EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Taleigh Cook

Final Grade: Satisfactory/Unsatisfactory

Semester: Fall

Date of Completion:

Faculty: **Frances Brennan**, MSN, RN; **Amy Rockwell**, MSN, RN;
Chandra Barnes, MSN, RN; **Nick Simonovich,** MSN, RN
Heather Schwerer, MSN, RN; **Brittany Lombardi,** MSN, RN, CNE

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 Checklists
Care Map Grading Rubric
Administration of Medications
Simulation Scenarios
Skills Demonstration
Evaluation of Clinical Performance Tool
Clinical Discussion Group Grading Rubric
Lasater Clinical Judgment Rubric
Faculty Feedback
Documentation
Clinical Reflection

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)

Faculty/Teaching Assistant's Name	Initials
Chandra Barnes	CB
Frances Brennan	FB
Amy Rockwell	AR
Nicholas Simonovich	NS
Heather Schwerer	HS
Brittany Lombardi	BL

Stacia Atkins	SA

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U", the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

***Grey shaded weekly competency boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Objective																
1. Describe how diverse cultural, ethnic, and social backgrounds function as sources of patient, family, and community values. (2,4,6)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Identify spiritual needs of patient (Noticing).									NA	S	NA	S	NA	S		
b. Identify cultural factors that influence healthcare (Noticing).									NA	S	NA	S	NA	S		
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).							NA	S	S	S	NA	S	NA	S		
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).							NA	S	S	S	NA	S	NA	S		
Faculty/TA Initials		NS					CB	BL	BL	HS	HS	HS	HS			
Clinical Location; Patient age**		Meditech Orientation					NA	3Tower Age-79		3Tower Age-76	NA	3Tower Ages-72 , 83	NA	3Tower Age-94		

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

****Document your clinical location and patient age in the designated box above.**

Comments:
Week 8-1(c,d) Great job this week showing respect for your patient's individual preferences, values, and needs while providing care. In your CDG, you did a nice job identifying your patient's abnormal assessment findings and priority concerns. This demonstrates the early development of clinical judgment, which is essential for safe and effective nursing practice. BL

Week 9(1a,c,d) You spent a lot of time listening and talking with your patient. You were able to incorporate her preferences and needs into the plan of care. You allowed her to have a say in the way that the care was provided while also educating her on why you were doing things. HS

Week 11 (1c, d) Great job showing respect for your patient's needs, while also being kind and compassionate. You also demonstrated the appropriate use of Maslow's hierarchy of needs during the head to toe assessment performed on your patient during this clinical experience, you were able to recognize physiological needs of your patient when performing the head to toe assessment. HS

Objective

1. Summarize knowledge of anatomy, physiology, chemistry, nutrition, psychosocial and developmental principles in performance of basic physical assessment through use of clinical judgment skills. (3,4, 5)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies: a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).							NA	**S**	S	S	NA	S	NA	S		
b. Use correct technique for vital sign measurement (Responding).							NA	**S**	S	S	NA	S	NA	S		
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).									NA	S	NA	S	NA	S		
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).									NA	S	NA	S	NA	S		
e. Collect the nutritional data of assigned patient (Noticing).									NA	S	NA	S	NA	S		
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).									NA	NA	NA	NA	NA	N/A		
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).									NA	~~U~~ NI	NA	S	NA	S		
Faculty/TA Initials		NS					CB	BL	BL	HS	HS	HS	HS			

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Comments:

Week 8- 2(a,b) Great job this week using correct techniques for measuring vital signs and completing a systematic head to toe assessment on your assigned patient. Your assessment was thorough and completed in a timely manner. BL

