EVALUATION OF CLINICAL PERFORMANCE TOOL
Nursing Foundations – 2025

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Tommy Dendinger

Final Grade: Satisfactory

Semester: Fall

Date of Completion: 12/1/2025

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: Stacia Atkins, BSN, RN

Teaching Assistant: Stacia Atkins, BSN, RN

DIRECTIONS FOR USE:

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U), and Not Available (NA).** The faculty member will initial if in agreement with the student's evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, U, or NA". If the student does not self-rate, then it is an automatic "U". A student who submits the clinical evaluation tool late will be rated as "U" in the appropriate competency(s) for that clinical week. Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

Skills Lab 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	S
b. Identify cultural factors that influence healthcare (Noticing).										S	S	NA	S	NA	NA	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).							S	NA	S	S	S	NA	S	NA	NA	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).							S	NA	S	S	S	NA	S	NA	NA	S
Faculty/TA Initials		NS					BL	CB	CB	SA	SA	SA	SA	SA	SA	SA
Clinical Location; Patient age**		Meditech Orientation					3T, 78	NA	N/A	3T, 64	3T, 79	NA	3T, 80/75	NA	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 7-1(c,d) Great job this week showing respect for your patient's individual preferences, values, and needs while providing care. In your CDG, you did a nice job identifying your patient's abnormal assessment findings and priority concerns. This demonstrates the early development of clinical judgment, which is essential for safe and effective nursing practice. BL

Week 9 (1c,d)- You reported that your client was not in need of anything, but you were able to assist the PCT's with hygiene care later that morning. SA

Week 10 (1d)- Nice job recognizing your client's priority of mobility and safety with their diagnosis and risk factors. SA

Week 12 1(c,d) – You coordinated your care effectively this week based on the client's needs and wishes. You used Maslow's to prioritize physiological needs through assessment. You were able to coordinate care with the PCT's and get your client cleaned up prior to her surgery. SA

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

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

Comments:

Week 7-2(a,b) Great job demonstrating correct technique for obtaining vital signs on your patient. You successfully completed the head to toe assessment and demonstrated that you understand the techniques of inspection, palpation, and auscultation. While you were able to perform all the steps, it will be important to work on efficiency and

confidence to help your assessments flow more smoothly and feel more natural. It's completely normal to feel nervous during your first assessments on an actual patient. With continued practice and experience, you'll become more efficient, and your skills will eventually become second nature. Stay positive and believe in yourself, knowledge, and ability. Self-awareness is an important part of learning, and I commend you for recognizing the need for improvement. BL
Week 9 (2a-e,g)- Throughout the shift your patient preferred to be left alone to sleep however you were able to communicate with him in order to complete all of your assessments. You did a nice job completing a thorough head to toe, fall/safety, and skin assessment on your patient. If you are having trouble with any part of your assessment, do no hesitate to ask your instructor for clarification, we never want to ignore an area just because we are unsure. SA

Week 10 (2a,g)- On competency a I am changing this to a "NI". Your time spent on day 1 in the client room was not an adequate amount of time to do a thorough assessment, majority of your time was in the hall reviewing the chart and even with prompting you to do things in their room that time was also short. Upon evaluation of your documentation and the nurse hand off report on day 2, some areas were omitted on your charting. When asked of the finding of the client's toe amputation, you replied by saying "I read he had a knee replacement". You did not respond when asked if you assessed the client's legs at all, which confirmed you did not do a thorough head to toe assessment. You stated "the family was in there and you did not want to bother them". We discussed the importance of your role and the assessment itself for the safety of your client and that family can help with recall if the client cannot. I assured you that I am here to help and you will not be in trouble by asking for help and that ignoring something and not charting on it can do more damage for your client's health outcomes. We never want to ignore or falsify any part of an assessment on documentation. Day 2 you did show improvement on time spent in the room. Competency g I am leaving as "NI" as in your CDG you did not provide your assessment findings and the risk factors to correlate with your priority problem and you described your client to have had "both legs stuck under a door", when it was just their foot in prompt 1. Please again do not hesitate to ask for help at any time during clinical. SA

