EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Mariah Robinson

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).										S	S	NA	S	NA	NA	
b. Identify cultural factors that influence healthcare (Noticing).										S	S	NA	S	NA	NA	
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).							NA	S	S	S	S	NA	S	NA	NA	
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).							NA	S	S	S	S	NA	S	NA	NA	
Faculty/TA Initials		NS					CB	CB	CB	FB	FB	FB	FB	FB		
Clinical Location; Patient age**		Meditech Orientation					NA	3T 45	N/A	3T 71	3T 92 (day 1) 78(day 2)	N/A	3T 70(day 1) 71 (day 2)	NA	NA	

* 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(1c,d): Great job showing respect for your patient's needs, being compassionate and kind while delivering care. 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, being you able to recognize physiological needs of your patient when performing head to toe assessment. CB

Week 9 (1a,b)-Mariah, you were able to identify the needs of this patient through the gathering of objective and subjective data.. You recognized how their prognosis was affecting them in a spiritual and cultural manner, and provided support in a manner that was appropriate for the time and situation. Great job! FB

Week 10 (1c)- Nice job considering your patient's preferences while coordinating appropriate care to ensure positive patient outcomes. You are also recognizing care needs based on Maslow's hierarchy of needs and critically thinking through assessments and diagnostic testing. FB

Week 12 (1c,d)- Great job being respectful of patient's values and wishes while coordinating care for your patient during this clinical rotation. You have demonstrated the use of Maslow's hierarchy of needs to provide appropriate care for your assigned patient. FB

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	**NI**	NI	S	S	NA	S	NA	NA	
b. Use correct technique for vital sign measurement (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).										S	S	NA	S	NA	NA	
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).										S	S	NA	S	NA	NA	
e. Collect the nutritional data of assigned patient (Noticing).										S	S	NA	S	NA	NA	
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).										NA	NA	NA	NA	NA	NA	
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).										S	S	NA	S	NA	NA	
Faculty/TA Initials		NS					CB	**CB**	CB	FB	FB	FB	FB	FB		

* End-of-Program Student Learning Outcomes

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

Comments:

Week 8(2a,b): Great job this week performing your first head to toe assessment on a real patient. You performed a systematic head to toe and retrieved all vital signs within a timely manner. Moving forward if you self-rate anything other than a “S” please leave an explanation of why. I will leave your rating of “NI” for your head to toe assessment, but this was the first time on a real patient, and I think you did an excellent job. CB

Week 9(g) An example of findings specific to this patient was a venous doppler that was positive for DVT and patient was showing signs of pitting edema +2 which is known to cause edema due to blocked blood flow leading to fluid buildup. Also, a wound culture and sensitivity was performed which showed two moderate bacteria’s indicating an infection for which in this case the patient was admitted for infection of surgical site from previous surgery. For (f) my patient didn’t have an NG tube, so that is why theres an NA.

Week 9 (2a,c)- Great job with patient assessments during this clinical rotation. You provided very thorough and structured assessments. You were able to identify the appropriate focused assessment based on information gathered during the initial assessment. Great job identifying the fall risk for your assigned patient and ensuring all precautions were in place. Make sure to access all lab values, and diagnostic testing to determine the relevance to your patient’s status. FB

Week 10(g) An example of a specific finding would be from an ultrasound for gallbladder; it was found that the pt had gallstones, and right pleural effusion which is a buildup of excess fluid between the layers of the pleura which in this case could have impacted the pts spo2 levels because of less lung surface available to deliver oxygen efficiently. The dropping of her SPO2 could have been for several factors such as dilaudid, htn, blood glucose levels, immobility and diminished lung sounds. (f) I didn’t have a pt with NG tube.