Week 9-I didn't feel that I was able to adequately define the rationale for why my patient reported only having pain with pressure as well as the reasoning for the diagnostic tests she had done when I was asked by the patient. I couldn't really explain what they were looking for or what the purpose of either test was. I am changing this to an NI, as you are learning, and the provider wasn't completely sure what the patient's issue was and that is why there was ongoing testing. They were attempting to find out what was causing the numbness/tingling, and pain she was experiencing in her neck/face. As you mentioned in your CDG post they were thinking she may have had a pinched nerve. Her original testing was done to rule out a stroke. There are many times when you may not know the answer to the question the patient is asking, it is important to ask someone else so that they can answer the patient's question. HS

Week 9 (2a,c,d)- You did a great job performing appropriate assessments. You provided pertinent information from assessments, labs to determine a priority problem for your assigned patient. Associated interventions were implemented that were relevant to the priority problem based off of information gathered. HS

Week 11 (2a-d) You did a great job with your assessment this week. Your patient on the second day had a lot of abnormal assessment findings, and you were able to identify them and document them within the EMR. He was especially challenging with his neuro assessment. You did a nice job completing his fall/safety and skin assessment and implementing the appropriate interventions for the plan of care based on your findings. HS

Objective

2. Select communication techniques and appropriate boundaries with patients, families, and health care team members. (1,2,3,4,6,7)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies: a. Receive report at beginning of shift from assigned nurse (Noticing).							NA	**S**	S	S	NA	S	NA	S		
b. Hand off (report) pertinent, current information to the next provider of care (Responding).									NA	S	NA	S	NA	S		
c. Use appropriate medical terminology in verbal and written communication (Responding).							NA	**S**	S	S	NA	S	NA	S		
d. Report promptly and accurately any change in the status of the patient (Responding).							NA	**S**	S	S	NA	S	NA	S		
e. Communicate effectively with patients and families (Responding).							NA	**S**	S	S	NA	S	NA	S		
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).							NA	**S**	S	S	NA	S	NA	S		
Faculty/TA Initials		NS					CB	BL	BL	HS	HS	HS	HS			

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Comments:

Week 8-3(e) Excellent job communicating with your patient during clinical this week. You also did a great job reflecting on and discussing your communication in your CDG as well. BL

Week 9 (3a-f) You were able to get a report from the night shift nurse and update the nurse prior to leaving at the end of the shift. You did a nice job communicating with your patient and the other members of the healthcare team during the shift. HS
Week 11 (3a-f) Great job receiving and providing pertinent information during shift report, and hand off report. Appropriate medical terminology was used during all communications provided. Good job communicating appropriately to the primary RN and other health care disciplines when necessary. You promptly informed the RN after obtaining the vital signs and noting the high blood pressure that required the nurse to provide intervention via IV medications on the first day. HS

Objective																
3. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Document vital signs and head to toe assessment according to policy (Responding).							NA	**S**	S	S	NA	S	NA	S		
b. Document the patient response to nursing care provided (Responding).							NA	**S**	S	S	NA	S	NA	S		
c. Access medical information of assigned patient in Electronic Medical Record (Responding).*		S					NA	**S**	S	S	NA	S	NA	S		
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).*		S							NA	S	NA	S	NA	S		
e. Provide basic patient education with accurate electronic documentation (Responding).									NA	S	NA	S	NA	S		
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).							NA	**S**	S	S	NA	S	NA	S		
*Week 2 –Meditech Orientation **Faculty/TA Initials**		NS					CB	BL	BL	HS	HS	HS	HS			

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Comments:

Week 2(4c,d): Satisfactory for listening attentively and actively participating in the Meditech orientation clinical. You showed beginning competence in the ability to access a patient's EHR, document care in an intervention, and locate patient data. You were able to access Lexicomp to locate patient education materials. Additionally, nursing policies and procedures were located on the health system intranet. Great job! NS/CB/BL

Week 8-4(a) Excellent job with your documentation this week in clinical. Your documentation for both your vital signs and head to toe assessment were thorough and accurate. 4(c) Great job in your CDG discussing the use of informatics and technology in the clinical setting. You provided a nice description of how you utilized the patient's vital signs data to look for trends and identify any changes. 4(f) Satisfactory completion of your CDG this week. Keep up all your hard work! BL

