

EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Seth Linder

Final Grade: Satisfactory

Semester: Spring

Date of Completion: 4/25/2025

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: Stacia Atkins, BSN, RN

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)
2/22/2025	1 hour	Submitted IC Scav. Hunt in wrong format	2/23/25, 1 hour
4/25/2025	1 hour	Incomplete vSim Yoa Li	4/25/2025, 1 hr

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

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
2/10/2025	Impaired Mobility	S/HS	NA	NA
2/17/2025	Ineffective Peripheral Tissue Perfusion	S/NS	NA	NA

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
Competencies:			N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
g. Assess developmental stages of assigned patients. (Interpreting)			N/A	S	S	S	N/A	N/A	S	S	S	S	S		N/A	N/A	S
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	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		No Clinical	5T, 50 M Guillain Barre Syndrome	3T 68 M Extremity Injury/Pain Lower 3T 58 F	4N, 60 M Red and blackened right	Digestive Health 2/19 Infection Control 2/20	N/A		3T 82 M COPD exacerbation and pneumonia	5T 84 F Left ankle fracture	3T 81 F Weakness, failure to	Erie County Senior Center				
Instructors Initials	SA		DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

**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 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, b, c, d, e)-Great job this week! This week you did a great job discussing your patient's pathophysiology of their illness. You were also able to review the diagnostics and discuss how they correlated with the patient's diagnosis. You were able to discuss the importance of the medications that your patient was taking and how they impacted the plan of care. HS

Week 6 1(a-h) – You did a great job this week demonstrating your clinical judgement by making correlations between the alterations in your patient's health and the nursing care required. You were able to discuss the pathophysiology involved with your patients' gangrenous toe and peripheral vascular disease. You were able to correlate risk factors such as smoking, diabetes, and hypertension related to atherosclerosis. Signs and symptoms were correlated, such as the non-healing necrotic tissue to the great toe, absent pulses on palpation (weak with doppler), redness, pain, and paresthesia. You were able to provide insight regarding the medical management procedure and diagnostic testing that was performed (angiogram/angioplasty) to help treat the problem. You discussed important nursing measures to be performed post-operatively to prevent complications. You were able to provide education related to nutrition/smoking cessation. Overall, you did a great job researching your patient to better understand his condition and were well-prepared to discuss your patient's situation throughout the week. NS

Week 9 – 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. KA

Week 9 – 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 10 Rehab Clinical Objective 1 B-F: This week you were able to correlate the patient's symptoms, diagnostic tests, pharmacotherapy, treatment, and nutritional needs based on their reason for being on the Rehab floor and their past medical history. You were able to bring these needs to light in your satisfactory care map of this patient as well. Great job! MD

Week 11 - (1 a, b, c, d, e)-Great job this week! This week you did a great job discussing your patient's history of hypertension, atrial fibrillation, and elevation cholesterol, and the treatment plan that was involved based on that and the current health issues she was experiencing. You were able discuss how the bone marrow biopsy plays a role in her some of her symptoms she was currently experiencing as well. HS

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
Competencies:			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
d. Communicate physical assessment. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
	SA		DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

**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 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 (2a-f)- You did a nice job with your assessment as well as documenting it within the electronic medical record. You also did a nice job communicating your findings to the RN. You were also able to discuss your focused assessment and the reasoning behind your decision of focus. HS

Week 6 (2a,e) – Good job with your assessments this week, noticing numerous deviations from normal. You were able to note the weak pedal/post tib pulse with the use of the doppler on day one, then noticed the improvement in blood flow post-operatively with a palpable pedal/post tib pulse. You noted the necrotic tissue, redness, and

paresthesia to the effected extremity. On day two, you closely assessed the groin puncture site for signs of a hematoma, and prioritized your focused assessment on the effected extremity. Good job prioritizing and focusing your assessments on pertinent data. NS

Week 9 – 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 focused assessment needing to be completed for your patient related to their diagnosis and monitored abnormal assessment findings. KA

Week 9 – 2b – You completed your patient’s fall assessment and recognized the patient was a high fall risk. You ensured all measures for high fall risk were completed and documented appropriately in the EMR for your patient. KA

Week 9 – 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 10 Rehab Clinical Objective 2 A, D, & F: While you were on clinical you performed a satisfactory physical assessment, communicated abnormal assessments to myself and to the primary nurse, and you were able to satisfactorily document all information to Meditech documentation. MD

Week 11 (2a-f)- You did a nice job with your assessment as well as documenting it within the electronic medical record. You also did a nice job communicating your findings to the RN, and the team leader. You did an excellent job documenting your pain assessment on your patient, and including all of the details associated with her pain. HS

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
Competencies:	S		N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	S
a. Perform standard precautions. (Responding)	S		N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
b. Demonstrate nursing measures skillfully and safely. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
d. Appropriately prioritizes nursing care. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
e. Recognize the need for assistance. (Reflecting)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
f. Apply the principles of asepsis where indicated. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			N/A	N/A	N/A	S	N/A	N/A	S	N/A	N/A	N/A	N/A		N/A	N/A	S
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			N/A	S	S	S	N/A	N/A	S	S	N/A	S	N/A		N/A	N/A	S
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		N/A	S	S	S	S	N/A	S	S	S	S	N/A		N/A	N/A	S
j. Identify recommendations for change through team collaboration. (Reflecting)			N/A	S	S	S	N/A	N/A	S	S	S	S	S		N/A	N/A	S
	SA		DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

**Evaluate these competencies for the offsite clinicals:

DH: 3a

IC: 3a, f, i

ECSC: 3a, j

Comments:

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 c, d, e)- You were able to prioritize your care for the day and adjust when necessary based on changes that occurred during the day. You were available to help others when needed, and ask for assistance when needed. HS

Week 6 3(b,f,g) – You gained valuable experience with your first foley catheter insertion as a student nurse, awesome job! You were tasked with inserting a catheter on a male patient experiencing significant urinary retention. You successfully placed the catheter on your first attempt without complications. Throughout the procedure, aseptic technique was followed. You did well putting on your sterile gloves and maintaining sterility throughout. You were competent in your approach, demonstrated knowledge of the procedure, had a successful first experience! Kudos to you for jumping at the opportunity to learn. NS

Week 6 3(c,d) – Throughout the week you were prompt with your nursing care, ensuring all assessments and interventions were performed in a timely manner. You utilized your time wisely, prioritizing care when needed, researching your patient, and printing out educational materials. I was impressed with the initiative you took in providing patient education and the work ethic demonstrated. Well done! NS

Week 9 – 3b – You did a great job managing your patient O2 which was being administered via nasal canula. You made sure to complete a focused respiratory assessment and vital sign assessment to ensure for effectiveness of the therapy. You also worked with the nurse to titrate the patient's oxygen to ensure the pulse ox was maintained at the prescribed levels. You had the opportunity to utilize the hospital's wound dressing protocol to apply a dressing to your patient's new wound that was on their toe. You did a nice job cleaning the blood from the site and applying the specified dressing to the toe. You also changed the bandage on the patient's elbow and applied the appropriate dressing per the wound care protocol as well. You did a nice job monitoring your patient's male purewick and providing peri care throughout your shift. You documented the external catheter in the EMR appropriately in your assessment. Nice job! KA

Week 10 Rehab Clinical Objective 3 C & D: While caring for your patient you were able to identify all of the priority needs for your patient based on their condition and report you received from the night shift nurse. You were able to communicate your priority assessments for the day and what interventions needed to be completed during your shift. Great job! MD

Week 11 (3 c, d, e)- You were able to prioritize your care for the day and adjust when necessary based on changes that occurred during the day. On the second day you had to rearrange your plan of care based on starting the day off with your patient getting a bone marrow biopsy at the beginning of the shift. You also had to administer medications and had to alter the plan as two different physicians came in the room to speak with the patient and the family members. HS

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
Competencies:			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
m. Calculate medication doses accurately. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			N/A	N/A	N/A	N/A	N/A	N/A	NA	S	N/A	N/A	N/A		N/A	N/A	S
o. Regulate IV flow rate. (Responding)	S		N/A	N/A	N/A	N/A	N/A	N/A	S	S	N/A	N/A	N/A		N/A	N/A	S
p. Flush saline lock. (Responding)			N/A	N/A	N/A	S	N/A	N/A	S	S	N/A	N/A	N/A		N/A	N/A	S
q. Monitor and/or discontinue an IV. (Noticing/Responding)			N/A	N/A	S	S	N/A	N/A	S	S	N/A	S	N/A		N/A	N/A	S
r. Perform FSBS with appropriate interventions. (Responding)	S		N/A	N/A	N/A	S	N/A	N/A	S	S	N/A	N/A	N/A		N/A	N/A	S
	SA		DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

**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 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. RH

Week 5 (3k, l, m, q,-) You did a nice job with medication administration this week! You were able to administer several PO medications. You followed the rights of medication administration and completed all checks prior to administering. You were able to research each medication and answer all questions related to the medications. HS

Week 6 3(k,l,m,p,q,r) – You did very well with medication administration this week. The rights of medication administration were observed, and safety checks were appropriately performed. You gained experience administering several PO medications, using clinical judgement to hold the xerelto prior to a vascular procedure to reduce the risk of bleeding. Accurate dosage calculations were confirmed. Experience was gained performing a saline flush to confirm IV patency prior to his procedure, while monitoring for signs/symptoms of complications. Your patient was diabetic requiring ACHS FSBS and insulin administration. Accurate technique was demonstrated with obtaining a FSBS for accurate results. The corrective scale was utilized to determine correct insulin dosages. You were able to perform a subcutaneous injection using the insulin pen with accurate documentation. Overall a great week of medication administration and new learning experiences! NS

Week 9 – 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 PO, SQ, and IV medications this week. You performed the medication administration process with beginning dexterity. KA

Week 9 – 3n – You did a nice job priming your piggy back and connecting your patient to the medication. You performed all IV skills with beginning dexterity. You documented all medication administration and line care appropriately in the EMR. Nice job! KA

Week 9 – 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 9 – 3q – You did a nice job monitoring your patient's IV site this week and documenting your assessment in the EMR. Great job! KA

Week 9 – 3r – You demonstrated proper technique when completing FSBS on your patient. You documented all information correctly in the EMR. KA

Week 10 Rehab Clinical Objective 3 K-L: This week on Rehab you were able to identify the rights of medication administration appropriately and provided a comprehensive analysis of the medications you administered to your patient. Included in the analysis was the type of medication, side effects, and nursing implications for each medication. You were able to provide further information based on the medication you were administering that was included in the nursing implications you discussed. You also were able to identify safe practice for medication administration and performed them well. You also were able to use the BMV and document in the EHR appropriately. Awesome medication pass! MD

Week 11 (3k, l, m, q)- You did a nice job with medication administration this week! You were able to administer several oral medications. You followed the rights of medication administration and completed all checks prior to administering. You were able to research each medication and answer all questions related to the medications. HS

