

**EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2025**

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

Student:

Final Grade: **Satisfactory**

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 Faculty Feedback

Care Map Grading Rubric Documentation

Administration of Medications
Simulation Scenarios Clinical Reflection

Skills Demonstration

Evaluation of Clinical Performance Tool

Clinical Discussion Group Grading Rubric

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
Faculty/Teaching Assistant’s Name			Initials
Chandra Barnes			CB

Lasater Clinical Judgment Rubric

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	N/A	S	N/A	N/A	S
b. Identify cultural factors that influence healthcare (Noticing).										S	S	N/A	S	N/A	N/A	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
Faculty/TA Initials		NS					CB	SA	SA	CB	CB	CB	CB	CB	CB	CB
Clinical Location; Patient age**		Meditech Orientation					N/A	3T 92	NA	4N 81	4N 66	N/A	4N 88	N/A	N/A	

* 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 able to recognize physiological needs of your patient when performing head to toe assessment. SA

Week 9(1c): Great job this week coordinating care around your patient's needs and preferences. CB

Week 10(1d): You did a great job this week utilizing Maslow's to determine the needs of your patient, ensuring that appropriate measures were taken. CB

Week 12(1a,b,d): Great job this week ensuring that all spiritual and cultural factors were taken into account when caring for your patient. You did a nice job meeting the needs of your patient, using Maslow's. CB

Objective

2. 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).							N/A	NH S	S	S	S	N/A	S	N/A	N/A	S
b. Use correct technique for vital sign measurement (Responding).							N/A	NH S	S	S	S	N/A	S	N/A	N/A	S
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).										S	S	N/A	S	N/A	N/A	S
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).										S	S	N/A	S	N/A	N/A	S
e. Collect the nutritional data of assigned patient (Noticing).										S	S	N/A	S	N/A	N/A	S
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).										S	N/A	N/A	N/A	N/A	N/A	S
g. Describe the findings and the rationale for diagnostic studies with the nursing implications										S	S	N/A	S	N/A	N/A	S

for assigned patient (Interpreting).																
Faculty/TA Initials		NS					CB	SA	SA	CB						

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

Comments:

Week 8(2a,b): Dehvin, you performed a systematic head to toe assessment and retrieved all vital signs within a timely manner. I changed your “NI’s” to a “S”, as you had a good first day. You performed an assessment as best you could and should not be so hard on yourself! Let this be an experience to reflect on how you move forward to approaching uncooperative clients. There are always areas for improvement, but with this being your first clinical, you did just fine! Great job! SA

Week 9(2a,b,c,e,f,g): Great job completing your head to toe assessment and obtaining vital signs on your patient. You did a good job ensuring safety, completing the John Hopkins Fall Risk Assessment, and you were able to describe the factors that related to that score in your CDG. Great job performing a dysphagia screen on your patient before allowing clear liquids after NPO status. You did an excellent job maintaining your patient’s NG tube, clamping it, and ensuring proper placement. You were also able to discuss a priority problem for your patient and lab and diagnostic findings that may correlate to that diagnosis. CB

Week 10(2a,e,g): Your great with performing and documenting your head to toe assessment on your patient. You were able to obtain nutritional data on your patient and correlate the importance of good nutrition related to your patient’s situation. You were able to discuss diagnostic studies that were performed on your patient that led to the priority problem of impaired skin integrity. CB

Week 12(2a,d,g): Great job performing your head to toe assessment, being very thorough and detailed. Although you are unable to document a skin assessment, this was also performed during your head to toe. You did a nice job describing labs and diagnostic test that you patient had performed related to their priority problem. CB

