

EVALUATION OF CLINICAL PERFORMANCE TOOL
Advanced Medical Surgical Nursing- 2025

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
Chandra Barnes, MSN, RN; Brian Seitz, MSN, RN, CNE
Brittany Lombardi, MSN, RN, CNE

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. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

Clinical Assignments
Completion of Patient Care
Meditech Documentation
Observation of Clinical Performance
Evaluation of Clinical Performance Tool
Onsite Clinical Debriefing
Clinical Discussion Rubric
Preceptor Feedback
Nursing Care Map Rubric
Skills Lab Checklists/Competency Tool
Lasater Clinical Judgment Rubric
Virtual Simulation scenarios
Pathophysiology Grading Rubric
SBAR/Physician Orders Rubric
Hand-Off Report Competency Rubric

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
2/7/2025	1H	Didn't do Quality Scavenger Hunt CDG	
Initials	Faculty Name		
CB	Chandra Barnes, MSN, RN		
FB	Fran Brennan, MSN, RN		
BL	Brittany Lombardi, MSN, RN, CNE		
AR	Amy Rockwell, MSN, RN		
BS	Brian Seitz, MSN, RN, CNE		

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	Mid-term	9	10	11	12	13	14	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Manage complex patient care situations with evidence of preparation and organization. (Responding)	S	S	S	S	NA													
b. Assess comprehensively as indicated by patient needs and circumstances. (Noticing)	S	S	S	S	NA													
c. Evaluate patient's response to nursing interventions. (Reflecting)	S	S	S	NA S	NA													
d. Interpret cardiac rhythm; determine rate and measurements. (Interpreting)	NA	S	S	NA	NA													
e. Administer medications observing the seven rights of medication administration. (Responding)	S	S	S	NA	NA													
f. Perform venipuncture skill with beginning dexterity and evidence of preparation. (Responding)	NA	S	S	NA	NA													
g. Respond appropriately to equipment alarms; IV pumps, ECG monitors, ventilators, etc. (Responding)	S	S	S	NA	NA													
Faculty Initials	FB	FB	FB	AR														
Clinical Location	PT MAN	PT MAN	PT MAN	PT Advocate	No clinical													

Comments:

Week 2 (1a,b)- Great job managing patient care and prioritizing care based on comprehensive assessment. FB

Week 3 (1a,b,c)- Satisfactory with managing three patients during your patient management clinical experiences this week! Great job! FB

Week 4 (1c)- Great job evaluating the plan of care and patient needs to determine the order of care for several patients during this clinical rotation. FB

Week 5 (1c)- Satisfactory during your Patient Advocate/Discharge Planner clinical experience and with your discussion via CDG posting. Preceptor comments:

"Excellent in all areas." Great job. AR

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

*End-of- Program Student Learning Outcomes

Objective

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

Weeks of Course:	2	3	4	5	6	7	8	Make up	Mid-term	9	10	11	12	13	14	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Correlate relationships among disease process, patient's history, patient symptoms, and present condition utilizing clinical judgment skills. (Noticing, Interpreting, Responding)																		
b. Monitor for potential risks and anticipate possible early complications. (Noticing, Interpreting, Responding)	S	S	S	S	NA													
c. Recognize changes in patient status and take appropriate action. (Noticing, Interpreting, Responding)	S	S	S	S	NA													
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. (Noticing, Interpreting, Responding, Reflecting) *	NA	NA S	S	S	NA													
e. Respect patient and family perspectives, values, and diversity when planning, giving, and adapting care. (Responding)	S	S	S	S	NA													
Faculty Initials	FB	FB	FB	AR														

***When completing the 4T Care Map CDG refer to the Care Map Rubric**

Comments:

Week 2(2a,b)- Great use of clinical judgement skills to determine patient needs, plan care for patients, and implement appropriate nursing interventions. FB
 Week 3 (2a,b,d)- Great job with correlation of patient condition, pathophysiology of disease process, and monitoring of any possible complications. Based off assessments you were able to implement the plan of care for several patients. (2d) Providing care for a patient involves the nursing process and the implementation of a plan of care, as you care for patients you are using your clinical judgement to provide the care, prioritize, and formulate a nursing plan of care. Therefore, this competency was changed to a "S". FB