Week 12 (2a-e,g)- Although your client was bed ridden due to having a broken back, you were able to perform a head to toe assessment and vital signs appropriately. You were able to perform and see the importance of collecting blood vitals with your client that received platelets prior to going to surgery. SA

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

* End-of-Program Student Learning Outcomes

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

Comments:

Week 7-3(c,e) It's understandable to feel anxious when communication barriers arise, especially early in your clinical experiences. This week, your nerves affected your confidence and made it more difficult for you to communicate effectively with your patient. With more practice and exposure, you'll gain confidence in adapting your communication style to meet each patient's needs. BL

Week 9 (3a-f)- You did a nice job receiving report from the previous shift and updating the nurse at the end of your shift. Remember if you are having trouble getting the client to cooperate always ask for assistance so that duties of assessing and hygiene care can be provided appropriately. SA

Week 10 (3e)- This competency was also changed to “NI”. It is important to effectively communicate with a client and their family as a nurse. Through communication, you can develop a rapport with your client to learn more about them. 3f was also changed to “NI”, as it is also important to participate as an accountable member of the healthcare team by performing important assessments and documenting your care accurately to ensure all providers were on the same page for the safety and care plan of your client. I would like to see you in the room when therapy or the provider is in the client’s room, so you can learn how each department has a role with your client’s care, and you will not be in the way, this is to your benefit to get the overall picture of your client’s treatment plan. SA

Week 12 (3a,b) – You are gaining more experience in receiving and providing hand-off report. You were able to utilize the SBAR sheet to update the assigned RN on your client’s status prior to the client leaving the floor for surgery. You were accountable for your assessments and nursing interventions and participated as an active member of the health care team with the PCT’s. You noticed elevated blood pressure per your CDG and communicated with the client. SA

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

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

Comments:

Week 2- 4(c,d) Great job listening attentively and actively participating in the Meditech orientation clinical. You demonstrated beginning competence in accessing a patient's EHR, documenting care in an intervention, and locating patient data. You were able to access Lexicomp and locate patient education materials, as well as find nursing policies and procedures on the health system intranet. Great job! NS/CB/BL

Week 7- 4(a) Excellent job with your documentation this week in clinical. Your documentation for both your vital signs and head to toe assessment were thorough and accurate. 4(c) Great job in your CDG discussing the use of informatics and technology in the clinical setting. You provided a nice description of how you utilized the patient's vital signs data to look for trends and identify any changes. 4(f) Satisfactory completion of your CDG this week. Keep up all your great work! BL
Week 9 (4a-f)- Nice job on your CDG initial post and response this week, you met all of the requirements within the rubric. You stated your client's priority problem was pain, it sounds like pain was a big concern for this patient as well based on all of the factors you discussed within your post. Nice job putting all of those items together. If you need guidance on locating information on your client, do not hesitate to ask your instructor or the primary nurse! SA

Week 10 (4a-f)- You did a nice job getting your vital signs and documenting them efficiently. However, it is changed to "NI" for the lack of assessment and information not documented because of it on day 1. I changed d and e to "S" as you spent thorough amount of time in the client's chart reviewing information and asking questions in relation to your CDG and the care map. SA

Week 12 (4a-f) – You do a good job of accessing your client's EHR each week to enhance your understanding and investigate different aspects of their care. I appreciate your commitment to improvement and learning in the clinical setting while researching your client's chart. You were able to obtain several sets of blood vitals and document them correctly in the TAR with mine and the primary nurses assistance. SA

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).							S	NA	S	S	S	NA	S	NA	NA	S
b. Apply the principles of asepsis and standard/infection control precautions (Responding).							S	NA	S	S	S	NA	S	NA	NA	S
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).										NA	S	NA	NA	NA	NA	S
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).							NI	NA	NI	S	S	NA	S	NA	NA	S
e. Organize time providing patient care efficiently and safely (Responding).							NI	NA	NI	S	S	NA	S	NA	NA	S
f. Manages hygiene needs of assigned patient (Responding).										S	S	NA	S	NA	NA	S