Objective

3. 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).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
b. Hand off (report) pertinent, current information to the next provider of care (Responding).										S	S	N/A	S	N/A	N/A	S
c. Use appropriate medical terminology in verbal and written communication (Responding).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
d. Report promptly and accurately any change in the status of the patient (Responding).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
e. Communicate effectively with patients and families (Responding).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
f. Participate as an accountable health care team member in the provision of patient centered care (Responding).							N/A	S	S	S	S	N/A	S	N/A	N/A	S
Faculty/TA Initials		NS					CB	SA	SA	CB	CB	CB	CB	CB	CB	CB

* 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 all findings, and communicating effectively with your staff RN. You can always access your patient's chart or ask the primary nurse for more information so do not get discouraged if you do not hear everything during hand off. SA

Week 9(3b,e): Great job with handing off pertinent information related to your patient before the end of the clinical day. You did a great job communicating with the bedside nurse, patient, and peers. CB

Week 10(3b,d,e): You did a great job reporting off and accurately reporting any sort of changes to the bedside nurse. You were also to have effective communication with your patient and your peers this week, good job! CB

Week 12(3e): Excellent job this week communicating with your patients, peers, and floor staff. You did a nice job communicating during your medication pass, ensuring that your patient was aware of what meds they were receiving. CB

Objective															
4. Exemplify advanced searches in accessing electronic health care information and documenting patient care. (1,4,8)*															
	Week	Mid-	Week	Week	Week	Week	Week	Final							

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

* 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. Your documentation on everything was great, we expect not all information to not be completed when documenting, but remember the extreme importance of obtaining all vital signs and getting those in asap. You completed your first cdg, meeting all requirements per the grading rubric, excellent job! SA

Week 9(4e,f): You did a good job this week with documentation of your findings while obtaining vital signs and a head to toe assessment on your patient. Your CDG was satisfactory completing all requirements per the CDG grading rubric. CB

Week 10(4c,f): You were able to access the EMR this week in clinical to collect data related to your patient's nutritional status and AM-PAC mobility level. Great job on your CDG, meeting all requirements per the grading rubric. CB

Week 12(4c,e,f): You did a great job this week accessing your patient's information on the electronic medical record. You were able to verify medication and provide education related to medication taking. Satisfactory completion of your cdg, following the cdg grading rubric, nice job! CB

Objective

5. 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							N/A	S	S	S	S	N/A	S	N/A	N/A	S

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

* 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:

Week 8: On 3T the fire extinguisher is located across from room 3036 and the pull station is located across room 3037. Thank you! SA

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 clients' rooms. SA

Week 9(5c,d,f): Great job managing basic patient care needs and providing hygiene needs for your patient. Great job maintaining your patient's indwelling catheter, providing foley cath care, and using proper technique to remove the catheter when the healthcare provider placed the order. CB

Week 10(5a,c,d,g): Excellent job this week ensuring that your patient was educated on the importance of getting up to the chair and ensuring that the correct technique was utilized. You were able to manage basic care needs with knowledge and preparation. Good job completing wound care of a pressure ulcer on the heel and a lower leg ulcer. You were able to use clean technique with the appropriate supplies and ordered solutions. CB

Week 12(5c,e): Nice job with maintaining your patient's indwelling catheter, following correct technique and completing the theraworx bath as per the healthcare providers orders. Great job with time management this week with your medication administration. You were able to organize your time and prioritize your patient's needs. CB

Objective																
6. 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).										N/A S	S	N/A	S	N/A	S	S
Faculty/TA Initials		NS							SA	CB	CB	CB	CB	CB	CB	CB

* End-of-Program Student Learning Outcomes

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

Comments:

Week 9(6a): You did a great job using clinical judgement skills this week in clinical. You knew that your patient's priority problem related to the knee injury. You were able to correlate diagnostic findings and labs, to implement interventions related to the problem. CB

Week 10(6a): Great job using clinical judgement this week during your clinical time with your patient. You were able to put pieces of assessment data together to recognize your patient's priority problem of impaired skin integrity. Great job correlating findings to your priority. CB

Week 12(6a): You were able to develop a plan of care for your patient related to their priority problem this week in clinical, good job! In your cdg, you listed appropriate interventions you implement for your patient's priority problem. CB

