

**EVALUATION OF CLINICAL PERFORMANCE TOOL  
Medical Surgical Nursing – 2025**

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

**Student:**

**Final Grade:** Satisfactory/Unsatisfactory

**Semester:** Spring

**Date of Completion:**

**Faculty:** Dawn Wikel, MSN, RN, CNE; Rachel Haynes, MSN, RN; Kelly Ammanniti, MSN, RN, CHSE;  
Monica Dunbar, DNP, RN; Heather Schwerer, MSN, RN; Nick Simonovich, MSN, RN

**Faculty eSignature:**

**Teaching Assistant:** Stacia Atkins, BSN, RN

**DIRECTIONS FOR USE:**

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S)**, **Needs Improvement (NI)**, **Unsatisfactory (U)**, and **Not Available (NA)**. The faculty member will initial if in agreement with the student’s evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written 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:**

- Skills Lab Competency Tool & Skills Checklists
- Simulation, Prebriefing, & Reflection Journals
- Nursing Care Map Rubric
- Meditech Documentation
- Clinical Debriefing
- Clinical Discussion Group Grading Rubric
- Evaluation of Clinical Performance Tool
- Lasater’s Clinical Judgment Rubric & Scoring Sheet
- Virtual Simulation Scenarios

**ABSENCE (Refer to Attendance Policy)**

Date	Number of Hours	Comments	Make-up (/Date/Time)

Faculty’s Name	Initials
<b>Kelly Ammanniti</b>	<b>KA</b>
<b>Stacia Atkins</b>	<b>SA</b>
<b>Monica Dunbar</b>	<b>MD</b>
<b>Rachel Haynes</b>	<b>RH</b>
<b>Heather Schwerer</b>	<b>HS</b>
<b>Nick Simonovich</b>	<b>NS</b>
<b>Dawn Wikel</b>	<b>DW</b>

## PERFORMANCE CODE

### SATISFACTORY CLINICAL PERFORMANCE

**Satisfactory (S):** Safe, accurate each time, efficient, coordinated; confident, focuses on the patient; some expenditure of excess energy; within a reasonable time period; appropriate affective behavior; occasional supporting cues; minimal faculty feedback related to written clinical work.

### UNSATISFACTORY CLINICAL PERFORMANCE

**Needs Improvement (NI):** Safe; accurate each time; skillful in parts of behavior; focuses more on the skill and self rather than the patient; inefficient, uncoordinated, anxious, worried, flustered at times; expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues; faculty feedback required in several areas of clinical written work.

**Unsatisfactory (U):** Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/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 boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
2/3/2025	Impaired Mobility	S/RH	N/A	N/A

Note: Students are required to submit two satisfactory care maps over the course of the semester. If the care map is not evaluated as satisfactory upon initial submission, the student must revise the care map based on instructor feedback/remediation and resubmit. A maximum of two remediation attempts will be provided for a single care map and if still unsatisfactory, the student will be required to start fresh and initiate a care map on a new patient. At least one care map must be submitted prior to midterm.

---

**Objective**

1. Illustrate correlations to demonstrate the pathophysiological alterations in adult patients with medical-surgical problems. (2,3,4,5)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>			S	S	S	S											
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	S	S	S											
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	S	S											
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	S	S											
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	S	S	S											
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	S	S	S											
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	S	S	S											
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S	S											
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S	S											
	Indicate your clinical site as well as your patient's age and primary medical diagnosis in this box weekly.	Meditech, FSBS, IV Pump Sessions	3T-70, aspiration pneumonia	5T-85, left femoral fracture fixation	4N-82, right toe necrosis-amputation. Flu	5T-82, right knee total arthroplasty, UTI aeb											
Instructors Initials	HS		KA	RH	NS												

\*\*Evaluate these competencies for the offsite clinicals: DH: 1h IC: 1a, b, e, h ECSC: 1g, h

**Comments:**

\*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Week 1 (1h)- During week 1, the Meditech, FSBS and IV pump sessions were all considered clinical hours. You came prepared to each of them and demonstrated competency accordingly. For this reason, you have earned an S for this competency. NS/SA/DW/HS

Week 3 – 1a, b, c, e– You did a nice job discussing on clinical your patient’s disease process and what nursing was doing to help the patient. You were able to discuss symptoms we were monitoring and managing in your patient as well as pertinent labs for your patient diagnosis. You also set a goal for your patient and were able to discuss your patient’s work towards meeting that goal. You managed a very complex patient and should be proud of everything you accomplished this week! KA