Week 4 (2a,b)- Good use of clinical judgement as you correlate the relationship between patient's disease process, current symptoms, and present condition. You are also assessing for potential risks and anticipating possible complications as you prioritize care for your assigned patients. Keep up the good work! FB

*End-of- Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

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	Mid-term	9	10	11	12	13	14	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Critique communication barriers among team members. (Interpreting)																		
b. Participate in QI, core measures, monitoring standards and documentation. (Interpreting & Responding)	NA	NA	NA	NA	NA													
c. Discuss strategies to achieve fiscal responsibility in clinical practice. (Responding)	S	S	S	S	NA													
d. Clarify roles & accountability of team members related to delegation. (Noticing)	S	S	S	NA	NA													
e. Determine the priority patient from assigned patient population. (Interpreting) (Patient Mgmt.)	S	S	S	NA	NA													
Faculty Initials	FB	FB	FB	AR														

Comments:

Week 2 (3d,e)- Great discussion, noticing accountability of delegation and the clarification of roles. You also did a great job interpreting facts to determine the need for prioritization of assigned patient during this clinical rotation. FB

Week 3 (3e) Great job with prioritizing the delivery of care to your assigned patients during the clinical experiences this week. FB

Week 4 (3d,e)- You have demonstrated the process of delegation, responsibility, and accountability of the interdisciplinary team members. Great job determining priority care of assigned patients. Keep up the great work! FB

Week 5- Satisfactory during your Quality Scavenger Hunt clinical and with documentation. You did not complete the required CDG for this clinical. AR

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

*End-of- Program Student Learning Outcomes

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. (1,2,4,5,7)*

Weeks of Course:	2	3	4	5	6	7	8	Make up	Mid-term	9	10	11	12	13	14	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Critique examples of legal or ethical issues observed in the clinical setting. (Interpreting)																		
b. Engage with patients and families to make autonomous decisions regarding healthcare. (Responding)	S	S	S	S	NA													
c. Exhibit professional behavior in appearance, responsibility, integrity and respect. (Responding)	S	S	S	S U	NA													
Faculty Initials	FB	FB	FB	AR														

Objective 4a: Provide a comment for the highlighted competency each week. If no clinical experiences, put "NA" for that week.

Comments:

2a.) It wasn't my patient. But how ever there was a patient on the floor that I was on. I am not sure why she was brought into the hospital. However, the nurse stated that the patient could not make her own decisions anymore and that she was ready for discharge but a facility would not take her because she didn't need any skilled nursing. This patient had a boyfriend, and he had come up to the floor and wanted the patient to sign a check. The patient was newly appointed to a legal guardian. The charge nurse had to defend the patient for her rights and the patient's boy friend was not very happy and security had to escort him out of the hospital. "In contemporary guardianship systems, it is likely that most court-appointed guardians will eventually be called upon either to make or to assist the ward to make health care decisions of many sorts. These decisions may involve matters as simple as scheduling physician or dental appointments for the ward, helping her to complete medical history forms, and authorizing nonemergency treatment for minor illnesses or injuries.¹ They may also involve such critical decisions as whether to permit risky surgical procedures, to switch from curative care that is unlikely to cure in favor of palliative care and aggressive pain management, or to direct health care providers to terminate ongoing, life-sustaining treatments including artificial respiration, nutrition, or hydration. Often, these health care decisions must be made in circumstances where time is of the essence or stress levels are high due to the seriousness of the ward's medical situation and the possible deleterious, irreversible consequences of a "wrong" decision" (Dayton, 2012).

Dayton, A. K. (2012). *Standards for Health Care Decision-Making: Legal and Practical Considerations*. Utah Law Review. <http://open.mitchellhamline.edu/cgi/viewcontent.cgi?article=1250&context=facsch>

[Standards for Health Care Decision-Making: Legal and Practical Considerations](#)

Week 2 (4a)- These types of issues can be very complicated. It is important to listen and educate the patient's significant other of the legality of the situation. There may be a good reason why there is an appointed guardian for decisions. First, we try to deescalate the situation and if that does not seem to be successful calling security is the best option. Families and relationships can be difficult. FB