Week 14(6a): Satisfactory completion of your first nursing care map. Please see my feedback on the care map grading rubric below. CB

Objective

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

* 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

Week 12(7a-d, g): You did a great job with medication administration. You were able to identify why your patient was receiving the medication, potential side effects, and appropriate patient education. You reassessed your patient after giving medications, ensuring their safety. You followed the rights of medication administration with 3 medication checks, verifying the correct patient and their allergies. You were able to utilize the BMV for medication administration documentation. Although administering medications was difficult with your patient, you maintained a professional demeanor and were able to learn how medication administration is not always straight forward. CB

Objective

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

Faculty/TA Initials

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* 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 7(8f): Dehvin, this competency was changed to an “U” due to your clinical tool being submitted after the due date and time. Please be sure to address the “U” when completing your clinical tool for week 8. I am going to copy the directions from page 1 of the clinical tool: *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 was having trouble figuring out the correct way to fill in my first clinical tool. The first submission was turned in on time, but the format was incorrect, so the correct submission was unfortunately submitted late. Next time I will turn in my clinical tool on time and ensure that the format is correct and efficient. SA

Week 8: A strength I gained from this clinical is therapeutic communication and empathy. Although my patient did not want me to assess them nor obtain any information for my assessment, I was able to be understanding, empathetic, and use therapeutic communication to ensure the patient that as a nurse we are just trying to deliver the best high-quality care to help them get better in their situation. From this week’s clinical an area of growth I need to focus on is self-reflection based on a patient’s needs, and the process of completing a head-to-toe assessment based on a patient’s conditions. To improve this area, I will practice more in-depth head-to-toe assessments with conditions that may require me to alter my assessment while still being able to complete it thoroughly for documentation purposes, in a timely manner. I aim to strengthen my clinical competence by reflecting on my own actions and obtaining feedback from my instructors to apply that knowledge to the next clinicals to follow. **Great plan, keep remaining positive!** SA

Week 8(8d,f,h): Excellent job following the student code of conduct, exhibiting professionalism while in the clinical setting, and ensuring that patient privacy was respected. SA

Week 9: An overall strength that I gained from this week’s clinical was putting myself in the position to think like a nurse and perform skills that I was checked off for in skills lab, in the real clinical setting. I was able to remove a foley catheter from my patient, perform a dysphagia screening, and preform a bag bath adjusted around my patient’s needs! Overall, the skills that I was able to perform on my patient were strengths for me in this week’s clinical because they allowed me to build on my confidence for my future nursing profession. An area for self-growth and improvement that I want to focus on is becoming more knowledgeable and comfortable with documentation as well as navigating my way through my patient’s charts. To build upon this skill I will practice documentation more thoroughly in the computer lab and utilize my resources to become more confident with areas of documentation for growth and general understanding. **Dehvin, you did a great job with all the skills you were able to utilize to provide excellent care to your patient. Documentation and navigating the EHR will get easier with more experience, but you have a great plan in place.** CB

Week 10: A strength that I gained from this week’s clinical was demonstrating effective communication with my patient and the healthcare team. I was able to ensure my patient had felt heard and supported when he was uncertain about the skills being done during his assessments. I was able to educate my patient about the importance of the assessments and address his concerns when regarding his care. This experience strengthened my overall clinical communication skills, my confidence within the healthcare setting, and reminded me the importance of building trust with my patients. An area of self-growth that I need to improve on is stepping further out of my comfort zone by taking initiative and volunteering for tasks to build and enhance my clinical experience. To improve in this area, I will be more prone to answering call lights without hesitation to broaden my experience by actively seeking opportunities to continuously engage with multiple patients with various health concerns. **Dehvin, you did a great job this week with your patient. Communication is a major part of nursing when caring for patients with complex situations. I think putting yourself out in situations to gain confidence is a great way to feel more comfortable while gaining experience.** CB