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
Competencies:			N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	S
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	S
b. Communicate professionally and collaboratively with members of the healthcare team using hand-off communication techniques. (SBAR) (Responding)			N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	S
c. Report promptly and accurately any change in the status of the patient. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	NI	N/A		N/A	N/A	S
d. Maintain confidentiality of patient health and medical information. (Responding)			N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	S
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			N/A	S	S	S	S	N/A	S	S	S	S	S		N/A	N/A	S
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
g. Provide a clear, organized hand-off report to your patient's next provider of care. (Responding)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
			DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

**Evaluate these competencies for the offsite clinicals:

DH: 4a, b, d

IC: 4b, d, e

ECSC: 4a, b, d, e

Comments:

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 (4a)- You were able to professionally communicate with your patient even though he was being challenging at times, you were able to prioritize and perform all of the necessary care. (4e)- Great job with your CDG this week! You were able to find an article that pertained to your patient and discussed the relevance. You successfully met all of the requirements on the rubric for your initial posting and the response to a peer. You answered all of the questions with a thorough explanation for each one. You also provided an in-text citation and a reference for the initial and peer response. Nice job! HS

Week 6 4(b) – You were able to gain experience collaborating with several members of the health care team this week. You had the opportunity to accompany your patient to the operating room for his procedure. During the procedure, you used professional communication to collaborate with the vascular surgeon and other members of the team to help enhance your knowledge and understanding of the patient's condition. Throughout the week your communication with your peers, team members, and faculty was consistently professional and inquisitive. Well done! NS

Week 6 4(e) – Great work with your CDG requirements this week! You answered all questions appropriately with good supporting details and utilized an appropriate, reputable resource to support the discussion. All criteria were met for a satisfactory evaluation. See my comments on your posts for further details. APA formatting looked spot on, well done! NS

Week 7 (4e)- According to the CDG Grading Rubric, you have earned an S for your participation in the Infection Control discussion this week. Your post was thoughtful and supported by evidence from the Davi's Diseases and Disorders resource. Also, good job with your APA formatting. I just have one suggestion. If you directly quote something from a resource, your in-text citation should include the page or paragraph number that you found it from. Additionally, the only time you use a paragraph number is when there are no page numbers in the resource. Here is an example of the correct formatting: (Sawyer-Sommers, 2023, para 2). DW

Week 9 – 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 9 – 4e – Seth, you did a nice job responding to all the CDG questions on your patient's SDOH risk factors and pertinent resources for them this week. You were thoughtful with your initial response to the questions as well as with the response to your peers. You included a reference and in-text citation in both posts. Remember to include the page number or paragraph number if there are no page numbers when you are in-text citing a direct quotation from your reference. Terrific job! Keep up the nice work! KA

Week 10 Rehab Clinical Objective 4 E: For clinical this week you provided a CDG that was satisfactory per the CDG rubric. In this CDG, you provided information on your team leading that was interesting and detailed regarding your experience. The reference and in-text citation you provided were satisfactory. Please see me if you have further questions! MD

Week 10 Rehab Clinical Objective 4 B & G: This week as Team Leader you were tasked to give a formal SBAR report to me at the end of the clinical week on Rehab. You did a great job giving me information on your patient you cared for! Some things to consider adding to your SBAR would include adding the admitting doctor, responses to treatment when discussing what was treated (BP in this instance), more detail on pain assessment, including diagnostics, diet, and wound care orders. You did a wonderful job overall! Keep up the great work! MD

Week 11 (4C)- Upon the review of documentation it was identified that your patient had a drop in their SpO2 on the second set of vital signs and that the provider was in the room at the time they were obtained. However, documentation did not show that any interventions were completed to address the SpO2 of 90%. After discussing this situation with the team leader, it was identified what interventions could be completed to attempt to increase the SpO2 and when that did not work notifying the RN and completing the necessary documentation to show the steps that were taken to address the situation. HS

(4e)- Nice job on your CDG this week! You successfully met all of the requirements on the rubric for your initial posting and the response to a peer. You answered all of the questions this week. You were able to discuss what you were concerned about based on your patient's diagnosis and the handoff report you received. You discussed your priority assessment and what interventions you implemented to prevent additional complications. Lastly, you discussed how you prioritized your care and how you advocated for your patient. You also provided an in-text citation and a reference for the initial and peer response. Nice job! HS

Week 12 (4e)-Nice job on your CDG this week! You were satisfactory for CDG posting this week, you provided both an in-text citation and a reference. You discussed the activity that you created for the senior center and how it met the needs of older adults. You also discussed some of the challenges that you noticed during your activity with some of the older adults related to declines in their functional abilities, and how you adapted to these issues during the activity. HS

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
Competencies:			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
a. Describe a teaching need of your patient.** (Reflecting)			N/A	S	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			N/A	S NI	S	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
			DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

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:

Week 4 (5a & b)- Education, I provided verbally, was about ambulating. The education was to wear the ankle weights provided by physical therapy to help with ambulating while using a walker. The reason for the ankle weights was to keep the patients' legs under their torso while trying to walk. This helped their balance as well as strengthening the muscles to regain the ability to walk. The patient validated the learning by using the ankle weights while attempting to walk with the walker. **What resource did you use for this education? I know you said physical therapy provided some, but what resource did they gather than information from? Please include what resource you used when answering 5b in the future. Since this was your first week, I will put "NI" but in the future it will be a "U".** RH

Week 5 (5a & b)- Education I provided to my patient was on wound care and how to properly change a dressing. I explained to the patient that proper hygiene and wound cleaning techniques prevent further infection and promote healing. I also explained what the signs of infection look like such as redness, pain, swelling, or pus, so they understand when it is time to seek medical attention. I utilized Lexicomp to provide the information to the patient. **Great job! HS**