3a.) An example of a legal situation would be on Tuesday morning when a Code Blue was called on the overhead. My preceptor and I went down the code, and the patient was brought in on the gurney and the Lucas machine compressing her heart. 4 other students and myself performed chest compressions until the time of death was called. The patient was a full code. The advanced directives are a legal document with the patient's wishes on if they want life saving measures. A legal issue would be not performing CPR on a Full code patient. The lady arrived with EMS, with no family. This can be a difficult situation, but if there is no documentation on hand we will always do everything to sustain or regain life. If it is determined the patient does not want to be resuscitated we would stop all life saving measures. Great example. FB

4a.) An example from both days, is the RN witnessing the consent for surgery. Obtaining a consent for treatment is important. If it isn't obtained the hospital can get in a lot of trouble. Yes, this is very important to make sure the consent is signed and the physician went over all the details of the surgery including any risks that are involved. It is also important to get the consent signed before any mind-altering medications are given to the patient. FB

5a.) A legal example would be patient advocacy and discharge planner keeping a paper trail on what they are doing and what they have done. Keeping a paper trail is helpful in case if a case goes to court. You are correct, it is very important to keep a "paper trail"/documentation in case legal action is brought forth. AR

Week 5 (4c)- You have received an unsatisfactory for this competency due to not completing the CDG that was required for your Quality Scavenger Hunt clinical experience. Be sure to follow the instructions on pages 1-2 of this tool to correctly address the unsatisfactory for Week 6. AR

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	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Reflect on your overall performance in the clinical area for the week. (Responding)	S	S	S	S	NA													
b. Demonstrate initiative in seeking new learning opportunities. (Responding)	S	S	S	S	NA													
c. Describe factors that create a culture of safety (error reporting, communication, & standardization, etc. (Interpreting)	S	S	S	S	NA													
d. Maintain the principles of asepsis and standard/infection control precautions (Responding)	S	S	S	S	NA													
e. Practice use of standardized EBP tools that support safety and quality. (Responding)	S	S	S	S	NA													
f. Utilize faculty feedback to improve clinical performance. (Responding & Reflecting)	S	S	S	S	NA													
Faculty Initials	FB	FB	FB	AR														

Comments:

Week 2 (5a)- Reported on by assigned RN during clinical rotation 1/14/2025– Satisfactory in all areas. Student goals: No student goals are provided. You must provide a goal for every clinical rotation. Additional Preceptor comments: “Only lacking in experience.” BD/FB

Week 3 (5a)- Reported on by assigned RN during clinical rotation 1/21/2025– Satisfactory in all areas, except excellent in member of profession-demonstrates professionalism in nursing. Student goals: “Continue to advance skills.” No additional Preceptor comments. JF/FB Reported on by assigned RN during clinical rotation 1/22/2025- Excellent in all areas, except satisfactory in provider of care-establishment of plan of care, manager of care-communication skills, delegation. Student goals: “Continue to challenge myself with “difficult” patients.” No additional preceptor comments.” JF/FB

Week 4 (5a) Reported on by assigned RN during clinical rotation on 1/28/2025 –Excellent in all areas. Student goals: “Get more comfortable with hanging fluids.” Additional Preceptor comments: “We had a very busy day and she did great! She’ll be a great RN!” KS/FB Reported on by assigned RN during clinical rotation on 1/29/2025 – Excellent in all areas.” Student goals: “To get more IV start experience.” Additional Preceptor comments: Katelyn did great work on clinical today-she got to practice multiple nursing skills, including IV start, NG tube placement, and IV, PO and subQ med administration. SV/FB

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	Mid-term	9	10	11	12	13	14	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Establish collaborative partnerships with patients, families, and coworkers. (Responding)																		
b. Teach patients and families based on readiness to learn and discharge learning needs. (Interpreting & Responding)	S	S	S	S	NA													
c. Collaborate and communicate with members of the healthcare team, patients, and families to achieve optimal patient outcomes. (Responding)	S	S	S	S	NA													
d. Deliver effective and concise hand-off reports. (Responding) *	S	NA	NA	NA	NA													
e. Document interventions and medication administration correctly in the electronic medical record. (Responding)	S	S	S	NA	NA													
f. Consistently and appropriately posts in clinical discussion groups. (Responding and Reflecting)	S	S	S	S U	NA													
Faculty Initials	FB	FB	FB	AR														

