communication)   | Does not identify examples of how technology and information management are related to quality and safety  |
| Implements nursing clinical judgment when making practice decisions  | Uses the Clinical Judgment Template. Thought process flow and are consistent (Noticing contributes to Interpreting, which contributes to Responding, which contributes to Reflecting)   | Uses the Clinical Judgment Template. Thought process does not flow or is inconsistent (Noticing does not contribute to Interpreting, etc.)  | Does not use the Nursing Clinical Judgment Template  |
| **Grade**   | **Complete**   | **Incomplete**  |