Week 9(4a,b,c) You did a nice job this week documenting all of the care and interventions you provided to your patient. HS
(4f)- Nice job on your initial CDG post and the peer response you met all of the rubric requirements and provided a thorough response to your peer. I would agree with pain as a priority problem for her. HS

Week 11 (4a,b,c)- You did a nice job documenting this week. You managed time well and successfully documented your vital signs and head to toe assessment in a timely manner. You were also able to utilize the Electronic Medical Record to obtain information regarding the patient's history and treatment plan. You had a different patient each day which made it more challenging when reviewing the chart to retrieve past medical history and test results.
(4f)- Nice job on your initial CDG post and the peer response you met all of the rubric requirements and provided a thorough response to your peer. For the priority problem impaired verbal communication would be an appropriate problem for him. HS

Objective																
4. Exemplify psychomotor skills and nursing care safely using evidence-based practice. (3,4,5,7,8)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).							NA	**S**	S	S	NA	S	NA	S		
b. Apply the principles of asepsis and standard/infection control precautions (Responding).							NA	**S**	S	S	NA	S	NA	S		
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).									NA	NA	NA	~~NA~~ S	NA	NA		
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).							NA	**S**	S	S	NA	S	NA	S		
e. Organize time providing patient care efficiently and safely (Responding).							NA	**S**	S	S	NA	S	NA	S		
f. Manages hygiene needs of assigned patient (Responding).									NA	S	NA	S	NA	S		

g. Demonstrate appropriate skill with wound care (Responding).									NA		NA	NA	NA	NA		
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).							NA	**S**	S							
Faculty/TA Initials		NS					**CB**	**BL**	**BL**	**HS**	**HS**	**HS**	**HS**			

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

****You must document the location of the pull station and extinguisher here for your first clinical experience.**

The Fire extinguisher was in-between Rm #3035 and Rm #3034, pull station was underneath and before the 3rd floor sign in the hall.

Great job! BL

Comments:

Week 9 (5 d,e,f)- You did a nice job going right in the patients room and getting your assessment completed. You were able to assist the patient with the meal tray and hygiene care. You planned your time efficiently in order to complete all tasks. You did all of these tasks in a timely manner and maintained safety and encouraged independence from the patient. HS

Week 11 (5 d,e,f) You did a nice job completing the necessary interventions and care for your patient each day. The patient on the second day had a lot going on and you were able to prioritize and organize the care effectively. You also did a nice job completing the hygiene care and performing the Foley care. You worked with another student so that you were able to safely complete the hygiene care since the patient was a two assist to turn. HS

Objective																
5. Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Utilize clinical judgment skills to develop a patient-centered plan of care (Responding).									NA	S	NA	S	NA	S		
Faculty/TA Initials		NS							BL	HS	HS	HS	HS			

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Comments:

Week 9 (6a) Excellent job utilizing your clinical judgment skills to care for your patient this week. You assured the plan of care fit your patient's needs and preferences. You will continue to grow these skills as you progress through the semester and program. HS

Week 11 (6a) Nice job using your clinical judgement skills and identifying the patient's abnormal assessment findings along with his priority problem in order to establish interventions that were appropriate for the plan of care specific to him. HS

Objective																
6. Convert basic pharmacology principles into safe medication administration. (3,5,6,7)*																
Clinical Experience	**Week 1**	**Week 2**	**Week 3**	**Week 4**	**Week 5**	**Week 6**	**Week 7**	**Week 8**	**Mid-Term**	**Week 9**	**Week 10**	**Week 11**	**Week 12**	**Week 13**	**Week 14 Make-Up**	**Final**
Competencies: a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).									NA				NA	S		
b. Recognize patient drug allergies (Interpreting).									NA				NA	S		
c. Practice the rights of medication administration and safety checks prior to medication administration (Responding).									NA				NA	S		
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).									NA				NA	S		
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).									NA				NA	S		
f. Assess the patient response to PRN medications (Responding).									NA				NA	S		
g. Demonstrate medication administration documentation appropriately using BMV (Responding).									NA			~~NA~~ S	NA	S		
*Week 11: BMV **Faculty/TA Initials**		NS							BL			HS	HS			