Week 12: A strength that I gained from this week's clinical was gained from observing an ankle fracture surgery. By being able to witness this procedure in the operating room, the next day of clinical I was able to prioritize my patient's needs, and execute interventions in my nursing diagnosis, to perform a focused assessment allowing me to administer the proper medication as needed. I was able to better understand more in depth the importance of these types of assessments based on my patient's conditions and as a result I altered my plan of care as a student nurse around that. I believe this is a strength for me because it allowed me to prioritize and deliver patient centered care around my patient's conditions and administer the correct medications ordered in my patient's chart. An area of growth I need to focus on moving further in clinicals is building an emotional balance; being in the health care setting I will unfortunately always be met with many challenges that will test my resilience, but I must learn how to process difficult situations in a healthy manner to maintain my well-being to ensure I can advocate for my patients effectively. To improve in this area, I will actively seek feedback from my clinical instructors and experienced nurses to incorporate their insight from their past experiences to allow myself to grow professionally and emotionally as a future nurse. Dehvin, I am glad you got to experience a surgical procedure. This not only allowed you to prioritize your patient's plan of care, but it also gave you insight to the reason things are implemented to ensure patient safety and patient outcomes. I know the situation that was observed by all of us in the clinical setting was very unsettling and sudden, but always remember that we are here for all of you in this time. It never gets easier when something like this happens, you just learn to how to process these situations with coping mechanisms that work for you. I am proud of you for speaking up and letting us help you work through your feelings during debriefing. CB

Final comment: Dehvin, you did an excellent job this semester! You came to each clinical prepared and ready to take on any patient assigned to you. You have grown over the weeks with your confidence and knowledge of not only the environment of the hospital and clinical setting, but also your patients and their needs. Every single one of your patient's were pleased with the care you provided and the time that you spent with them. Great job, and I am excited to see your growth continue! CB

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/17/2025	Impaired Skin Integrity	*S/CB	*NA/CB

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: Dehvin Shumate		Course Objective: Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*					
Date or Clinical Week: 11/17/2025							
Criteria		3	2	1	0	Points Earned	Comments
N o t i c i n g	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 listing abnormal assessment findings and lab/diagnostics. A couple of things that should be included are intermittent confusion and fall score. Under the lab/diagnostics I would have also included the abnormal CXR for your patient. Risk factors were accurate but cataracts should be included here and decreased physical mobility assessment findings should be listed under that portion (remember to be specific).
	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	
I n t e r p r e t i n g	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	Nice job listing nursing priorities for your patient and highlighting the appropriate priority problem! Remember to go through Skyscape and list all priorities that are related to your patient. Decreased activity intolerance, impaired gas exchange, impaired tissue integrity, and risk for surgical site infection could have been included. You highlighted appropriate data related to your patient's priority from the assessment and lab/diagnostics boxes. Amputation and infection are relevant for potential complications but mobility would not be because your patient already has mobility related issues. Pain or necrosis could be options for a potential complication.
	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)	2	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
R e s p o	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Excellent job listing appropriate interventions that were individualized for your patient. Interventions were prioritized with a frequency and rationale for each. My only suggestion here is that you would assess wound characteristics before repositioning your patient, that you would
	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	

n d i n g	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	want to collaborate with wound nurses for wound care, and have case management set up wound care before discharge.