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

* 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: The location of the fire extinguisher was by the front desk by the elevators, fire pull station was by room 3037 Great job! BL
Week 7-5(d,e) You demonstrated nice effort and attention to detail while completing tasks, showing that you had prepared for the experience. However, your nerves seemed to greatly affect your pace, which made it difficult to complete tasks efficiently. As you gain more confidence and experience with clinical routines, your time management will continue to improve. Focus on staying calm, planning your care before entering the room, and prioritizing tasks—these strategies will help you work more smoothly and safely in future clinicals. BL

Week 9 (5d,e,f)- You were able to manage your time in order to provide all of the necessary care for your patient. When it was time for the bag bath you assisted the PCT's with getting the client cleaned up. Since you have limited experience in providing this care it can be overwhelming, but we cannot omit this duty as hygiene is a huge part of the client's overall well-being. Be sure to ask for guidance if unsure how to get started. SA

Week 10 (5a-g)- You did a nice job working with your client on their hygiene care and assisting OT with ambulation from chair to bed. Nice job on your first foley removal, you followed all steps appropriately and stayed in communication with the client during the process. You were able to observe and document the details of the urine and removal as well. Wound care was done by the night nurse and the day nurse did not want to remove the dressing during your time there so you were unable to assess and help with wound care so that was changed to "NA". SA

Week 12 (5a,b,d-f) – You were able to maintain asepsis in all care interactions this week, especially related to purewick catheter management. We discussed important measures to be taken related to Purewick care and you also gained experience with emptying a drainage container and measuring output. You were able to assist the PCT's and provide pre-surgical hygiene care to your client in order to reduce the risk of infection during surgery. You also were able to provide assistance in log rolling the client during their hygiene care to not risk worsening their fracture. SA

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).										NI	S	NA	S	NA	S	**S**
Faculty/TA Initials		NS							CB	SA	SA	SA	SA	SA	SA	**SA**

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

Comments:

Week 9 (6a)- You did a nice job utilizing clinical judgement skills based on your patient's priority problem and then identifying interventions specific to the patient and developing the plan of care. Clinical judgement will improve as you continue to learn in lecture! SA

Week 10 (6a)- You were able to identify the goals the client has to use an assisted device in order to ambulate safely. SA

Week 12 6(a) – This week you identified numerous nursing priorities and identified impaired mobility as your priority nursing problem related to her recent back fracture and upcoming surgery. Good work discussing the assessment findings and risk factors that supported your priority problem in your CDG. Your CDG demonstrated clinical judgement in correlating her nutritional status with being NPO, and monitoring for skin breakdown due to using a purewick to the healing process. SA

Week 14 (6a)- Excellent job on your Care Map on your patient with Impaired Mobility, the rubric is attached below. SA

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

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

Week 12 (7a-g)- You were tasked with administering PO medications this week. You were prepared to discuss each medication by conducting research through skyscape. You answered questions appropriately and developed and understanding for why each medication was being administered. You ensured each medication was swallowed safely by being present at the bedside. You were able to communicate with the patient, maintained composure, and administer the medications as prescribed. You gained experience in documenting medication administration as well. A PRN pain medication was administered by the primary nurse and you were able to perform the reassessment of that medication and document it appropriately for effectiveness. SA

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**** 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: A: An area of strength I had was with communication with the patient. You made a good effort attempting to communicate with your patient; however, there is room for growth in building confidence and adapting your communication to meet the patient's specific needs. Working on strategies such as speaking clearly, using visual cues, and confirming understanding will help you become more effective and adaptable in patient interactions. With continued practice and experience, your communication skills will strengthen significantly—keep focusing on these areas as you move forward. BL **B: An area of weakness I felt like I had was with performing the head to toe assessment, I felt that it could've been performed more fluently and not take as much time to perform.** It's great that you recognized an area for growth and are reflecting on how to make your head to toe assessment more smooth and efficient. Your nerves during your first attempt are completely normal, and understandably they interfered with your speed and confidence. The fact that you completed it carefully shows a solid understanding of the steps, and with continued practice, your confidence and efficiency will improve. Keep practicing and building on your foundation! BL