* End-of-Program Student Learning Outcomes
Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

Comments:
Week 11 (7g) - You are satisfactory for this competency by attending the Bedside Medication Verification (BMV) clinical orientation, actively listening, observing, and discussing accurate medication documentation and safe administration with the use of the BMV scanner. NS/CB/SA

Objective

2. Exemplify professional conduct through self-reflection, responsibility for learning, and goal setting. (1,5,7)*

Clinical Experience	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Mid-Term	Week 9	Week 10	Week 11	Week 12	Week 13	Week 14 Make-Up	Final
Competencies: **a. Reflect on areas of strength****(Reflecting)							U	~~S~~ U	U	S	NA	S	NA	S		
b. **Reflect on areas for self-growth with a plan for improvement. ****(Reflecting)							U	~~S~~ U	U	S	NA	S	NA	S		
c. Incorporate instructor feedback for improvement and growth (Reflecting).							U	**S**	S	S	NA	S	NA	S		
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).							U	**S**	S	S	NA	S	NA	S		
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).							U	**S**	S	S	NA	S	NA	S		
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).							U	**S**	S	S	NA	~~S~~ U	NA	S		
g. Comply with patient's Bill of Rights (Responding).							U	**S**	S	S	NA	S	NA	S		
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).							U	**S**	S	S	NA	S	NA	S		
i. Actively engage in self-reflection. (Reflecting)							U	**S**	S	S	NA	S	NA	S		
Faculty/TA Initials		NS					CB	BL	BL	HS	HS	HS	HS			

* End-of-Program Student Learning Outcomes

Clinical judgment terminology embedded in each competency – noticing, interpreting, responding, reflecting

**** Strength/weakness reflection (a,b): Must have different written example each week of clinical/lab. You must explain your plan for how you will improve. Example, "I am having a difficult time with obtaining a manual BP. I will get a BP cuff from Amy and practice manual BP's with at least three members of my family this week." Please ensure that you answer this section in-depth with your plan of action. Each week must be different.**

Comments: (we want that in detail)

Week 7(8a-i): Taleigh, you did not self-rate yourself for these competencies, therefore you receive a "U". Please be sure to address this competency next week when completing your tool. The following are directions from page 1 of the tool: *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. **CB**
I Taleigh will make sure to fill out all the boxes from here on out and self-rate myself for all competencies. BL

Week 8-8(a,b) These competencies were changed to a "U" for this week because you did not provide a written example for a strength or an area in need of self-growth (see the example highlighted in red above). Each week you have clinical, you must provide a written response for both competencies 8a and 8b. Please be sure to address the "U" on your Clinical Evaluation Tool for Week 9 according to the guidelines outlined on page 2 of this document. If you have any questions or need assistance, please do not hesitate to reach out. 8(i) You did a wonderful job reflecting on your first clinical experience in your CDG this week. You provided a nice description of your thoughts and feelings before and after the experience. Keep up all your great work! BL