Week 3 – 1d – You did a nice job reviewing all your medications before you administered them to the patient. You were able to discuss the reason why the patient was taking the medication as well as what we were monitoring the patient for. You also were able to discuss what information was needed to determine if the medication should be administered (i.e. blood pressure, pulse). KA

Week 4: 1(c, d, e) This week you did a great job of discussing your patient’s pathophysiology of their illness as well as discussion of their medications. You were able to correlate why each medication was related to their care. RH

Week 5 1(a-h) – Good job this week making correlations in your patient’s health alterations. You discussed the pathophysiology involved with his non-healing diabetic foot ulcers leading to the need for amputation. You also discussed his history of diabetes leading to end-stage renal disease. You used clinical judgement to question his history of diabetes, as it was not reported or included in his EHR. You noticed that he was not prescribed FSBS checks, and review the chart to notice normal glucose levels in his daily labs. Good work being the nurse “detective” in trying to put the pieces together. You did well discussing his prescribed medications, making correlations to his current and past medical history. You discussed the medical treatment involved, including the amputation procedure and dialysis treatment. Overall good job this week with new learning experiences! NS

**Objective**

2. Perform physical assessments as a method for determining deviations from normal. (3,4,5)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>			S	S	S	S											
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	S	S	S											
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	S	S	S											
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	S	S	S											
d. Communicate physical assessment. (Responding)			S	S	S	S											
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	S	S	S											
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	S	S											
	<b>HS</b>		<b>KA</b>	<b>RH</b>	<b>NS</b>												

\*\*Evaluate these competencies for the offsite clinicals: DH: N/A IC: 2f ECSC: N/A

**Comments:**

Week 1 (2f)- By attending the Meditech clinical update & providing your full, undivided attention during the demonstration of documenting IV solutions and the IV assessment, you are satisfactory for this competency. NS

Week 3 – 2a, d – You did a nice job thoroughly assessing your patient and notifying your nurse of any pertinent information. You were able to identify the GI and neuro focused assessments being important to be completed for your patient related to their diagnosis and monitored abnormal assessment findings. KA

Week 3 – 2f – You utilized the EMR to research your patient and determine what care needed to be provided to your patient throughout the day. You also utilized the EMR to research your patient's health history and information related to the patient's current hospital visit. KA

Week 4: (2a-f) This week you performed a full head to toe assessment on your patient as well as a fall/safety assessment and skin assessment. You were able to identify your patient's laceration dressing was loose and did a wound assessment after removing the dressing. You were able to communicate any abnormalities in your assessment to myself and the nurse. You charted all your findings in the EHR appropriately. RH

Week 5 2 (a,e) – You did well with your assessments this week, noticing numerous deviations from normal. Specifically, you gained experience with assessing a patient scheduled for dialysis, ensuring patency of the AV fistula. You were able to note the thrill on palpation and bruit upon auscultation and documented your findings accurately. You were able to prioritize your focused assessments based on his priority problem. You were able to identify rhonchi in his lung fields, which was correlated to his diagnosis of influenza a. You also noticed improvement from day one to day two. NS

## Objective

3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>	S		S	S	S	S											
a. Perform standard precautions. (Responding)	S		S	S	S	S											
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	S	S	S											
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S	S	S											
d. Appropriately prioritizes nursing care. (Responding)			S	S	S	S											
e. Recognize the need for assistance. (Reflecting)			S	S	S	S											
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S	S	S											
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			S	NA	NA	S											
h. Implement DVT prophylaxis (early ambulation, SCDs, TED hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	S	NA	S											
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S	S	S											
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S	S											
	HS		KA	RH	NS												

\*\*Evaluate these competencies for the offsite clinicals:

DH: 3a

IC: 3a, f, i

ECSC: 3a, j

Comments:

Week 3 – 3b – You did a great job with the new skill of administering medications through a NG tube. You reviewed information about the NG tube before administering the medications to ensure the proper procedure was performed. With continued practice and review of this skill you will become timelier and more efficient with this skill,

but you were able to administer both the medications and water flush with beginning dexterity! Nice job! You also had the opportunity to manage a Foley catheter this week. You monitored the patient's output and documented the findings in the EMR. You provided peri care as appropriate and monitored the patient for signs and symptoms of complications related to catheter placement. KA