***When completing 4T Hand-Off Report see 4T Hand- Off Competency Rubric**

Comments:

Week 2 (6d) This competency was completed satisfactorily according to the hand-off report rubric, score of 24/30 points. No RN comments provided. BD/FB (6c) Great job with communication and collaboration skills demonstrated as you worked with assigned RN and other healthcare disciplines. FB

Week 3 (6f)- Satisfactory CDG posting related to your patient management clinical experiences this week! Keep up the great work! FB

Week 4 (6e)- Great job with documenting accurately and appropriately for all aspects of care delivered. (6f) Great job with determining an educational plan for one of your assigned patients. Educational plan was thorough with all areas of CDG expectations met. FB

*End-of- Program Student Learning Outcomes

Week 5 (6c)- Satisfactory discussion related to your Patient Advocate/Discharge Planner clinical experience. (6f)- While your CDG posting for your Patient Advocate/Discharge Planner clinical was satisfactory, you have received an unsatisfactory for this competency due to not completing the CDG that was required for your Quality Scavenger Hunt clinical experience. Be sure to follow the instructions on pages 1-2 of this tool to correctly address the unsatisfactory for Week 6. AR
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	Mid-term	9	10	11	12	13	14	15	Make up	Final
Competencies:	S	S	S	S	NA													
a. Value the need for continuous improvement in clinical practice based on evidence. (Responding)																		
b. Accountable for investigating evidence-based practice to improve patient outcomes. (Responding)	S	S	S	S	NA													
c. Comply with the FRMCSN "Student Code of Conduct Policy." (Responding)	S	S	S	S	NA													
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S	S	S	S	NA													
Faculty Initials	FB	FB	FB	AR														

Comments:

Week 3 (7a) Great job recognizing areas of improvement related to evidence-based practice and within your clinical practice. FB

Week 4 (7d)- Great job displaying a great attitude, commitment to provide optimal care, and enthusiasm for the caring of individuals at a very vulnerable and often difficult time of their lives. FB

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Firelands Regional Medical Center School of Nursing
Care Map Grading Rubric

Student Name:				Course Objective: Formulate nursing care plans, correlations, or clinical reports that demonstrate patient-centered care of diverse populations, evidence-based practice, and clinical judgment.			
Date or Clinical Week:							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)		
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)		
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)		
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	5. State the goal for the top nursing priority.	Complete			Not complete		
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)		
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)		
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete		
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete		
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete		

*End-of- Program Student Learning Outcomes

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete		
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete		
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete		
Reference An in-text citation and reference are required. The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both. The care map will be graded “unsatisfactory” if both in-text citation and reference are not included.							
Total Possible Points= 45 points 45-35 points = Satisfactory 34-23 points = Needs Improvement* < 23 points = Unsatisfactory* *Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines. ***Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *** Faculty/Teaching Assistant Comments:						Total Points:	
						Faculty/Teaching Assistant Initials:	

Care Map Evaluation Tool**
 AMSN
 2025

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials

** AMSN students are required to submit one satisfactory care map (CDG) during the 3-week 4T clinical rotation. If the care map is not evaluated as satisfactory upon initial submission, the student has one opportunity to revise the care map based on instructor feedback. **Students that are not satisfactory after these 2 attempts will be required to meet with course faculty for remediation.**

Comments:

Pathophysiology Grading Rubric
Firelands Regional Medical Center School of Nursing
Advanced Medical Surgical Nursing
2025

Student Name:

Clinical Date:

1. Provide a description of your patient including current diagnosis and past medical history. (4 points total) - Current Diagnosis (2) - Past Medical History (2)	Total Points: Comments:
2. Describe the pathophysiology of your patient's current diagnosis. (6 points total) Pathophysiology-what is happening in the body at the cellular level (6)	Total Points: Comments:
3. Correlate the patient's current diagnosis with presenting signs and symptoms. (6 points total) - All patient's signs and symptoms included (2) - Explanation of what signs and symptoms are typically expected with this current diagnosis (Do these differ from what your patient presented with?) (2) - Explanation of how all patient's signs and symptoms correlate with current diagnosis. (2)	Total Points: Comments:
4. Correlate the patient's current diagnosis with all related labs. (12 points total) - All patient's relevant lab result values included (3) - Rationale provided for each lab test performed (3) - Explanation provided of what a normal lab result should be in the absence of current diagnosis (3) - Explanation of how each of the patient's relevant lab result values correlate with current diagnosis (3)	Total Points: Comments:
5. Correlate the patient's current diagnosis with all related diagnostic tests. (12 points total) - All patient's relevant diagnostic tests and results included (3) - Rationale provided for each diagnostic test performed (3) - Explanation provided of what a normal diagnostic test result would be in the absence of current diagnosis (3) - Explanation of how each of the patient's relevant diagnostic test results correlate with current diagnosis (3)	Total Points: Comments:
6. Correlate the patient's current diagnosis with all related	Total Points:

medications. (9 points total) • All related medications included (3) • Rationale provided for the use of each medication (3) • Explanation of how each of the patient's relevant medications correlate with current diagnosis (3)	Comments:
7. Correlate the patient's current diagnosis with all pertinent past medical history. (4 points total) • All pertinent past medical history included (2) • Explanation of how patient's pertinent past medical history correlates with current diagnosis (2)	Total Points: Comments:
8. Prioritize nursing interventions related to current diagnosis. (6 points total) • All nursing interventions provided for patient prioritized and rationales provided (6)	Total Points: Comments:
9. Discuss the role of interdisciplinary team members in the care of the patient. (6 points total) • Identifies all interdisciplinary team members currently involved in the care of the patient (2) • Explains how each current interdisciplinary team member contributes to positive patient outcomes (2) • Identifies additional interdisciplinary team members (not involved currently) that should be included in the care of the patient to ensure positive patient outcomes (2)	Total Points: Comments:
Total possible points = 65 51-65 = Satisfactory < 51 = Unsatisfactory Course Objective: 2. Formulate nursing care plans, correlations, or clinical reports that demonstrate patient-centered care of diverse populations, evidence-based practice, and clinical judgment. (1,2,3,4,5,8)* Clinical Competency: 2(a.) Correlate relationships among disease process, patient's history, patient symptoms, and present condition utilizing clinical judgment skills. (Noticing, Interpreting, Responding) *End-of-Program Student Learning Outcomes	Total Points: Comments:

Firelands Regional Medical Center School of Nursing

AMSN –4 Tower - Hand-Off Report Competency Rubric

Faculty: Brittany Lombardi, MSN, RN, CNE; Brian Seitz, MSN, RN, CNE; Chandra Barnes, MSN, RN

Student Name: _____ **Date:** _____

Must complete satisfactorily during 4 Tower debriefing.

23-30 points = Satisfactory	< 23 points = Unsatisfactory
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CRITERIA

	Meets Expectations 5	Needs Improvement 3	Does Not Meet Expectations 0	POINTS
Introduction Safety (1,2)*	Introduction provided (includes patient name, room number etc.). Provides socioeconomic factors (e.g. social support), allergies, and alerts (falls, isolation, etc.)	Provides introduction and communicates most of the safety concerns of the patient.	Does not provide introduction and/or does not address the safety concerns of the patient.	
Situation (3)*	Presents chief complaint and current status (including code status, recent changes, and response to treatment).	Presents most information but missing pertinent data e.g. current status, changes etc.	Information is incomplete and/or disorganized. Not possible to understand and obtain an adequate and clear picture of the patient's situation.	
Background (4)*	Provides detailed and organized background information regarding presenting diagnosis and signs/symptoms; includes pertinent past medical and surgical history.	Provides background information but information disorganized and difficult to understand. Missing some information related to past medical and surgical history.	Background information is incomplete and/or inaccurate. Missing pertinent information related to past medical and surgical history	
Assessment Laboratory/Diagnostic Testing (5)*	Provides clear, concise, pertinent assessment information e.g. vital signs, cardiac assessment, respiratory assessment. Communicates pertinent laboratory and diagnostic information and relates findings to current diagnosis/presentation.	Provides assessment information but material is disorganized. Communicates laboratory and diagnostic findings but information is not specific. Example: states hemoglobin is low without stating specific number or why it is abnormal.	Assessment information is incomplete and needs improvement. Does not communicate findings in a way that can be understood.	
Actions (4,5)*	Explains interventions performed or required. Provides rationale.	Explains interventions performed/required but does not provide rationales.	Does not include all interventions performed and does not provide rationales.	
Communication Prioritization (1,4,5,6)*	Communicates and prioritizes any outstanding patient issues and the plan of care. Example: patient having change in mental status - would explain CT ordered. Includes patient teaching provided.	Communicates all information but is slightly disorganized in presentation.	Overall communication of hand-off report needs improvement. Incomplete report and/or disorganized in presentation	
			TOTAL POINTS	