I Taleigh cook will make sure to respond to all competencies in objective 8 and provide a written response for competencies 8A and 8B from here on out. HS
I believe a strength of mine would be assessing the situation and the environment that the patient is in and trying to accommodate to their needs, as well as I can, without getting distracted and while maintaining professionalism. Great job! Each patient interaction will be different; therefore, it is always imperative to be professional and treat each patient according to their specific needs. HS
I'm having a difficult time remembering to ask about numbness and tingling in all extremities of the body. I will practice a full head to toe assessment on a couple family members while remembering to ask for numbness and tingling everywhere not just in focused areas or where pain is noted. Great plan! HS
Week 11- I believe a strength of mine for week 11 would be that I remembered to ask about numbness and tingling everywhere. I also think my focused assessments are improving along with my ability to remind myself of the importance of my assessment before other healthcare workers come in and take over. Great job! It does become challenging when there are many interruptions during the day. Something that I need to work on is not being afraid to check everywhere on the patient even if it makes them uncomfortable, I need to fully assess more private areas better. I will fix this by educating the patient more on why it's important for me to see all areas and get help if needed turning them. This becomes easier as you continue to get more experience. HS
(8f)- This competency was changed to a U because you did not submit the correct version of the tool by the deadline. HS
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. HS
I Taleigh Cook will make sure to submit the correct form of the clinical tool by the deadline. I will do this by ensuring that the previous clinical tool I have downloaded has initials from my clinical instructor. HS
I Taleigh Cook will focus on charting more effectively and efficiently by documenting exactly what I am assessing more in the moment, while keeping prior assessments in mind for context rather than replication. This approach will help ensure that each entry reflects the client's current status, not just a repetition of previous notes. I believe a strength of mine is noticing when something changes about the patients medical status and noticing the difference while using interventions to improve the patients ailments and pain at the same time.

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
		*	*

Note: Students are required to submit one satisfactory care map by 11/17/2025 at 0800. If the care map is not evaluated as satisfactory upon initial submission, the student may revise the care map based on instructor feedback/remediation and resubmit one time by 11/24/2025 at 0800 to receive a satisfactory evaluation. ***See Attached Nursing Care Map Grading Rubric**

Firelands Regional Medical Center School of Nursing
Care Map Grading Rubric

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**		

Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**		
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**		

Reference

An in-text citation and reference are required.
The care map will be graded "needs improvement" if missing either the in-text citation or reference, but not both.
The care map will be graded "unsatisfactory" if both in-text citation and reference are not included.

Total Possible Points= 45 points
45-35 points = Satisfactory
34-23 points = Needs Improvement*
< 23 points = Unsatisfactory*
***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *****

Faculty/Teaching Assistant Comments:

Total Points:

Faculty/Teaching Assistant Initials:

Firelands Regional Medical Center School of Nursing
Nursing Foundations 2025
Simulation Evaluations

Student Name: Taleigh Cook					
Performance Codes: S: Satisfactory **U**: Unsatisfactory			**Evaluation** *(Refer to LCJR)	**Faculty Initials**	**Remediation Date/Evaluation/Initials**
Date: 11/4/25	Simulation #1 (2,3,5,8) *	Scenario	S	HS	
		Survey	S	HS	
Date: 11/24/25 or 11/25/25	Simulation #2 (2,3,5,7,8) *	Scenario			
		Survey			

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Taleigh Cook (A), Keely Harpster (M)
GROUP #: 1
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/4/2025 1030-1130

CLINICAL JUDGMENT COMPONENTS					**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) *					
• Focused Observation:	E	A	D	B	Sought information on how patient slept overnight. Asked further questions regarding difficulty sleeping Focused observation on vital signs. Noticed temp of 99.2, noticed HR 80, noticed BP 130/74, Noticed RR 20, noticed Spo2 of 89% on RA.
• Recognizing Deviations from Expected Patterns:	E	A	D	B	Noticed shortness of breath. Asked patient about symptoms of SOB. Noticed yellow sputum in the tissues. Asked the patient further questions regarding sputum characteristics. Asked about antibiotic use. Noticed abnormal lungs sounds, identified as wheezing (set as crackles)
• Information Seeking:	E	A	D	B	Noticed reddened heels. Med nurse introduced herself when entering the room. Identified patient with name and DOB, compared with wristband prior to medication administration. Remember to ask about allergies prior to med administration. Noticed reddened heels. Identified patient with name and DOB, compared with wristband when entering the room. Identified patient with name and DOB, compared with wristband prior to medication administration.