Week 6 (5a & b)- Education that I provided to my patient this week was an overview of what an angiography is. I made sure to provide the patient with this literature before they had the procedure done, in case they had any questions. My goal was to alleviate any anxiety they might have had by having them understand was going to be done. I was able to locate this education information from Lexicomp. **Loved the fact that you identified the teaching need independently and had the resources printed and ready to go for him. This goes a long way in helping to reduce fears and anxiety for upcoming diagnostics or procedures. Just taking the time to explain the process and visually show what is going to occur helps the patient the feel informed and involved. Well done prioritizing this education this week! NS**

Week 9 (5a & b)- Education that I provided to my patient this week was an overview of COPD and hypertension. The patient has been diagnosed with both, and they actively cause the patient to struggle with activities of daily living. The education provided explanations of what the diseases are, causes, treatments, and when to call a doctor. I was able to locate this information from Lexicomp. **Terrific job! You did very well with him! KA**

Week 10 (5a & b)- Education that I provided to my patient this week was over care for their fracture and the open reduction external fixation (ORIF) surgery they had a week prior. The patient was still showing signs of edema on the affected extremity and was still at risk for further complications if they did not care for the limb appropriately. I was able to locate the information from Lexicomp. Great! MD

Week 11 (5a & b)- Education that I provided to my patient this week was about their risks from their recent diagnosis of thrombocytopenia. The patient was unaware that they had been diagnosed with thrombocytopenia. I also provided the patient with education on the bone marrow biopsy procedure they had received, and was interested in reading the information I provided from Lexicomp. Great job printing out the information for the husband on the bone marrow biopsy, especially since he was not there when the physician was in the room. HS

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)			N/A	N/A	U	S	N/A	N/A	S	S NA	N/A	N/A	N/A		N/A	N/A	S
b. Identify factors associated with Social Determinants of Health (SDOH) &/or cultural elements that have the potential to influence patient care.** (Noticing, Interpreting, Responding, Reflecting)			N/A	S	U	S	N/A	N/A	S	S	S	S	N/A		N/A	N/A	S
			DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

****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 4 (6b)- Factors associated with Social Determinants of Health that have the potential to influence patient care would be education as well as transportation. If the patient does not understand their diagnosis due to a lack of education, they may struggle understanding their needs and recognizing complications. If the patient is not able to drive due to their diagnosis of Guillain Barre, they may not be able to make it to their appointments and get the proper treatment they need to get better. **This could also lead to having a poor support system. If the patient is unable to drive to and from appointments, they will be relying on someone to take them places. If the patient's support system is small, this could lead to more issues. RH**

Week 5 (6b)- Factors associated with Social Determinants of Health that have the potential to influence patient care would be living situation and financial strain. The patient is homeless and with limited access to stable housing, it makes wound care, hygiene, and infection prevention more difficult. With a financial strain the patient may struggle to afford medications and supplies to keep up with the proper care they need. **Seth, that is an excellent example of a SDOH but unfortunately you did not self-evaluate yourself and therefore it becomes a U.**

6a,b- 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. **HS**

Week 5 (6a)- I received a U because I forgot to self-rate. I will make sure this does not happen again by checking three times before I submit my clinical tool, that everything is done correctly. **Thank you, Seth! NS**

Week 5 (6b)- I received a U because I forgot to self-rate. I will make sure this does not happen again by checking three times before I submit my clinical tool, that everything is done correctly. **Thank you, Seth! NS**

6a- You satisfactorily completed your care map please refer to the rubric at the bottom of the tool. HS

Week 6 (6b)- Factors associated with Social Determinants of Health that could affect my patient this week would be employment as well as financial strain. The patient was suffering from blocked arteries which was causing the tissue on their toe to become necrotic. This was causing the patient to have trouble walking which can cause them to not be able to work. If the patient is unable to work due to their medical problems, it could cause a financial hardship on their family. **I know this was a primary concern of his, to be able to return to work by the following Monday. There are times where patients have medical procedures that can put them out of work for extended periods of time, which certainly could impact their health outcomes if financial strain occurs. Good thoughts in discussing how this could impact your patient! NS**

Week 6 (a) – Satisfactory completion of a care map for the priority nursing problem of ineffective peripheral tissue perfusion. See the attached grading rubric. NS

Week 9 (6b)- Factors associated with Social Determinants of Health that could affect my patient this week would be physical mobility and substance abuse. The patient states that they rarely get up to walk because they physically cannot get up on their own. I also saw in the patient's chart that they have a history of smoking and still currently smoke cigarettes. Both SDOH put them at risk of further complications with their current diagnoses of COPD and hypertension. **Great job discussing his SDOH risk factors in your CDG this week! KA**

Week 9 – 6a – You did not complete a care map on this patient this week. KA

Week 10 (6b)- A factor that could, potentially, be associated with Social Determinants of Health would be physical activity. The patient is 84 years old and reported that they usually had moderate exercise two days a week prior to their surgery on their left leg, which is already below the recommended amount. After the surgery, the patient had a hard time ambulating on their own and this could put them at risk of impaired healing from not getting up and moving. This could also make it hard for the patient to carry out their normal activities of daily living. **Great job identifying SDOH! What kinds of resources could you offer her on discharge? MD**

Week 11 (6b)- Factors associated with Social Determinants of Health that could affect my patient would be economic stability and education/health literacy. The patient may not be able to afford healthy food or medications that would help to improve their condition. The patient is morbidly obese and has an extensive history of health concerns. The patient also may not understand how serious their current condition is and may need education on how to properly care for themselves. **I would agree, economic stability could be a concern especially since they were discussing the next steps for her once she is discharged from the hospital and if she would be accepted to inpatient rehab or need to go to another facility. HS**