Week 10 (2a,c,d)- You did a great job performing all assessments. You also demonstrated the ability to gather information from assessments performed to determine a priority problem for your assigned patient. After determining the priority problem, you implemented all necessary interventions. You are demonstrating the ability to use clinical judgment and critical thinking, putting information together from assessments and diagnostic testing, great job! Keep up the great work! FB

Week 12: (f) my pt did not have an NG tube. (g) An example of a specific finding I found was of an CT that was performed due to abdominal distention, colostomy bleed and ascites. Whenever I assessed the pt he didn’t have a distended stomach it was non tender, and round. The findings were evidence of colectomy with L sided colostomy, moderate ascites, interval hepatic surgery including L hepatectomy and surgical clips identified. When it came to the ascites fluid was obtained and concluded in the discharge summary that paracentesis fluid was reviewed and discussed with GI and didn’t appear cancerous, so I thought that was a great thing considering all the patient had already gone through.

Week 12 (2a,c,d)- You did a great job performing appropriate assessments. You provided pertinent information from assessments, labs, and diagnostic testing 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. (2g) Great job interpreting the lab data and diagnostic procedures that provides substantial information for the priority problem. Keep up the good work! FB

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	S	NA	S	NA	NA	
b. Hand off (report) pertinent, current information to the next provider of care (Responding).										S	S	NA	S	NA	NA	
c. Use appropriate medical terminology in verbal and written communication (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
d. Report promptly and accurately any change in the status of the patient (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
e. Communicate effectively with patients and families (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	

f. Participate as an accountable health care team member in the provision of patient centered care (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
Faculty/TA Initials		NS					CB	**CB**	CB	FB	FB	FB	FB	FB		

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

Comments:

Week 8(3a,c,d,e): Great job receiving hand off report on your patient. Good job using medical terminology while communicating with your patient, reporting abnormal findings, and communicating effectively with your staff RN. CB

Week 9 (3a,b)- 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 staff RN and other health care disciplines when necessary. Get very familiar with report sheet and don't be afraid to ask questions if you are missing information or don't understand something being reported. FB

Week 10 (3e)- Great job communicating with your patient this week. Communication comes in many forms and building a trusting relationship is very important to a successful plan of care. FB

Week 12 (3d,e)- You have demonstrated the ability to respond appropriately to any changes that may occur with your assigned patient. Reporting changes from assessments, vital signs, or symptoms has been prompt and to the appropriate reporting structure. You have also displayed the ability to communicate appropriately with patients and their families. Great Job! FB

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	S	NA	S	NA	NA	
b. Document the patient response to nursing care provided (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
c. Access medical information of assigned patient in Electronic Medical Record (Responding).*		S					NA	**S**	S	S	S	NA	S	NA	NA	
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).*		S							S	S	S	NA	S	NA	NA	
e. Provide basic patient education with accurate electronic documentation (Responding).										S	S	NA	S	NA	NA	
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).							NA	**S**	S	S	S	NA	S	NA	NA	
*Week 2 –Meditech Orientation **Faculty/TA Initials**		NS					CB	**CB**	CB	FB	FB	FB	FB	FB		

* 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(4a,b,c,f): Satisfactory job with documentation of the head to toe assessment and vital signs of your patient. Make sure to note any areas you may have forgot to assess, so that assessments and documentation are thorough and accurate. You did a good job utilizing Meditech for documentation and to look up patient information. You completed your first cdg, meeting all requirements per the grading rubric, excellent job! CB

Week 9 (4 a,b,c) Great job with head to toe assessment, vital signs, and focused assessment. You documented thoroughly and in a timely manner. Good job accessing pertinent information and additional information within the electronic medical record for the one of the first times. Accessing information will get easier the more experience you get with the EHR. You were able to identify and gather important information regarding your patient's problems and testing to provide an accurate plan of care, nice job! (4f)- CDG was appropriately posted following the CDG rubric, on time, and in a substantive manner. Your response to a peer also followed all the CDG rubric guidelines. Keep up the great work. FB

Week 10 (4 a,b)- Great job with documentation this week with minimal editing needed. (4c)- You were able to access the medical record, gather pertinent information and interpret data. (4f)- Your discussion post was complete and thorough providing supporting data for the priority problem. You also completed a substantial comment to one of your peers. FB

Week 12 (4a,b)- You are progressively showing improvement with documentation. Documentation has been thorough and accurate with minimal editing required. (4c) You have displayed the ability to access the electronic health record and gather all relevant information. (4f) Your initial CDG post and peer response was within the guidelines provided within the CDG rubric, nice job! FB