INTERPRETING: (1,2,4,6,7) * • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritized vital signs when entering the room Prioritized Spo2 when noticing Spo2 of 89% on RA Prioritized oxygen administration 2L per NC. Prioritized raising HOB for shortness of breath and cough. Made sense of provider's orders for oxygen. Focused assessment on lungs after intervention for low Spo2. Prioritized elevating heels with pillows after noticing redness to the heels. Made sense of adventitious lung sounds related to pneumonia (identified wheezes instead of crackles) Did not make sense of MAR with inhaler already being administered per RT. Made sense of it being a PRN medication for shortness of breath. Did not make sense of HS medication order (Lotensin) initially. When prompted by the patient, made sense of MAR and HS administration, prevented med error. Made sense of PRN guaifenesin for cough. Asked patient if she thought she needed it (information seeking). Made sense of not crushing or chewing guaifenesin. Made sense of AM medications to be administered and identified correct indication for the patient.
RESPONDING: (1,2,3,4,5,6,7) * • 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	Introduced self and role when entering the room. Med nurse introduced herself when entering the room. Identified patient with name and DOB, compared with wristband prior to medication administration. Raised the bed for proper body mechanics. Remember to lower the side rail. Elevated HOB for patients cough. Good teamwork to locate the oxygen tubing. Good communication with the patient throughout the assessment and medication administration. Established rapport. Strong teamwork and collaboration throughout. Roles clearly defined. Manual pulse obtained, temperature obtained, RR obtained, BP obtained, Spo2 obtained. Offered water for patient's cough HEENT assessment performed. Asked additional questions related to HEENT assessment. PERRLA noted. Remember to ask orientation questions and numbness/tingling for neuro assessment. Skin turgor assessed Asked additional questions for resp assessment (chest pain, tightness, etc) Initiated oxygen therapy at 2L per nc. Educated patient on use of oxygen and plan of care. Good focused respiratory assessment. Listened anteriorly, laterally and posteriorly. Abdominal assessment performed. Asked about N/V. Looked first, auscultated second, palpated last. Remember to ask about last BM. Remember to ask neuro questions for orientation. Assessed ROM in upper extremities. Assessed skin on the upper extremities. Assessed cap refill. Assessed grip strength. Assessed for edema in the lower extremities. Assessed GU system, asked patient about any symptoms. Remember to ask about urination pattern. Cap refill assessed in lower extremities., assessed push/pull. Assessed pulses in bilat. Lower extremities. Assessed skin on the heels. Asked about assistive devices.

	Educated on water intake and the use of incentive spirometry for breathing. Educated on multivitamin to be administered. Educated on atorvastatin for cholesterol. Used BMV scanner to scan medications. Remember to ask about allergies prior to medication administration. Corrected self with HS medication when prompted by the patient. Elevated HOB for medication administration safety. Provided water for pills. Educated on potential side effects of medications. Revaluated oxygen and resp. status after O2 administration.
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Everyone participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions. Members of the team noticed areas for improvement and discussed ways to make improvements in the future. The assessment nurse and medication nurse demonstrated collaborative communication between the team members and the patient.
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** Performance Codes: **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** • Demonstrate collaborative communication with patients and the seven rights (1,7,8)*) • Identify and provide accurate patient education (1,2,3,4,5,7) * ***Course Objectives**	**Satisfactory Completion of NF Simulation #1**