Week 4: (3a, b, d) You used proper hand hygiene throughout both clinical days. You were able to care for your patient while assisting therapy in helping your patient with their ADLs all while keeping safety in mind. You also were able to prioritize your day and organize your day in a way that allowed you to get all things done in a timely manner. You did great working around and with all the various therapies your patient had this week. RH

Week 5 3(a,f) – You cared for a patient on droplet precautions for influenza A this week. Appropriate precautions were implemented including the use of a mask during each patient encounter. NS

Week 5 3(c,d) – You used good time management this week to ensure all aspects of care were completed prior to your patient leaving the floor. In doing so, you were provided the opportunity to observe a surgical procedure and a dialysis treatment. Great job prioritizing your care appropriately. NS

**Objective**

3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>			S	S	S	S											
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	S	S	S											
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	S	S	S											
m. Calculate medication doses accurately. (Responding)			S	S	S	S											
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			S	NA	S	NA											
o. Regulate IV flow rate. (Responding)	S		NA	NA	S	NA											
p. Flush saline lock. (Responding)			S	NA	S	NA											
q. Monitor and/or discontinue an IV. (Noticing/Responding)			NA S	NA	S	NA											
r. Perform FSBS with appropriate interventions. (Responding)	S		S	NA	NA	NA											
	<b>HS</b>		<b>KA</b>	<b>RH</b>	<b>NS</b>												

\*\*Evaluate these competencies for the offsite clinicals: DH: N/A IC: N/A ECSC: N/A

**Comments:**

Week 1 (3o)- During the IV pump session, you actively participated in the programming and maintenance of the Alaris IV pump. Additionally, you accurately identified abnormal IV site assessment data with an IV site monitoring activity. HS

(3r)- The student was able to satisfactorily perform a Quality Control check of the glucometer as well as demonstrate skills and knowledge required for proper fingerstick blood glucose measurement with the ACCU-CHEK Inform II glucometer. SA/DW

Week 3 – 3k – You did a nice job administering your medications this week. You observed the rights of medication administration and was able to answer all questions about your medications. You had the opportunity to pass NG and IV medications this week. You performed the medication administration process with beginning dexterity. KA

Week 3 – 3n – You had the opportunity to practice drawing up 2 medications from vials, including reconstituting one of the medications before administration and administering both slow IV push to your patient. You performed all IV skills with beginning dexterity. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

Week 3 – 3p – You did a nice job flushing your patient’s IV this week and ensuring patency of the IV line. You were able to document this appropriately in the EMR. KA

Week 3 – 3q – You did a nice job monitoring your patient’s IV site this week and documenting your assessment in the EMR. KA

Week 3 – 3r – You demonstrated proper technique when completing FSBS on your patient. You utilized the information received from the monitor to determine the need for insulin utilizing the patient’s prescribed coverage scale. You documented all information correctly in the EMR. KA

Week 4: (3k-m) You did great with your medication administration this week. You identified all medications and were able to provide me with detailed information about each medication, why the patient was getting the medications, and what to look for after administering the medications. You performed all checks prior to administration. You were organized and diligent while administering medications. You were able to scan all medications in the EMAR and chart them appropriately. You administered PO and SubQ medications this week. You were able to advocate for your patient to receive pain medication while in therapy so they could continue their therapy with limited pain by looking at her PRN medication orders and administering them. RH

Week 5 3(k-q) – You were well-prepared for medication administration this week, demonstrating knowledge obtained through skyscape related to the indications, side effects, and nursing implications for each. You discussed the clinical judgement involved with determining which medications to administer prior to surgery and dialysis. Although many of the medications were held both days, you still gained experience with administering PO medications safely. On day 1, you gained experience with assessing patency of an IV site with a saline flush, monitoring for sign of potential complications. You did a great job priming tubing and initiating fluids according to provider orders prior to surgery. The IV pump was set up accurately and infection control measures were followed. NS

**Objective**

4. Use therapeutic communication techniques to establish a baseline for nursing decisions. (1,5,7)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>			S	S	S	S											
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S	S											
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			S	S	S	S											
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	S	S	S											
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S	S											
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	S	S											
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S	S	S											
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			S	S	S	S											
			KA	RH	NS												

\*\*Evaluate these competencies for the offsite clinicals:

DH: 4a, b, d

IC: 4b, d, e

ECSC: 4a, b, d, e

**Comments:**

Week 3 – 4b – You completed the SBAR worksheet and provided your RN with handoff communication related to your patient utilizing the SBAR you developed. You made sure all pertinent information and changes in patient status were communicated to your nurse during hand-off report. You also practiced your SBAR during debriefing and provided an accurate report to your classmates and faculty. KA

Week 3 – 4e – Marilyn, you did a nice job choosing a relevant article to the patient you cared for this week and answering all the CDG questions on it. You were thorough in thoughtful with your original response as well as your response to your peer. You also included a reference and in-text citation for both responses. In the future, remember only the first letter of the first word of the title and the first letter of the first word after a colon in the title are capitalized. Overall you did a very nice job! Keep up the excellent work! KA

Week 4: (4b, e, f, g) You did a good job staying in communication with the nurse caring for your patient this week. You were able to use SBAR communication to keep the nurse informed of the care you provided and if there were any changes in your patient's status. You were also able to provide an SBAR handoff at the end of the day to the next provider of care. You did great with your clinical discussion post and finding an evidence-based article that related to your patient this week. RH

Week 5 4(a,b) – You were able to accompany your patient to different areas of the hospital this week for beneficial learning experiences. You were able to communicate and collaborate with members of the surgery and dialysis team. Positive remarks were given by the nurses in those units related to your excitement to learn and professionalism in interactions. Well done! NS

Week 5 4(e) – You did a nice job with all of your CDG requirements this week. All areas of the CDG grading rubric were appropriately addressed for a satisfactory evaluation. See my comments on both of your posts for further details. For APA formatting, overall you did well. One tip for future success with APA formatting: in your initial post's reference, the journal title should be italicized along with the volume number .. *Hemodialysis International*, 25(4). Otherwise, you were spot on! Good job taking Kelly's feedback from the previous week for the article title. NS

**Objective**

5. Implement patient education based on teaching needs of patients and/or significant others. (1,6)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>																	
<b>a. Describe a teaching need of your patient.** (Reflecting)</b>			NI	S	S	S											
<b>b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)</b>			NA NI	S	S	S											
			KA	RH	NS												

**\*\*5a & b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab- describe the patient education you provided; be specific- include the topic, method of delivery, reason for teaching need, materials to support learning through above resources (if applicable), and method used to validate learning.**

**Example: Education related to orthostatic hypotension (changing positions slowly by sitting at the side of the bed or chair for a few minutes before moving to another position, utilizing the walker when ambulating) was provided to my patient through discussion and demonstration. This was necessary to maintain patient safety as he/she was experiencing a drop-in blood pressure and dizziness when getting out of bed. A patient education sheet was printed from Lexicomp and given to the patient. The teach back method was used to validate learning.**

**Comments:**

- A. I could have taught my patient to continue to cough and deep breath but he had trouble with mobilizing the secretions. He could not teach anything back because he could not speak. This would be a great teaching topic. We also worked with him about using the different communication boards provided to him. In the future you could also think of possible teaching for the family. Every week you have clinical you are expected to identify a teaching need whether it is geared towards the patient or the caregivers. KA
- B. I did not use any recourses to provide education Every week you have clinical you need to describe a teaching need and discuss where you gathered the information from. Lexicomp and UpToDate on the hospital intranet or your Skyscape are great resources. KA
  
- A. I taught the patient the indications for her pain med. Oxycodone PRN for serious pain 6-10, every four hours and Tylenol prn every four hours for mild pain. I also taught or reinforced the importance of nonslip socks or slippers to prevent falls after the patient stated that she just walks barefoot at home. These are great educational topics. The correct use of pain medication and the prevention of falls will both help her with her healing and prevent her from injuring herself. RH
- B. Utilized the EMR and skyscape. RH
  
- A. I taught my patient (more like reinforced) the fact that the doctor wants the patient to keep his foot elevated with 3 pillows.
- B. Lexicomp handout on toe amputation states to keep the foot elevated to reduce swelling. This is probably something that will continuously need to be reinforced with him. Providing a hand-out for his own reference can be beneficial. Based on the interactions with him, I believe he

**will need continuous reminders from nurses and other healthcare providers to ensure he remains compliant. How did he respond to your education and reinforcement? Did he understand why this was necessary or did he push back on the education provided? NS**