Week 7-8(b) A friendly reminder moving forward, be sure to provide a detailed plan for improvement (see example above) for your area of self-growth. 8(i) You did a wonderful job reflecting on your first clinical experience in your CDG this week. You provided a nice description of your thoughts and feelings before and after the experience. Keep up all your hard work! BL

Week 9 (8A): An area of strength I had this week was performing the head to toe assessment more fluently and completing it without any delays. It will become easier the more clinical time you have, begin working on time management in order to get to the next interventions as well as medication administration, nice job! SA

(8B): An area for self-growth is when I am checking for lung sounds, it took me a little longer to find them this week and I think that I could do it better. My plan for improvement is to practice checking lung sounds on at least 3 of my family members or friends before my next clinical. Communication is key during these experiences, ask your primary nurse or instructor for assistance. Not only with the staff but your client as well. Much can be discovered when you keep communicating with your client. SA

Week 10

A: An area of strength I had this week was with removing my patients' foley catheter. When doing this skill for checkoffs it seemed like it would be a more difficult thing to do, but when I had to do it on a real patient it was more easier than I thought it would be. You did a nice job with foley removal. It is definitely stressful but not as it is with check offs once you get experience. SA

B: An area for self-growth is with finding pulses. My patient this week had pulses that were weaker which made them harder to find. I would like to practice finding different pulses like dorsalis pedis or radial to be able to find pulses easier if they were to be weaker. My plan for improvement is to practice checking pulses on at least 3 friends or family members before my next clinical. Pulses can be tough to find. If you have trouble ask for assistance from the instructor or the primary nurse. We can also grab the doppler which may be needed on someone with lymphedema such as your client. SA

Week 10 (8c)- I changed this to "NI" as last week I provided guidance on your tool to ask for my help. Taking your instructor's feedback is a critical part of your academic and career growth and this is how we evaluate that you have learned from past experiences. I understand that the clinical setting can be intimidating but nurses have a responsibility to always be involved with their patient. If you are feeling hesitancy or apprehensive, I cannot help if you do not communicate. But we cannot just avoid our client, that is not appropriate nursing care. You did improve on day 2 with getting in their room more, so let's keep that momentum going as the next clinical will involve much more attention to detail with medication administration! You have one more week of clinical so I would like to see you more involved in the client's room. SA

Week 12

A: An area of strength I had this week was with finding pulses. I felt better with being able to find them this week compared to week 10. SA

B: An area for self-growth is with medication administration. Even though my experience with medication administration was positive, I think that with only doing administration once during clinicals so far there's still ways I could improve to be better at doing administration. My plan for improvement is to review information about medication administration before my next clinical and to ask for help during clinicals if needed. Next semester will move quicker so there will be med administration each time with a lot more medications. Remember to review the MAR and follow the times due and be prepared to communicate those medications with your client. SA

Final comment: Tommy, you did a nice 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 knowledge of not only the environment of the hospital and clinical setting, but also your patients. You did not get the opportunity to perform NG care, so please seek this opportunity out in your MSN semester. Great job, and I am excited to see your growth continue! SA

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/17/2025	Impaired Mobility	SA	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: Tommy Dendinger				**Course Objective:** 6			
Date or Clinical Week: 11/17/2025							
	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	Appropriately listed 12 assessment findings. Consider adding the use of walker for ambulation.
	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	Appropriately lists 10 abnormal labs and diagnostic testing.
	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	Appropriately listed 7 risk factors. Consider adding the risk for more amputations and risk for complications of diabetes.
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Correctly listed nursing priorities with highlighting top priority.
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	Completed an appropriate goal statement.
	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	Correctly highlighted all relevant data.
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	Listed three appropriate potential complications, including the signs and symptoms for each correctly. Consider the potential complication of more amputations without proper diabetic management.
	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**	2	All interventions listed are appropriate to the patient and are realistic. Frequency is missed on three interventions. Monitoring nutritional status and energy level could be two interventions. Would prioritize encouraging the use of call light as well as fluid and food intake above monitoring
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	

	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	nutritional status. Educating on the fluid intake while they are on a 1200 mL fluid restriction is important to monitor the edema but also monitor for the risk of dehydration. Consider assessing heartrate prior to ambulation. Assess the fall and safety risk prior to each ambulatory duty. Consider educating on diabetic management, education with ambulation would be a HIGH priority ("to have improved mobility by discharge"), administer DM medications, monitor glucose levels, educate diabetic foot care, educate on hygiene care, and educate on skin care. All of these will help them reduce the risk of impaired mobility complications by following their diabetic management, reducing risk of skin ulcers, understanding what to look for after discharge, reducing risk of amputation, and reduce risk of falling and injuries.