Skills Lab
Competency Evaluation

Lab Skills

S: Satisfactory
U:Unsatisfactory

	Week 1 (4)*	Week 2 (2,3,5,8)*	Week 3 (2,3,4,5,8)*	Week 4 (2,3,4,5,8)*	Week 5 (2,3,4,5,8)*	Week 6 (1,2,3,4,5,8)*	Week 7 (2,3,4,5,8)*	Week 8 (2,3,4,5,8)*	Week 9 (2,3,4,5,8)*	Week 10 (2,3,4,5,6,8)*	Week 11 (2,5,7)*
	Date: 8/18/2025	**Date:** 8/27/2025	**Date:** 9/4/2025	**Date:** 9/11/2025	**Date:** 9/16/2025 9/18/2025	**Date:** 9/23/2025	**Date:** 9/30/2025	**Date:** 10/7/2025 10/9/2025	**Date:** 10/14/2025	**Date:** 10/21/2025	**Date:** 10/28/2025
Evaluation:	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**	**S**
Faculty Initials	HS	HS	AR	HS	HS	AR	HS	FB	HS	AR	AR
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Lasater Clinical Judgement Rubric Comments:

Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. 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 most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse.

Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. Communicates effectively; explains interventions, claims and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust treatment as indicated by patient response. Displays

Firelands Regional Medical Center School of Nursing
Nursing Foundations 2025
Skills Lab Competency Tool

Student Name: Taleigh Cook

Week 1 (Technology Lab): During this lab you were able to satisfactorily navigate:

- Edvance360 Learning Management System.
- Skyscape Resource System.
- Assessment Technologies Institute (ATI) / Shadow Health.
- Guided tour of library and computer lab. HS

Week 2 (Hand Hygiene; Vital Signs; PPE): During lab this week you were able to satisfactorily demonstrate:

- Appropriate hand hygiene utilizing hand sanitizer and soap/water.
- Accurate verbalization of procedure for donning & doffing PPE.

Appropriate level of skill during guided practice with measurement of radial and brachial pulses, along with manual blood pressure. Vital signs skills will be observed 1:1 with faculty during Week 3. Keep up the good work! HS

Week 3 (Vital Signs):
Excellent work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature (Tempa Dot), radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two out of two blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 158/88 and you identified it as 158/88! The second measurement was set at 112/60 and you interpreted it as 116/62. Great job! You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You did require one prompt during completion of your 1:1 observation in regards to waiting 1-3 minutes following a change in position before obtaining the blood pressure and pulse. As a reminder, always verify by looking at the ID band when the patient is stating their name and date of birth. Overall, you did a good job with your first Meditech documentation, however you documented the pulse was “regular” rather than “irregular” as instructed. In addition, you did not include a linked nursing note as instructed. The remainder of your documentation was accurate and complete. Unfortunately, you documented under your employee account rather than your student account. Be very careful to only document under your student account for all future school practice and clinical documentation. Keep up the great work!! AR

Week 4 (Assessment): Satisfactory with head to toe assessment guided practice, hand-off report activity, Lexicomp/Intranet navigation activity, and the assessment/safety activity utilizing your clinical judgment skills. Great job! You will be observed 1:1 for Head to Toe Assessment competency during Week 5. HS
Week 5 (Assessment; Mobility): Excellent job in lab this week! You have satisfactorily performed a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall very well done. You paid close attention to detail and were clearly well-prepared. You did not require any prompts throughout your assessment, nice work! You demonstrated professional and informative communication. Job well done!
Feedback on documentation this week: With this being the first time that you fully documented these interventions, there are some areas for improvement. You did a good job, overall, with your Meditech documentation. You documented on the interventions listed below; however, some areas were inaccurate and omitted. Please review each area of documentation within the next two weeks so you can examine areas that were omitted. I want you to feel comfortable and confident with Meditech documentation.

- **Pain**- Documentation complete and accurate.
- **Vital signs**- documentation complete and accurate.
- **Safety**- Documentation complete and accurate.

- **Physical reassessment**- HEENT- omitted missing teeth from teeth condition. Cardiovascular- omitted edema note- toes to knee bil. and the entire left upper extremity.