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	S	NA	S	NA	NA	
b. Apply the principles of asepsis and standard/infection control precautions (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).										NA	NA	NA	NA	NA	NA	
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
e. Organize time providing patient care efficiently and safely (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
f. Manages hygiene needs of assigned patient (Responding).										S	S	NA	S	NA	NA	
g. Demonstrate appropriate skill with wound care (Responding).											S	NA	S	NA	NA	
h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).							NA	**S**	S							

Faculty/TA Initials		NS					CB	CB	CB	FB	FB	FB	FB	FB		

* 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.**

Comments: I found the pull station and extinguisher both at the entrance of 3T double doors and once you walk in its there also one of each when you get past the double doors. Great job! CB

Week 8(5a,b): Great job utilizing correct body mechanics and raising the bed while performing an assessment. You did a great job ensuring that you foamed in/out when entering/exiting patients' rooms. CB

Week 9 For (c) I didn't perform anything with foley due to my patient did not have one.

Week 9 (5 d,e)- Nice job with the management of the care you provided to your assigned patient. You organize your time appropriately to provide safe, efficient care while making sure to provide care that contributes to positive patient outcomes. FB

Week 10 for (c) I didn't perform anything with a foley due to my pt didn't have one, however my pt did have a purwick and I did have to adjust it a few times due to it making a bubbling sound indicating it was not in the right position. (g) when it comes to wound care, I didn't directly need to perform wound care dressing changes but I ensured the pt was repositioned q2h, the pt had a mepilex patch on that is changed q3days but I observed it to make sure there was no visible drainage, or that it wasn't soiled.

Week 10 (5e) Great job managing time effectively to provide all necessary care for your patient and meeting all basic care needs. (5f) Great job offering and/or encouraging hygiene care for your assigned patients. FB

Week 12: (c) My patient didn't have a foley. (g) I didn't perform anything with wound directly, however the patient did have a colostomy bag in which I emptied and ensured the stoma looked healthy and that the bag was intact with skin with no irritation. Great job with the care provided to your assigned patient during this clinical rotation. You managed the care of this patient's ostomy/wound appropriately. FB
Week 12 (5 d,e)-You have demonstrated great management of care for your assigned patient making sure all pertinent interventions were completed. You organize your time appropriately to provide safe, efficient care to ensure positive patient outcomes. (5f)- Try to encourage hygiene care for all patients, this is very important to not only make the patient feel better, but also for infection control. FB

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).										S	S	NA	S	NA	S	
Faculty/TA Initials		NS							CB	FB	FB	FB	FB	FB		

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

Comments:

Week 9 (6a)- You provided care to your assigned patient using information gained through the semester in theory and lab. The care provided used clinical judgment and the established plan of care for your patient, great job! FB

Week 10 (6a)- Great job utilizing clinical judgement while providing care to your patient during this clinical rotation. It is wonderful to see you apply the knowledge you have gained in theory to the care of your patients at the bedside. FB

Week 12 (6a)- You are demonstrating the ability to apply knowledge that you have gained in theory and use clinical judgment skills while delivering patient centered care to your assigned patients. Great job! FB

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).													S	NA	NA	
b. Recognize patient drug allergies (Interpreting).													S	NA	NA	
c. Practice the rights of medication administration and safety checks prior to medication administration (Responding).													S	NA	NA	
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).													S	NA	NA	
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).													S	NA	NA	
f. Assess the patient response to PRN medications (Responding).													S	NA	NA	
g. Demonstrate medication administration documentation appropriately using BMV (Responding).												S	S	NA	NA	
*Week 11: BMV **Faculty/TA Initials**		NS							CB			FB	FB	FB		