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		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
h. Actively engage in self-reflection. (Reflecting)	S		N/A	S	S	S	S	N/A	S	S	S	S		N/A	N/A		S
	SA		DW	RH	HS	NS	DW	SA	SA	KA	MD	HS	HS		SA	SA	SA

**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:

Week 1 (7a)- An area of strength in this week was demonstrating evidence of growth. During the head-to-toe check off this semester I felt confident in performing a thorough assessment, as compared to last semester, I had a lot less confidence. With repetition and continued practice I feel more comfortable with my nursing skills. SA

Week 1 (7b)- An area I could improve on is my time management. I felt overloaded with information during the first few weeks of the course and had a hard time on deciding which tasks to complete first. I will practice in the weeks to come with organizing my schedule and putting more time aside to focus on school work. **Great plan! SA**

Week 4 (7a)- An area of strength this week was that I was able to make my patient feel comfortable. When I first met my patient, they were quiet and did not seem to want to talk. By the end of the second day my patient had opened up to me, talking about their life. I was able to get to know my patient which also helped me give them the best care possible. **You could tell you were in the room more with your patient on the second day. I am glad you were able to get to know them better. RH**

Week 4 (7b)- An area I could improve on is being more efficient with my patient care. I felt that I was constantly bothering them with tasks I needed to complete, which would eventually make them tired. I will improve each week by getting more practice in upcoming clinical as well as practicing my skills at home to be more efficient in completing my tasks. **Learning to cluster care takes practice, but this is a good goal to have. RH**

Week 5 (7a)- An area of strength this week was teaching and patient education. With the patient's history and current situation, they are at risk of being readmitted to the hospital and with some education on things such as wound care and infection prevention, they can hopefully take better care of themselves. This will help to prevent further complications. **Nice job! Educating is a huge part of our role as healthcare providers. HS**

Week 5 (7b)- An area I could improve on is helping others while I have down time. I use too much time researching my patient, while I could help answer call lights instead. To try to improve on this I will try to answer at least three call lights that are not from my specific patient on my upcoming clinicals. **This becomes a little tricky as a student. Be sure that you are able to complete all of your research however, if someone needs help or there is a call light you shouldn't walk past it. HS**

Week 6 (7a)- An area of strength this week was performing my nursing interventions in a timely manner. I have noticed myself becoming more comfortable in the clinical setting, which allows me to complete things that need done, faster. **Awesome! Always great when you can notice the improvements in yourself. From my standpoint, you have numerous positives throughout the week, I was impressed with your knowledge, work ethic, performance, and overall desire to learn. Your motivation and focus on self-improvement are evident. A very bright future ahead for you! NS**

Week 6 (7b)- An area I could improve on this week is asking questions. I feel like I don't ask enough questions because I don't want to bother people. I will try to improve this by being open about not knowing something and asking questions to help myself understand. My plan is to ask a few more questions during each clinical to better my understanding of topics. **An important competency of nurses is the spirit of inquiry. This is a persistent sense of curiosity that helps to improve learning and nursing practice. The more you ask the more you will learn. I thought you did well asking appropriate questions this week. Continue to do so and you will learn something new every day. Keep up the hard work! NS**

Week 7 (7a)- An area of strength this week was asking questions to help myself understand what was going on during the procedures. I made sure to not interrupt the staff during the procedure, and asked the questions at appropriate times. **Excellent! DW**

Week 7 (7b)- An area I could improve on this week would be to talk to the patient more, to make them comfortable. I did not want to interrupt the staff by talking, but I felt at times the patient was wondering what I was doing. I will improve on this by making sure I always introduce myself to the staff and patients that are present, as well as stating my reason for being there. **Good thinking, Seth! No matter what your role is in a clinical setting, it is always important to develop a rapport with the patient and loved ones. DW**

Week 7 (7f)- Unfortunately, you received a U for this competency due to submission of the scavenger hunt in written format. There was an oversight in the directions that required submission in typed format. This resulted in 1 hour of missed clinical time, which was made up following completion of the typed form on 2/23/25. Please be sure to address this U in the comments below, when completing your week 8 tool. Failure to do so will result in a continued U. **DW**

Week 7 (7f)- I received a U for this competency because I did not pay attention to detail and read directions. I will make sure this does not happen again by diligently reading all the instructions before submitting any assignments. **SA**

Midterm Comment – Seth, great job throughout the first half of the medical-surgical nursing semester. It appears that you have had the opportunity to perform numerous skills, enhance your clinical judgement, provide patient care, and reflect on your experiences. You are satisfactory in all competencies at this point of the semester, awesome work! Continue to seek out opportunities for the competencies presented in objective 3 related to medication administration, specifically IV therapy, regulating an IV flow rate, and flushing an IV. Also, be sure to notify faculty regarding limited experience with caring for a patient with a foley catheter so that they can seek out opportunities for you. Be sure to seek out opportunities for fingerstick glucose checks as well. The more experience you can get the better! You have satisfactorily completed both of the required care maps for the semester. Continue to work hard as we enter the second half of the semester, you are doing a great job! SA

Week 9 (7a)- An area of strength this week was administering a subcutaneous injection, safely and accurately, under supervision. The patient stated that they did not even feel it. **Wonderful job! KA**

Week 9 (7b)- An area I could improve this week during clinical would be to improve familiarity with medications. The patients spouse asked what the reason was for administering Lovenox, and I was unable to tell them without asking the instructor. I will familiarize myself with medications by reviewing further at home after clinical. This will allow me to have more repetitions with learning medications. **You looked up and knew your meds and was able to identify this with me when we discussed the medications. Maybe it would help to practice patient teaching related to the medications and using layman's term. In time you will get better at answer questions when put on the spot. Overall nice job though. KA**