**WEEK 6- A) I taught my patient about staying hydrated by drinking water, not only to help with constipation but also because she was having multiple bowel movements within an hour, saying that it was getting looser each time. This is a form of fluid loss, and she was also on a diuretic.**

**B) I utilized Skyscape. Maintaining hydration is under teaching needs for several of the meds she is on, and major for helping resolve constipation.**

**Objective**

6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
a. Develop and implement a priority care map utilizing the nursing process and clinical judgment. (Noticing, Interpreting, Responding, Reflecting)			NA	S	NA	NA											
b. <b>Identify factors associated with Social Determinants of Health (SDOH) &amp;/or cultural elements that have the potential to influence patient care.**</b> (Noticing, Interpreting, Responding, Reflecting)			S	S	S	S											
			KA	RH	NS												

**\*\*6b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab. Refer to CMS Social Determinates of Health Screening Tool in the Resources folder for the course.**

**Comments:**

See Care Map Grading Rubrics below.

Week 3 - 6B- Social determinant of health could be the fact that he has never gotten married, so potentially has been taking care of himself at his old age. He has many siblings, but one sibling even stated that he was very private, and one day he went to have a surgery and nobody knew about it. **I agree living alone is a SDOH that can affect the patient's ability to manage his overall health. Now that he has a debilitating chronic illness the question is will he have support to return home or will he need to be placed in a care facility. KA**

Week 4- 6b- SDOH relating to patients age and husbands age. Patient stated that she lives with her husband at home who is the same age as her (85). They are both older and have to take care of each other. This may cause some stress and if her husband has his own health issues, he may not be able to do as much to help her out at home. **I wonder if they have any children or family around that could also come and assist once she is home. This could definitely be an issue if one of them falls and injures themselves and they are back in this same situation. RH**

**Week 5-6b) potential SDOH- substance use. Dialysis nurse mentioned he needs it so much because he drinks too much. I wasn't sure if she meant alcohol or fluids in general... Also, in the chart it mentioned his daughter had hx of some substance abuse. Pt mentioned he stopped smoking, this would have been a SDOH if he still does. Interesting, I did not notice this in his chart. Good job using observational and communicative assessment skills to learn more about your patient. I think this would fall under the Social and Community Context SDOH. People's relationships and interactions with others have a major impact on their health and well-being. He has a significant health history that can be difficult to cope with and manage. If he doesn't have the support, or if his support also relies on the use of substances, then he can**

certainly have negative health outcomes. Here is a SDOH link that can help you to understand the ramifications of SDOH. <https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health> NS

Week 6b) SDOH is that the pt lives at home alone and states that she has to climb 14 steps; That is where she said her bathroom and bedroom is.

## Objective

7. Illustrate professional conduct including self-examination, responsibility for learning, and goal setting. (7)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
a. Reflect on an area of strength. ** (Reflecting)	S		S	S	S	S											
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		S	S U	S	S											
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		S	S	S	S											
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		S	S	S	S											
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S		S	S	S	S											
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	S		S	S	S	S											
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		S	S	S	S											
h. Actively engage in self-reflection. (Reflecting)	S		S	S	S	S											
	HS		KA	RH	NS												

\*\*Evaluate these competencies for the offsite clinicals: DH: All IC: All ECSC: All

\*\*7a and 7b: You must address these competencies in the comments section after each clinical experience. Please write a different comment each week. Remember that a goal includes what you will do to improve, how often you will do it, and when you will do it by (example- "I had trouble remembering to do the three checks of the six medication rights prior to administering medications. I will review the six rights and medication administration content in the textbook twice before the next clinical. Additionally, I will request to meet with my clinical faculty member to practice preparing and administering at least three medications before the next clinical.")

Comments:

7a) I did good with remembering how to do a thorough head to toe assessment in lab. Great job! HS

7b) My area for improvement was remembering to remove the soiled stoma dressing before putting on my sterile gloves during trache care. To improve I will practice at home with the kits that I was allowed to keep, one more time before my first clinical. **That is a great plan for improvement. HS**

7A) my strength was feeling confident in checking blood glucose and giving subcutaneous meds from now on. **You did a nice job overall with both of these skills, especially working with such a complex patient. KA**