* 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)							NA	**S**	S	S	S	NA	S	NA	NA	
b. **Reflect on areas for self-growth with a plan for improvement. ****(Reflecting)							NA	**S**	S	S	S	NA	S	NA	NA	
c. Incorporate instructor feedback for improvement and growth (Reflecting).							NA	**S**	S	S	S	NA	S	NA	NA	
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
g. Comply with patient's Bill of Rights (Responding).							NA	**S**	S	S	S	NA	S	NA	NAN	
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).							NA	**S**	S	S	S	NA	S	NA	NA	
i. Actively engage in self-reflection. (Reflecting)							NA	**S**	S	S	S	NA	S	NA	NA	
Faculty/TA Initials		NS					CB	**CB**	CB	FB	FB	FB	FB	FB		

Week 12 (7a)-Great job identifying the action, classification, rationale, and side effects of each medication administered during this clinical rotation. (7c,d)-You demonstrated the use of the seven rights of medication administration and correctly administered oral medications to your assigned patient. (7g) You demonstrated appropriate use of the barcode medication verification system for patient identification and administration of medications was saved. You were well prepared for your first medication administration experience. FB

* 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:

Week 8: My strength was being able to effectively communicate with the patient, despite being nervous upon entering the room because it flowed naturally once in the room. You had great communication skills with your patient and did an amazing job despite your nerves! CB

My weakness would be that I was trying to remember every little thing that I overlooked the simplest things such as for the head-to-toe assessment questions I forgot to ask about passing gas, and I also forgot to palpate the abdomen, pt did say it was tender but I overlooked it. To improve that I will make sure that I go through the full head-to-toe assessment a few times until I can feel more confident without forgetting. With experience, all the different questions and steps of the head to toe assessment will be second nature, but you have a good plan in place to help with remembering. CB

Week 8(8a,b,d,f,h,i): Excellent job following the student code of conduct, exhibiting professionalism while in the clinical setting, and ensuring that patient privacy was respected. Great job reflecting on your first clinical in your cdg, keep up all of your hard work! CB

Week 9-My strength going into the patients room was feeling confident because the patient just so happened to have a negative pressure wound vac which we just went over in class, although I didn't perform any wound changes or documentation for the output I thought it was a great experience to reflect on because I had gained some knowledge about the pump and how it worked first hand. As far as self-growth goes, I plan on learning more about different types of wounds, dressings, and how to confidently assess to my pts needs further down line for improvement. Mariah, when you are providing an area of improvement, provide a plan on how you are going to achieve improvement. Example: I need to improve on documentation in the health record, I will practice over the next week in the library lab at least 3 times before the next clinical day. FB

Week 10 My strength this week was being able to identify an issue and utilize time management, what I mean by this is when I did my VS for my pt her SPO2 was down to 84, I calmly went and got the nurse to address the situation and we administer 2L of O2 and the pt was stabilized after. I plan on utilizing my critical thinking to help with self-growth in concepts of understanding theres a problem and addressing the situation promptly, which will be good when it comes to prioritization. Mariah, you are doing a great job assessing your patients and noticing abnormalities. When you are identifying a weakness or area of improvement try to focus on a plan to improve on a weakness. If critical thinking is an area that you might want to improve on you might research a different disease process before the next clinical and ask yourself questions such as why and how a disease occurs. FB

Week 12: My strength going into this week was being able to identify and address situations accordingly by asking questions whenever I was unsure of a few things when it came to documentation purposes. This was the first pt I had that had a colostomy and I wasn't sure how to document a few things in physical assessment but without hesitation reached out to my instructor for further education so that I was able to continue to learn and grow from little situations such as that. Great job, do not ever hesitate to ask if you are unsure, want clarification, or just to verify. FB So, I can consider both a strength and a weakness although I was not confident in what to put in some documentation for the physical assessment, I knew that I was able to get the answers I needed by not being afraid to ask questions. To improve, I will be sure to thoroughly go through the assessment questions to be comfortable with being able to identify where specific details of my assessment belongs. Practice different scenarios that are out of the normal for assessments. Next semester you will be going into a lot of the abnormal assessments that occur with the body systems. You are doing a great job assessing the abnormal conditions that you have been exposed to. Be curious and investigate all abnormalities that you see. The more experience you get the more knowledge you gain, the better you become as a nurse. You are going to a wonderful nurse and a great asset to the nursing profession. FB

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/17/2025	Impaired Gas Exchange	*S 45/45 FB	*NA