Week 10 (7a)- An area of strength this week was collaborating with other departments of the hospital. I was with the patient during their physical therapy session and helped as much as I could. I was attentive and open to helping with anything to make the therapists job easier, so they could help the patient as much as possible. **Awesome! It is great to collaborate with everyone! MD**

Week 10 (7b)- An area I could improve on this week would be organizing my notes. I get in a hurry and write things on any paper I have available which spreads out the information. This makes it hard to comprehend later, when I do not remember exactly which information was for what day or section. I will practice doing better by either taking the time to group the information or label the information. **Great goal! MD**

Week 11 (7a)- An area of strength this week was documenting accurately. I felt that I was very thorough with my assessment and paid close attention to accurate documentation of the assessment. **Nice job! HS**

Week 11 (7b)- An area of improvement this week would be giving a handoff report. I feel that I could be more detailed in the information that I give, instead of highlighting just the most important findings. There are many details that need to be included, to give the other nurse all the information they need, to give the patient proper care. I will practice by filling out an SBAR report every day that I am on clinical and including more detail during handoff report. **Great plan! Each experience will help you become more thorough in the report process. HS**

Week 12 (7a)- An area of strength this week was communicating and helping the seniors with their activity. They planted flowers and filled out a guessing game based on pictures of flowers. I helped the seniors with planting as well as making sure they were able to see the flower pictures so each of them had a fair chance at guessing. **Great job! HS**

Week 12 (7b)- An area of improvement this week would be to try and let the seniors have more independence with doing the flower planting. I was worried the seeds were too small for them to handle, so we put the seeds in the pots for them. Next time I would put the seeds in separate baggies to help promote independence and let them do it themselves. **HS**

Final Comment – Seth, congratulations on completing the clinical, lab, and simulation portion of the MSN course with a satisfactory evaluation! All of your hard work and dedication has paid off as you have reached the end of a challenging semester. You were able to take the knowledge learned in Nursing Foundations and grew in your nursing role. You enhanced your skills and clinical judgement throughout the semester as you learned about the various disease processes for a medical-surgical patient. You have met expectations for successful completion of the Medical-Surgical Nursing (MSN) clinical requirements. It was a pleasure to work with you throughout the semester, both in the clinical and classroom setting. You consistently came to clinical, simulation, and lab prepared to learn, used good clinical judgement, and grew throughout the semester. I look forward to watching you continue your journey as you officially become a senior and enter the psychiatric nursing course. Keep up the hard work, and keep focusing on your goals!! **SA**

Student Name: Seth Linder				Course 6			
Date or Clinical Week: Week 5				Objective:			
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	You provided a thorough list of abnormal assessment findings, lab findings and risk factors. HS
	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	You provided a nice list of nursing priorities and selected the appropriate priority problem. You identified an appropriate goal specific to the patient. You were able to highlight all of the related data to support your priority problem. Nice job identifying potential problems and the signs and symptoms to monitor the patient for. HS
	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	You provided a list of nursing interventions that were prioritized, included a frequency and individualized to the patient with a rationale for each one. HS
	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	Great job reassessing all of the abnormal assessment findings. HS
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	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:

Seth,

Great job on your nursing care map! You did a nice job identifying all of the abnormal assessment findings which led you to the priority problem for the patient. You were able to determine appropriate interventions specific to the patient to implement the plan of care. You then successfully re-evaluated the abnormal assessment findings to determine the plan of care should be continued. Great job! HS

Total Points:45/45

Faculty/Teaching Assistant Initials: HS

Student Name: Seth Linder				Course Objective: 6			
Date or Clinical Week: Week 6							
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	Twelve abnormal assessment findings were identified based on the care provided during the clinical week. Five abnormal diagnostics were provided. Consider including his abnormal blood glucose levels in this section. Otherwise, all other abnormal diagnostics were listed. A list of 9 risk factors were identified, based on the patient's current and past medical history.
	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	A thorough list of nursing priorities were identified based on the care provided. It was appropriately determined that ineffective peripheral tissue perfusion is the top priority problem. Based on this problem, a specific goal statement was provided. After determining the priority problem, appropriate data from the noticing section was highlighted in support of the ineffective peripheral tissue perfusion. Three potential complications were listed, each relevant to the priority problem, including specific signs/symptoms to monitor for each.
	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	A list of 14 nursing interventions were provided specific to the priority problem. Interventions are prioritized appropriately with assessments taking highest priority. Each listed intervention includes a frequency to be performed. Interventions listed are realistic to the patient situation, with specific medication prescriptions included. Appropriate rationale is provided for each.
	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
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	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	A table of the most recent assessment findings was included, with updates post-operatively demonstrating improvement. Based on the re-assessments, it was appropriately determined to continue the plan of care until the goals have been met.
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	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: Seth, you did a great job demonstrating your clinical judgement in making correlations between the priority problem of ineffective peripheral tissues perfusion and the nursing care required. It seems as if you have a good understanding of your patient's situation. You are satisfactory with your second care map submission of the semester, well done! Keep up the hard work! NS

Total Points: 45/45 – Satisfactory

Faculty/Teaching Assistant Initials: NS

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

Student name: Seth Linder								
Skills Lab Competency Evaluation Performance Codes: S: Satisfactory U: Unsatisfactory	Lab Skills							
	Week 1	Week 1	Week 1	Week 1	Week 1	Week 2	Week 2	Week 9
	Insulin (2,3,5,7)*	Assessment (2,3,4,5,7)*	IV Math Application (3,7)*	Lab Day (1,2,3,4,5,6,7)*	IV Skills (2,3,5,7)*	Trach (1,2,3,4,5,6,7)*	EBP (3,7)*	Lab Day (1,2,3,4,5,6,7)*
	Date: 1/7/25	Date: 1/7/25	Date: 1/8 or 1/9/25	Date: 1/8 or 1/9/25	Date: 1/10/25	Date: 1/15 or 1/16/25	Date: 1/15 or 1/16/25	Date: 3/10/25
	Evaluation:	S	S	S	S	S	S	S
Faculty/Teaching Assistant Initials	SA	SA	SA	SA	SA	SA	SA	KA
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA

*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 1/8/25. 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. SA

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

Week 9

(Lab Day- Skills Review)- You satisfactorily participated in lab by practicing NG skills and IV pump. KA

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

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

* Course Objectives

Comments:

Juan Carlos vSim – All necessary requirements for the vSim scenario were completed appropriately. NS

Simulation #1

Please review the comments placed on the simulation scoring sheet below. In addition, review the individual faculty feedback placed within the Simulation #2 Prebrief and Reflection Journal dropboxes. SA

Simulation #2

Please review the comments placed on the simulation scoring sheet below. In addition, review the individual faculty feedback placed within the Simulation #2 Prebrief and Reflection Journal dropboxes. SA

Yoa Li vSim – I received a U because I did not turn the assignment in on time. I will be sure to be more organized and check assignment due dates. I will try to set reminders to make sure I complete assignments before the due date.

Simulation #1

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse

STUDENT NAME(S) AND ROLE(S): Linder (M) Palagyi (A)

GROUP #: 2

SCENARIO: MSN Scenario #1 – Musculoskeletal/Respiratory

OBSERVATION DATE/TIME(S): 2/26/25 0800-1000

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (2) * • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	Obtain vital signs (BP, oxygen, respirations, pulse, temp). notices abnormal vitals (tachy and oxygen saturation) Full pain assessment. Numerical rating, radiation, location, asks about numbness/tingling. Noticed redness on lower extremity. Noticed normal capillary refill Does cardiovascular assessment and pulses in bilateral feet. Noticed leg was warm to touch. Notice edema in feet (+1). Notice normal capillary refill Does respiratory assessment when patient complains of SOB. Notices crackles. Notices lack of mobility due to surgery and pain. Reassess pain after medication administration to ensure it is improved. Rating, description, location, radiation. Reassess pedal pulses. Reassess vital signs. Notice lack of SCD use/SCD refusal. Notice refusal of PT/OT and ambulation.
INTERPRETING: (1) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritized pain assessment and respiratory assessment on patient. prioritized cardiovascular assessment (check pulses) Prioritized calling healthcare provider with abnormal assessment findings to get new orders. Prioritize oxygen therapy Prioritize IM pain medication rather than PO Make sense of morphine dosage calculation and enoxaparin dosage

	calculation. Made sense of post-operative complications. Educated patient on complications. Prioritized new healthcare provider orders (pain medications and blood thinner). Attempt to interpret ABG. Identify it as metabolic alkalosis but is really respiratory alkalosis. Make sense that refusal of SCDs was a cause of DVT/PE
RESPONDING: (2,3,4,5,6) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Introduce self when entering room. Roles clearly defined. Put head of bed up when patient complains of SOB. Call healthcare provider related to assessment findings. SBAR utilized, does not include background until prompted. Some details generalized (states HR is not normal but does not specify actual findings). Receives new orders from healthcare provider. Readback orders to provider for verification but does not include route of medication administration. Make sure to always read back the entire order when taking verbal orders. Educated patient on plan of care and what is going to happen with new orders Start to educate on why patient is having difficulty breathing but does not elaborate when patient states she doesn't understand why she is feeling short of breath Morphine and enoxaparin administration: verify name/DOB, verify allergies, scan patient, scan medications. Morphine and enoxaparin medication calculation correct. Use of correct needle size for both injections. Use of witness for waste of morphine. Be sure to waste prior to putting needle on so you are not walking around with an open needle. Use of needle safety. Education provided on medications administered. Explain that enoxaparin is for prevention of blood clots. Further education provided on how it is impacting patient's current shortness of breath. Provides examples as to why it could be happening (lack of movement, history of a fib, history of smoking, high blood pressure). Education provided to patient about risk factors that caused embolism. Encourage movement, encourage cough/deep breathe to open lungs, medications that were administered to assist (blood

	thinner) Call healthcare provider with abnormal results from previous orders. SBAR much more organized this time. Educate patient on PE and DVT results. Educate on treatment plan and how to prevent from the PE/DVT getting worse. Educate on importance on PT/OT compliance and ambulation. Educate on incentive spirometer.
REFLECTING: (7) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Group led discussion regarding the patient scenario. Students began with description of patient and what initial priority assessment would be as well as how priority assessment changed upon starting assessment on patient (group 1 focus was pain and 6Ps, second group was non-surgical leg circulation and respiratory/cardiovascular). Discussion about risk factors for developing DVT/PE and what education was provided to patient regarding this (lack of movement, refuse SCD, non-compliant with therapy). Discussion about compartment syndrome and what interventions were necessary when compartment syndrome was identified (pillow/elevation/ice). Discussion regarding ABG interpretation and how came to that conclusion. Each member of group stated strength and area of improvement for simulation. Group also discussed use of proper pronouns for patient and how report with nurse was inappropriate and unprofessional. Options to handle the situation included reporting it to the charge nurse or director in order for that nurse to not have that patient assignment again.
SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: 1. Select focused physical assessment priorities based on individual patient needs. (2)* 2. Implement appropriate nursing interventions based on patient’s assessment. (1,3,6)* 3. Communicate appropriately with the patient, family, team members, and healthcare providers incorporating elements of clinical judgment and	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Focuses on the most relevant and important data useful for explaining the patient’s condition. In simple, common, or familiar situations, is able to compare the patient’s data patterns with those known and to develop or explain intervention plans; has difficulty, however, with even moderately difficult data or situations that are within the expectations of students; inappropriately requires advice or assistance. Responding: Generally displays leadership and confidence and is able to

conflict resolution. (4,7)* 4. Provide patient-centered care with consideration to cultural, ethnic, and social diversity. (2,3,6)* 5. Provide appropriate patient education based on diagnosis. (5)* * Course Objectives	control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.
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Simulation #2