7B) my weakness was being late on meds. I was so focused on trying to document, for this one instance, I could have waited, so I wouldn't have been that far behind. To improve I will check the MAR before I go in the patient's room just so that I am aware of how many meds are due. In this case there was a lot, plus it took me time to look each one up. So next time looking at the MAR, if I notice there's a lot of meds, at least I will be aware so I can hurry up with other things, and manage my time better with the morning assessment. **I am glad you recognized that your time management could have better on the first day. You had a lot of care and medications to provide and it was your first day back which played a part in the delay. I agree being more diligent of what is due when and recognizing what needs to be done now versus what wait is important. With continued practice I know you will master this skill. KA**

Week 4- 7a) my strength was attending to my patient, doing everything she needed, as she wished. This made her feel comfortable, happy, reduced her anxiety, and made her more compliant when it was my turn to ask something of her. **Your patient had a lot of needs and you did a great job assisting her and helping her feel comfortable while we were there.**

7b) weakness was keeping up with her pain. Sometimes she would deny pain when I asked or say it only hurt when she moved, then she would report pain to the PT/OT when it was time to walk. **What goal do you have to address your weakness this week? Please refer to the above highlight in green for requirements for a goal. You are receiving a "U" for not answering this question fully. Please address this "U" and how you will prevent it in the future. If you do not address the "U" it will remain a "U" until addressed. RH**

- To address this weakness, I will be sure to ask the patient to rate their pain every time if do my patient rounds, before, and after giving pain meds, and in my head to toe assessment. I will review the PQRST criteria before my next clinical so that I am prepared to ask all the right questions regarding pain.

WEEK 5 7A) my strength was passing meds. I feel much more comfortable, at least with the pills part. I think I would be able to give them alone.

7B) my weakness was charting. I just felt like it wasn't as good as it could be. My patient was gone majority of the time, and I left a nurses note. To improve I will review the different choices for example accessory muscle use, retractions, labored breathing, etc. prior to my next clinical. Sometimes there are things that I forget what they mean and it could potentially be the right choice. I'll continue to chart in the patient's room, so if I forget something I can check it right away at every clinical. **This week was definitely not your typical clinical week. Your patient was off the unit for a good part of both days; however, I think it was a good learning experience for you to see different departments of the hospital in addition to gaining an understanding of the patient perspective when being moved to surgery or dialysis. I hope you were able to learn despite your patient being occupied most of the week. As for medications, I thought you did a great job, especially with your safety checks when obtaining medications from the Pyxis. You did a great job with your IV fluids, demonstrating competence in preparing and initiating fluids. Keep up the hard work! NS**

Week 6- a) my strength was charting, on day two specifically. I learned from my mistakes, and I will carry that on in all future clinicals.

b) area of improvement was implementing fall risk. My patient ended up being independent. The miditech had her deemed high fall risk by protocol. I wanted to put the sign up and the physical therapist said she doesn't need the fall risk sign above her bed. In times like this I don't know what to do. I'm just trying to do I'm supposed to and implement what the safety and falls assessment in meditech wants. To improve I will review the john Hopkins fall score criteria before my clinical. And I will put the sign up anyway because it doesn't hurt anything when it comes to safety.

Student Name: Marilyn Miller		Course Objective:					
Date or Clinical Week: MSN week 4							
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)	3	All criteria met. RH
	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	
	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)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Good list of potential complications for your top nursing priority. RH
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	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	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	I like that you phrased the pain control as "acceptable pain level" because sometimes it is not possible to have a pain of 0/10 but to know that 2/10 is an acceptable level for the patient is a great goal. RH
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

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	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	All criteria met. RH
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	Complete			Not complete	3	

### 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:

Great care map for your patient this week. You included a variety of assessment findings and labs/imaging to support your top nursing priority. You had a detailed list of potential complications for the top nursing priority. Your interventions were tailored to your specific patient. Your interventions were thorough and prioritized appropriately. RH

**Total Points: 45/45**

**Faculty/Teaching Assistant Initials: RH**

Student Name:		Course Objective:					
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		

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		
<b>Reflecting</b>	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: <ul style="list-style-type: none"> <li>• Continue plan of care</li> <li>• Modify plan of care</li> <li>• Terminate plan of care</li> </ul>	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:**

Firelands Regional Medical Center School of Nursing  
**Medical Surgical Nursing 2024**  
**Skills Lab Competency Tool**