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: Mariah Robinson	**Course Objective:** Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*
Date or Clinical Week: 10/23/2025	

	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	Great job identifying all abnormal assessment findings, lab/diagnostic tests, and risk factors for this assigned patient. Noticing abnormal information assists in a systematic and comprehensive process to determine the priority problem for a patient. Make sure you are also providing subjective data such as: Patient states feeling dyspneic or Patient states shortness of breath while lying flat.
	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	Great job analyzing the data to determine the priority problem. The goal statement was generalized and provided as a positive statement. The potential complications were appropriate the signs and symptoms should represent the objective data you would note while assessing the patient. For example: Pneumonia (complication) Pleural effusions Dyspnea Restlessness Decreased oxygen saturations Increased respiratory rate Need for supplemental oxygen
	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	Good job providing several interventions that were prioritized and appropriate for the priority problem identified. Additional interventions that would be important to initiate for this patient would be: 1. Assess patient's depth of respirations including use of accessory muscles or pursed lip breathing to provide insight into work of breathing and adequate ventilation.
	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	2. Educate patient on chronic medical conditions that result in impaired gas exchange by discharge to promote prevention or health management. A rationale was provided for each of the interventions listed.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	All highlighted reassessment findings listed in the assessment findings, lab findings/diagnostic tests were reflected upon and evaluated for the nursing priority problem. Great job following the Nursing care map rubric, all components were complete.
	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: Excellent job for your first care plan, please review comments provided above. Satisfactory completion. Keep up the great work. FB

Total Points: 45/45

Faculty/Teaching Assistant Initials: FB

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

Student Name:					
Performance Codes: **S**: Satisfactory **U**: Unsatisfactory			**Evaluation** *(Refer to LCJR)	**Faculty Initials**	**Remediation Date/Evaluation/Initials**
Date: 11/4/25 or 11/11/25	Simulation #1 (2,3,5,8) *	Scenario	S	FB	NA
		Survey	S	FB	NA
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): Jessica Seciliot (A), Mariah Robinson (M)
GROUP #: 7
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/11/2025 1000-1100

CLINICAL JUDGMENT COMPONENTS					**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) *					
• Focused Observation:	E	A	D	B	Focused observation on pain when entering the room (0/10) Focused observation on vital signs. Noticed BP 130/74, Spo2 89% on RA, HR 78, RR 20, T 99.2
• Recognizing Deviations from Expected Patterns:	E	A	D	B	Noticed patients cough. Noticed tissues in patients' hand. Noticed yellow sputum. Did not seek further information on the characteristics of the sputum.
• Information Seeking:	E	A	D	B	Noticed low Spo2 (89%). Did not intervene initially. Discussed during debriefing, student provided insight into thinking that this was normal for the patient based on past medical history. Noticed crackles. Did not notice shortness of breath with low Spo2. Eventually noticed Spo2 of

	87%. Responded with intervention. Did not notice redness to the heels. Med nurse assessed cough further. Remember to ask about sputum characteristics (production, color, consistency, etc). Asked patient preference on how she takes medications. Remember to assess allergies.
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 full assessment. Did not prioritize full skin assessment due to immobility (didn't notice red heels). Did not prioritize oxygen administration for low Spo2 initially. Eventually noticed low Spo2 and shortness of breath. Made sense of order for oxygen therapy. Discussed during debriefing. Made sense of MAR and medications to be administered. Did not make sense of HS medication order (Lotensin) initially. Made sense of correct order with prompting by the patient. Made sense of medications already administered by RN and RT. Made sense of medications to be administered (indication for the patinet). Made sense of PRN medications available. Made sense of antibiotic for pneumonia.
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 Confirmed name and DOB with wristband when entering the room Orientation questions asked when entering the room (neuro assessment). Assessed numbness and tingling. Pupils assessed, remember accommodation assessment. Communicated vital sign results with the patient. Elevated HOB for shortness of breath/cough HEENT assessment performed. Cap refill assessed. Grip strength assessed. Cardiovascular assessment performed (auscultated heart sounds) Respiratory assessment completed, auscultated lung sounds anteriorly, laterally, posteriorly. Skin assessed on lower extremities. Palpated for temperature, moisture, edema. Pedal pulses assessed. ROM assessed in lower extremities. Did not do push/pulls of the feet. Assessed cap refill. GU assessment performed, asked about symptoms, characteristics. Assessed for nausea/vomiting, asked about last BM. Looked, listened, felt abdomen assessment in correct order. Good body mechanics raising the bed, lowered the bed for safety prior to leaving the room. Initiated oxygen at 2L per nasal cannula. Educated on the use of oxygen for shortness of breath. Remember to slow down during assessment to ensure all pertinent data is collected. Communicated assessment and vital sign results with the medication nurse. Confirmed name and DOB and compared with wristband, introduced self and role as medication nurse when entering the room. Educated patient on medications to be administered prior to administration. Educated on potential side effects (chest pain, dizziness, headache, nausea). Re-assessed Spo2 to evaluate effectiveness of interventions. BMV scanner utilized for medication safety. Rights of medication administration observed. Elevated HOB for med administration. Water provided.