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		
R e f l e c t i n g	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	Good job reassessing your patient to complete the reflecting/evaluation portion of the care map. Anything that is highlighted in the assessment box and lab/diagnostic box needs to be reevaluated for this portion. I agree that it is appropriate to terminate the plan of care on your patient because of them being discharged.
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> • 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: Dehvin, you did an excellent job completing your first care map! Remember when completing assignments with a grading rubric and guidelines, always have them out to follow. Keep up all of your hard work! CB

Total Points:

43/45

Faculty/Teaching Assistant Initials:

CB

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

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

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Dehvin Shumate (A), Sean Wilkins (M)

GROUP #: 9

SCENARIO: NF #1

OBSERVATION DATE/TIME(S): 11/11/2025 1300-1400

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
<p>NOTICING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B 	<p>Confirmed name and DOB and compared with wristband. Noticed cough when entering the room. Sought information related to pain (0/10). Noticed BP 129/73, Spo2 87% RA, temp 99.2, HR 80, RR 16. Noticed tissues with sputum. Noticed characteristics of sputum. Noticed Spo2 87%. Noticed shortness of breath. Sought further information throughout assessment. Sought more details related to “runny nose” Sought further information related to sputum production. Did not notice reddened heels Noticed crackles. Assessed allergies. Sought information related to nutrition, diet, etc. Asked patient how she prefers to take medications.</p>
<p>INTERPRETING: (1,2,4,6,7) *</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p>Prioritized vital signs when entering the room. Prioritized head to toe assessment after intervening on low Spo2. Prioritized focused respiratory assessment and oxygen administration for Spo2 of 87%, made sense of physician order for oxygen therapy to maintain >93%. Made sense of crackles related to pneumonia. Correlated with fluid in her lungs. Made sense of interventions to be performed for oxygenation status. Made sense of MAR and PRN medications. Made sense of medication indications and potential side effects.</p>
<p>RESPONDING: (1,2,3,4,5,6,7) *</p> <ul style="list-style-type: none"> • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: B E A D 	<p>Introduced selves and roles when entering the room. Good communication when entering the room, building rapport. Educated patient on plan of care. Elevated HOB for cough and shortness of breath. Communicated vital sign results with the patient. Good teamwork and collaboration with determining oxygen administration. Educated on rationale for oxygen. Explained the use of the nasal cannula. Assessed orientation (neuro assessment). PERRLA noted. HEENT assessment performed. Assessed sclera and conjunctiva. Assessed skin turgor. Cardiovascular assessment performed. Auscultated heart sounds. Respiratory assessed performed. Auscultated lungs anteriorly, laterally, and posteriorly. Maintained dignity and explained to patient assessments to be performed. Hand grip strength assessed, ROM assessed in upper extremities. Cap refill assessed in fingers. Palpated for moisture, edema. Asked about urinary symptoms, GU assessment performed. Assessed last BM. GI assessment performed. Looked, listened, felt</p>

	<p>(appropriate order). ROM assessed in lower extremities. Palpated skin for moisture, edema. Assessed push/pull in feet. Cap refill assessed in toes. Safety assessment performed. Re-assessed and evaluated breathing status and Spo2 post-intervention. Good teamwork and collaboration to identify lung sounds. Provided patient privacy. Educated on guaifenesin related to secretions. Assessed breathing status. Educated on medications to be administered. Educated on potential side effects. Educated on nutrition related to cholesterol. Educated on potential side effects of guaifenesin. Educated on fluid intake to thin/thin/loosen secretions. Continuously re-evaluated interventions being performed. Continuously educated patient throughout the scenario. Educated patient on coughing and deep breathing to expand lungs. Confirmed name and DOB and scanned wristband with BMV scanner for medication safety. Used the teach back method to confirm education understanding. Educated on smoking cessation. Educated on humidified air. Extensive education provided, very well done.</p>
<p>REFLECTING: (1,2,4,5,6,8) *</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>Everyone participated in extraordinary fashion during debriefing. Group members led debriefing with minimal prompting from faculty. 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. Accountability was taken for decision making and performance. Overall, an excellent debriefing session!</p>
<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p> <p>Scenario Objectives:</p> <ul style="list-style-type: none"> • 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 	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family.</p> <p>Interpreting: Focuses on the most relevant and important data useful for explaining the patient’s condition. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient’s data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success.</p> <p>Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. Communicates effectively; explains interventions; calms 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. Shows mastery of necessary nursing skills.</p> <p>Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences;</p>