Faculty Comments: _____

Faculty Signature: _____ **Date:** _____

Firelands Regional Medical Center School of Nursing
Advanced Medical Surgical Nursing 2025
Simulation Evaluations

<u>Simulation Evaluation</u> Performance Codes: S: Satisfactory U: Unsatisfactory	Rachael Heidebrink (Pharmacology) (1, 2, 6, 7)*	Week 8: Dysrhythmia Simulation (see rubric) (1, 2, 3, 5, 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)*	Comprehensive Simulation (see rubric) (1, 2, 3, 4, 5, 6, 7)
	Date: 2/14/2025	Date: 2/24-25/2025	Date: 2/28/2025	Date: 3/14/2025	Date: 3/21/2025	Date: 3/27/2025	Date: 4/7/2025	Date: 4/7/2025
Evaluation								
Faculty Initials								
Remediation: Date/Evaluation/ Initials								

* Course Objectives

Comments:

Firelands Regional Medical Center School of Nursing

Skills Lab Evaluation Tool
AMSN
2025

Skills Lab Competency Evaluation Performance Codes: S: Satisfactory U: Unsatisfactory	Lab Skills									
	Meditech Document (1,2,3,4,5,6)*	Physician Orders/SBAR (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 (1,2,3,4,6)*	Head to Toe Assessment (1,2,6)*	ECG/Hand-off report/CT (1,6)*	ECG Measurements (1,2,4,5,6)*
	Date: 1/7/2025	Date: 1/7/2025	Date: 1/7/2025	Date: 1/7/2025	Date: 1/9/2025	Date: 1/9/2025	Date: 1/10/2025	Date: 1/10/2025	Date: 1/10/2025	Date: 1/10/2025
Evaluation:	S	S	S	S	S	S	S	S	S	S
Faculty Initials	FB	BS	CB	AR	FB/CB/BS	AR	CB	BS/DW	BS	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/SBAR: Satisfactory completion of physician's order lab per the SBAR skills competency rubric: phone call to physician with SBAR report, receiving and reading back multiple physician orders, and hand-off report given to the next student in rotation. Discussion of the treatment, medications, and plan of care for a patient experiencing NSTEMI and STEMI. BS

Prioritization/Delegation: Satisfactory completion of the prioritization and delegation skills lab. You satisfactorily prioritized care for multiple patients using multiple methods (e.g. Maslow's hierarchy of needs, ABC, Nursing Process, etc.). You were able to appropriately delegate nursing tasks for patients, and you actively participated in the group discussion on delegation of nursing tasks. Great job! CB

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. FB/CB/BS

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

Central Line Dressing Change/Ports/Blood Draw: Satisfactory central line dressing change participation providing proper technique guidelines, maintenance of central line ports, and line flushing. You were satisfactory in accessing and de-accessing an infusaport device, demonstrated proper technique on how to draw blood from a CVAD, and properly labeled a blood tube per hospital policy. Great job! CB

Head to Toe Assessment: Satisfactory completion of the Head to Toe Assessment. Great job! DW/BS

*End-of- Program Student Evaluation/Comments: **ECG/Telemetry Placements/Hand-off report/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; satisfactory completion of handoff report activity. BS

ECG Measurements: Satisfactory participation in and practice of ECG measurements during the ECG Measurements Lab. You

EVALUATION OF CLINICAL PERFORMANCE TOOL
Advanced Medical Surgical Nursing- 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

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

Student eSignature & Date:

ar 11/15/2024

*End-of- Program Student Learning Outcomes