	Educated on importance of leaving HOB up for oxygenation.
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.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning** **Scenario Objectives:** • Demonstrate collaborative communication with patients and healthcare team members (1,3,8) * • Execute accurate and complete head to toe assessment (1,5,6,8) * • Select and administer prescribed oral medications following the six rights (1,4,5,7) * • Identify and provide accurate patient education (1,2,3,4,5,7) *	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 most obvious patterns and deviations in data and uses these to continually assess. Makes limited efforts to seek additional information from the patient and family; often seems not to know what information to seek and/or pursues unrelated information. Interpreting: Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful data. 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: 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. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. 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. **Satisfactory Completion of NF Simulation #1.**

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

Student Name: Mariah Robinson

Comments:

Week 1 (Technology Lab):

During this lab you were able to satisfactorily navigate:

- Edvance360 Learning Management System.
- Skyscape

Skills Lab Competency Evaluation Performance Codes: **S**: Satisfactory **U**:Unsatisfactory		**Lab Skills**									
	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**	**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	BL	HS	CB	AR	CB	NS	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

***Course Objectives**

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):

Great job in lab this week! You successfully completed the vital signs check-off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure assessment, you accurately obtained two consecutive readings on the Vital Sim manikin. The first measurement was set at 128/68, and you recorded it as 122/70—within the acceptable range for accuracy. The second measurement was set at 110/66, and you interpreted it as 110/64, also well within the desired range.

In addition, you demonstrated strong knowledge by verbally discussing axillary and rectal temperature measurement, as well as orthostatic vital sign assessment. You required one prompt for remembering to assess the patient's heart rate with orthostatic blood pressure measurements. Your documentation was thorough and accurate for

the vital signs; however, you omitted the pulse rate (84). Be sure to take some time to review this documentation next time you are in lab. Overall, excellent work—keep it up! BL

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):
Great job in lab this week! You have satisfactorily demonstrated a basic head to toe assessment in the skills lab. Your approach was systematic, thorough, and overall well done. You did require 1 prompt related to asking the type of pain your patient was experiencing. You demonstrated friendly, professional, and informative communication. Great job!
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**- omitted documentation of pulse oximetry and oxygen delivery method; omitted documentation of blood pressure.
- **Safety**- Documentation complete and accurate.
- **Physical reassessment**- HEENT (eye)- omitted normal eye position and no nystagmus. Cardiovascular- omitted documentation of left radial pulse. Neurological- omitted left eye reaction of brisk. Integumentary- omitted left should turgor of elastic. Gastrointestinal- omitted use of daily bowel movements aids used.

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. CB

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, irrigation, or removal of the NG tube. 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! CB

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. One prompt was required during insertion related assessing for allergies to latex or iodine prior to performing the procedure. Otherwise, you did not require any additional prompts, nice work! You maintained the sterile field throughout the Foley insertion, and did not contaminate the catheter or your gloves at any point. You correctly verbalized the differences in catheter insertion for a male patient. You also 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! NS
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: _____