Student name: Marilyn Miller								
<b>Skills Lab Competency Evaluation</b>	<b>Lab Skills</b>							
	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 2</b>	<b>Week 2</b>	<b>Week 9</b>
	<b>Insulin</b> (2,3,5,7)*	<b>Assessment</b> (2,3,4,5,7)*	<b>IV Math Application</b> (3,7)*	<b>Lab Day</b> (1,2,3,4,5,6,7)*	<b>IV Skills</b> (2,3,5,7)*	<b>Trach</b> (1,2,3,4,5,6,7)*	<b>EBP</b> (3,7)*	<b>Lab Day</b> (1,2,3,4,5,6,7)*
Performance Codes: <b>S:</b> Satisfactory <b>U:</b> Unsatisfactory	<b>Date:</b> 1/7/25	<b>Date:</b> 1/7/25	<b>Date:</b> 1/8 or 1/9/25	<b>Date:</b> 1/8 or 1/9/25	<b>Date:</b> 1/10/25	<b>Date:</b> 1/15 or 1/16/25	<b>Date:</b> 1/15 or 1/16/25	<b>Date:</b> 3/10 or 3/11/25
Evaluation:	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	
Faculty/Teaching Assistant Initials	<b>MD</b>	<b>KA/RH</b>	<b>HS</b>	<b>NS</b>	<b>HS</b>	<b>DW</b>	<b>KA</b>	
<b>Remediation: Date/Evaluation/Initials</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	

\*Course Objectives

**Comments:**

**Week 1**

(Insulin)- You were able to correctly prepare an insulin pen and administer subcutaneous insulin. Insulin requirements were accurately identified and calculated through the corrective scale and carbohydrate coverage orders. MD

(Assessment)- You were able to satisfactorily demonstrate the Basic Head to Toe Assessment during lab. KA/RH

(IV Math)-You satisfactorily participated in the IV Math learning session on 1/7/25 as well as the assigned IV Math practice questions and the IV Math Application lab on 1/8/2025. KA/DW/HS/SA

(Lab Day)- You satisfactorily completed the mandatory lab review of nursing foundational skills. This was achieved through simulating care for a patient in a scenario requiring competency in assessment, communication, medication administration (including PO and IM injection), nasogastric tube insertion and removal, patient mobility and hygiene, use of PPE for Contact Isolation, wound care, foley insertion and removal, development of nursing notes, and providing SBAR hand-off report. NS/MD/RH

(IV Skills)- You have satisfactorily completed IV lab including a saline flush, IV push medication administration with reconstitution, priming and hanging a primary and secondary IV solution, adjusting a flow rate to run by gravity, discontinuing IV therapy, and monitoring the IV site for infiltration and signs of complications. HS

## Week 2

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. DW/RH/NS/SA

(EBP Lab)- You actively participated in the online searching process for evidence-based practice literature, as well as reviewing example articles to determine appropriate selection and information needed when summarizing a research article. KA/LK

Firelands Regional Medical Center School of Nursing  
 Medical Surgical Nursing 2024  
 Simulation Evaluations

<b><u>Simulation Evaluation</u></b>	<b>Student Name:</b>							
	<b>vSim- Vincent Brody</b> (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	<b>vSim- Juan Carlos</b> (Pharmacology) (*1, 2, 3, 4, 5, 6)	<b>vSim- Marilyn Hughes</b> (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	<b>Simulation #1</b> (Musculoskeletal & Resp) (*1, 2, 3, 4, 5, 6, 7)	<b>Simulation #2</b> (GI & Endocrine) (*1, 2, 3, 4, 5, 6, 7)	<b>vSim- Stan Checketts</b> (Medical-Surgical) (*1, 2, 3, 4, 5, 6)	<b>vSim- Harry Hadley</b> (Pharmacology) (*1, 2, 3, 4, 5, 6)	<b>vSim- Yoa Li</b> (Pharmacology) (*1, 2, 3, 4, 5, 6)
Performance Codes:  S: Satisfactory  U: Unsatisfactory	<b>Date:</b> 1/27/25	<b>Date:</b> 2/10/25	<b>Date:</b> 2/24/25	<b>Date:</b> 2/26 or 2/27/25	<b>Date:</b> 4/9 or 4/10/25	<b>Date:</b> 4/14/25	<b>Date:</b> 4/24/25	<b>Date:</b> 4/25/25
Evaluation	S							
Faculty/Teaching Assistant Initials	KA							
<b>Remediation:</b> Date/Evaluation/Initials	NA							

\* Course Objectives

**Comments:**

**EVALUATION OF CLINICAL PERFORMANCE TOOL**  
**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 and Date:

11/21/24