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse

STUDENT NAME(S) AND ROLE(S): Seth Linder (A) Jessica Bower (M)

GROUP #: Part 1

SCENARIO: MSN Scenario #2 – GI/Endocrine

OBSERVATION DATE/TIME(S): 4/10/25 0800-1000

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES				
NOTICING: (2) * - Focused Observation: E A D B - Recognizing Deviations from Expected Patterns: E A D B - Information Seeking: E A D B	<u>Focused Observation</u> Focused assessment on vital signs. Full set of vitals obtained. Focused assessment on pain. Full pain assessment performed. Focused assessment on GI system. Looked, listened, palpated. Focused assessment on peripheral perfusion. Focused assessment of coffee-ground emesis. Did not focus on patient's perspective related to past medical history or overuse of aspirin. <u>Recognizing Deviations</u> Noticed patient pain. Noticed patient nausea. Noticed coffee-ground emesis. Noticed abdominal tenderness. Noticed hypotension and tachycardia after coffee-ground emesis. Noticed past medical history (PUD, smoker, GERD). Noticed melena stool in the bedpan. Noticed hyperactive bowel sounds. <u>Information Seeking</u> Confirmed patient allergies, name and DOB prior to medication administration. Sought additional information related to patients' pain and nausea. Asked about pain with bowel movement. Did not seek additional information related to symptoms of hypotension (dizziness, lightheaded, etc.). Did not seek information related to overuse of aspirin.				
INTERPRETING: (1) * - Prioritizing Data: E A D B - Making Sense of Data: E A D B	<u>Prioritizing Data</u> Prioritized vital sign assessment when entering the room. Prioritized pain assessment. Prioritized focused GI assessment. Prioritized re-assessment of vital signs after emesis. Prioritized notifying the HCP with change in vital signs after emesis. Prioritized medications for pain and nausea. Medication nurse prioritized fluid administration while assessment nurse prioritized NG tube. <u>Making Sense of Data</u>				

					Made sense of coffee-ground emesis related to GI bleed. Made sense of circulatory compromise related to GI bleed (hypotension, tachycardia). Made sense of need for fluid replacement promptly. Made sense of NG to LIWS. Made sense of side effects related to morphine/promethazine and impact on vital signs.
RESPONDING: (2,3,4,5,6) * • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B					<u>Calm, confident manner</u> Roles clearly defined. Good teamwork to confirm medication dosages. Strong teamwork to initiate interventions to be performed. Confidently communicated with the patient throughout the scenario. Handled conflict with the HCP professionally. Remained calm despite conflict. Nerves impacted performance in some instances (altered thought process). However, did not show nerves/anxiety to the patient. <u>Clear communication</u> Contacted HCP with new patient symptoms. Good assessment details provided. Give specific vital signs instead of saying “decreased” or “increased”. Provider conflict did not give time to read back orders. Consider calling back to confirm. Good communication with the patient updating on plan of care and interventions to be performed. Communicated findings with the provider after interventions performed. Contacted GI for consult. SBAR provided. Recommended EGD. Remember to give past medical history with SBAR. Strong communication among team members. Empathized with the patient situation and provided comfort. <u>Well-planned intervention</u> Emesis basin provided. Head of bed elevated. Re-assessed vitals after emesis. Maintained NPO status. Pertinent assessments performed in a timely manner. Stool for occult blood obtained. NG tube inserted promptly. Fluids initiated promptly. Re-assessed vital signs after interventions. Re-assessed pain after interventions performed. <u>Being Skillful</u> Good job with medication vial. Pay close attention to eMAR. Promethazine ordered IM, given IVP (discussed in debriefing). IV site confirmed patency with saline flush. Remember to flush in between medications. IV site patency confirmed prior to fluid administration with a saline flush using aseptic technique. IV tubing primed effectively. Good job working to get rid of air bubbles. Good job programming the IV pump.

	NG tube measured accurately from tip of the nose, to the ear, to xiphoid process. Provided reassurance to the patient during NG insertion. NG tube inserted to mark on the tube. Secured with tape. Confirmed placement with gastric aspirate. Xray confirmed placement. Connected to LIWS. Remember to secure to the gown to prevent dislodgement. Discussed proper labeling of the specimen for occult blood.
REFLECTING: (7) * - Evaluation/Self-Analysis: E A D B - Commitment to Improvement: E A D B	Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.
SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: - Identify priority nursing interventions from a list of physician’s orders. (1, 3, 6)* - Communicate professionally with the healthcare team utilizing SBAR communication. (4)* - Demonstrates ability to resolve conflict when interacting with healthcare team members with respect and civility. (4,7)* - Prioritize and implement appropriate nursing interventions based on nursing assessment findings. (1,3,6)* - Provide patient-centered care with consideration to cultural, ethnic, and social diversity. (2, 3, 6)* * Course Objectives	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Focuses on the most relevant and important data useful for explaining the patient’s condition. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient’s data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. Satisfactory Completion of MSN Scenario #2

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:

Seth Linder 4/25/2025

11/21/24