Mobility Lab 9/18/2025: Satisfactory completion of mobility lab through demonstration of the following: Logrolling/turning a patient, lifting a patient in bed, repositioning from lying to sitting, repositioning from sitting to standing, stand/pivot transfer from a bed to a chair, ambulating with a walker, ambulating with crutches, ambulating with a cane, use of a gait belt, and safe use of a wheelchair. Proper body mechanics were utilized to promote safety for the health care worker and the patient. Great job with active participation throughout the duration of the lab. HS

Week 6 (Personal Hygiene Skills):
Satisfactory with patient hygiene, making an occupied bed, shaving, oral care, hearing aid care, application of ace wraps, TED Hose/SCD's, and clinical readiness scenario during guided practice. Completed Meditech documentation for Hygiene and Ted Hose. Keep up the great work! AR

Week 7 (NG Skills: Insertion, Irrigation, and Removal; Feedings): Great job this week in lab demonstrating competence for Nasogastric Tube Insertion, Irrigation, and Removal through 1:1 observation. You are satisfactory in all NG skills. You did not require any prompts for the insertion, or the irrigation of the NG tube. You did require one prompt on the removal, regarding flushing the NG tube with 20ml of air in the clear port. Excellent patient education provided! You were able to practice administering intermittent tube feeding using the gravity method while also confirming tube placement with gastric residual. Additionally, you participated in the PO intake station for accurate calculation of carbohydrate intake, accurately measured gastric output through the NG tube, practiced assisting a visually impaired patient with their meal, and completed the assigned documentation in Meditech. Keep up the hard work! HS

Week 8 (Foley Skills: Insertion, Removal; Sterile Gloves; I&O, Documentation Lab):
You did a great job in the lab this week and were satisfactory with the following skills: Sterile Glove Application, Foley Catheter Insertion (female), and Foley Catheter Removal. You did require one prompt during the sterile glove application for gloving the non-dominant hand, using the four fingers underneath the second gloves cuff. You required a prompt for Foley catheter insertion regarding lubrication of the catheter tip for the female of 1-2 inches. You did not require any prompts for the removal of the catheter. You had very good communication with your "patient". Great job! You correctly verbalized the differences in catheter insertion for a male patient. Actively participated in the Intake and Output stations, and completed Meditech documentation related to Urinary Catheter Management and Intake & Output. Keep up the great work!!! FB

Documentation Lab – You have satisfactorily completed the documentation lab by actively participating in Meditech documentation related to vital signs, physical re-assessment, safety and falls, pain assessment, patient rounds, TED hose/SCD/Ace wrap, feeding method, Intake and Output, urinary catheter management, and writing a nurse note. You utilized your time wisely, asked appropriate questions, and gained experience with each intervention listed in preparation for clinical. Great job! CB

Week 9 (Wound Care: Dry Sterile, Damp to Dry Packed, Stoma Skills): You have demonstrated competence in the skill of wound assessment and wound care through guided observation of Dry Sterile Dressing and 1:1 observation of Damp to Dry Packed Wound Dressing Change. During the Damp to Dry Packed Wound Dressing Change, you did not require any prompts and initiated/maintained the sterile field and followed aseptic technique throughout. Your communication with the patient was excellent. Documentation was completed related to wound care and patient rounds in the Meditech system. Additionally, you participated in the stoma care station to gain additional knowledge and skills. Great job this week! HS

Week 10 (Safety; Infection Control; Prioritization; Weight; Pressure Ulcer Prevention; Soft Restraints; Doppler BP):
Satisfactory participation with the following stations: Prioritization, Patient Weight, Restraints, Doppler BP, Meditech documentation, and Patient Scenario involving Safety, Infection Control, and Pressure Ulcer Prevention. Keep up the hard work! AR

Week 11 (Medication Lab):
Satisfactory participation and performance of the following skills in the medication lab: Oral, IM, SQ, and ID medication administration; performance of IM injection on fellow student; performance of SQ & ID injection on practice pad/sponge; use of and drawing medication out of ampule and vial; communication/accountability activity with awareness of allergies & dosage calculation. AR

EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

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

Student eSignature & Date: _____