<p>the six rights (1,4,5,7) *</p> <ul style="list-style-type: none">Identify and provide accurate patient education (1,2,3,4,5,7) *	<p>accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses.</p> <p>Satisfactory Completion of NF Simulation #1.</p>
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Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: O=Observer

STUDENT NAME(S) AND ROLE(S): Devin Shumate (O)

GROUP #: 9

SCENARIO: NF #2

OBSERVATION DATE/TIME(S): 11/25/2025 1100-1200

CLINICAL JUDGMENT COMPONENTS	<u>OBSERVATION NOTES</u>
<p>NOTICING: (1,2,4,6,7) *</p> <ul style="list-style-type: none">• Focused Observation: E A D B	<p>Noticed several observations in students' performance, both positive and negative.</p> <p>Noticed the importance of identifying the patient before administering medications.</p> <p>Noticed several abnormal assessment findings.</p> <p>Noticed numerous important interventions performed.</p> <p>Noticed the importance of following the seven rights of medication administration.</p> <p>Noticed the importance of collaboration and communication amongst team members.</p> <p>Noticed several important education topics that were covered, but the need to deliver the information in a way that is not overwhelming to the patient.</p>
<p>REFLECTING: (1,2,4,5,6,8) *</p> <ul style="list-style-type: none">• Evaluation/Self-Analysis: E A D B• Commitment to Improvement: E A D B	<p>Observer did a great job actively paying attention to detail throughout scenario. Constructive feedback was provided related to areas for improvement, as well as recognition for interventions performed well. Good discussion and support amongst those performing in the scenario and the observer.</p>
<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p> <p>Scenario Objectives:</p> <ul style="list-style-type: none">• Demonstrate collaborative communication with patients and healthcare team members (1,3,8) *• Differentiate between need for complete head to toe versus focused assessment and execute accordingly (1,5,6,8) *• Select and administer prescribed oral and intramuscular medications following the six rights (1,4,5,7) *• Identify and provide accurate patient education (1,2,3,4,5,7) *• Recognize patient oxygenation and pain control needs and provide appropriate interventions (2,4,5,6,7) *	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information.</p> <p>Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses.</p> <p>Satisfactory completion of NF Simulation #2.</p>

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

Student Name: Dehvin Shumate

		Lab Skills	
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Skills Lab											
Competency Evaluation											
Performance Codes: 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	BL	HS	CB	AR	CB	FB	FB	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**

Comments:

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):

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 118/64, and you recorded it as 118/68—within the acceptable range for accuracy. The second measurement was set at 130/70, and you interpreted it as 130/72, 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. One prompt was needed for inserting the rectal thermometer probe into the anus towards the umbilicus. You communicated clearly and appropriately with the “patient.” Overall, your documentation was well done for the vital signs; however, you omitted the pulse strength and written note that was supposed to be linked. Be sure to take some time to review this documentation next time you are in lab. Keep up all your hard work! 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 about the type of pain the patient was having. 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-** Documentation complete and accurate.
- **Safety-** Documentation complete and accurate.
- **Physical reassessment-** Integumentary- omitted “no” to does the patient have wounds.

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. You did not require any prompts during the sterile glove application and Foley catheter insertion. You required one prompt for applying non-sterile gloves 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! FB

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. CB

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:

Overall, my clinical experience, labs, simulations, and lectures were a learning experience that built my confidence and knowledge. The foundational level prior to coming into the semester was very nerve wracking for me personally but as I continued through to the end I feel as if I have learned so much valuable information from my teachers and clinical interactions. I am excited to continue in my program and continue building my clinical judgment and I have been very pleased with how the program has changed and enhanced my critical thinking. Chandra helped me tremendously during clinical and I was very blessed to have her as my clinical instructor.

Student eSignature & Date: Dehvin Shumate; 1 December 2025