	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	Listed rationales for all interventions correctly.
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 findings were correctly highlighted. Completed an evaluation statement correctly. Used in text citations and reference.
	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. *****

Total Points:

42/45 Satisfactory

Faculty/Teaching Assistant Initials:

SA

Faculty/Teaching Assistant Comments: **Impaired Mobility** **Nice job completing the care map successfully, refer to the rubric comments to prepare you for future care maps. SA**	

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

Student Name: Tommy Dendinger					
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	NS	NA
		Survey	S	NS	NA
Date: 11/24/25 or 11/25/25	Simulation #2 (2,3,5,7,8) *	Scenario	S	BL	NA
		Survey	S	BL	NA

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Karsyn Brewer (M), Thomas Dendinger (A)
GROUP #: 5
SCENARIO: NF #1
OBSERVATION DATE/TIME(S): 11/11/2025 0800-0900

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (1,2,4,6,7) * • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B	Confirmed name and DOB, compared with wristband. Noticed BP 130/74, Spo2 of 89% on RA, temp 99.2, HR 78, RR 20 Focused observation on pain, reported as 0/10. Noticed wheezing when auscultating lung sounds (set as crackles). On re-assessment, noticed crackles. Noticed patient's cough. Asked about pain with cough. Asked patient about discomfort with abdomen palpation. Did not notice tissues with sputum. Did not notice redness to the heels. Asked patient about preference to take guaifenesin. Confirmed name and DOB with wristband prior to administering medications. Remember to ask about 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. Did not prioritize oxygen administration for Spo2 of 89% initially. Prioritized head to toe assessment after vital signs. Made sense of lung sounds being abnormal. Med nurse prioritized oxygen administration for shortness of breath and low Spo2. Prioritized elevating HOB, coughing and deep breathing. Did not make sense of MAR related to albuterol already being administered by RT initially. Recognized already administered. Made sense of PRN guaifenesin. Made sense of it being an expectorant. Made sense of medications to be administered in AM. Made sense of dosages to be administered.
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. Communicated vital sign results with the patient. Remember to raise the bed for body mechanics/safety. HEENT assessment performed. Looked in the mouth, felt around the ears and neck. Conjunctiva and sclera assessed. Neuro assessment performed (smile, raise eyebrows, remember to ask orientation questions). PERRLA noted. Remember to ask about numbness and tingling. Communicated with patient regarding assessments to be performed. Cardiovascular assessment performed (auscultated heart sounds). Respiratory assessment performed (auscultated anteriorly, laterally, posteriorly). Remember to ask about any respiratory symptoms such as shortness of breath, sputum production, etc. Good teamwork to elevate HOB for shortness of breath. Encouraged patient to cough and deep breath for low Spo2. ROM assessed in upper extremities. Initiated oxygen for low Spo2 at 2L per NC. Abdomen assessed, looked, listened, palpated. Asked about last BM, asked about flatus presence.

	Assessed GU system. Assessed urinary pattern, characteristics, and symptoms. Assessed skin of the lower extremities. Palpated for temperature, edema. Assessed pedal pulses bilaterally. Assessed ROM in lower extremities. Assessed push/pull of the feet. Remember to assess cap refill. Remember to assess bony prominence for skin breakdown. Communicated assessment results, ensured call light was within reach. Re-evaluated Spo2 after oxygen administration. Med nurse introduced self and role when entering the room. Used BMV scanner for med administration for safety. Educated patient on medications to be administered. Atorvastatin stated for heart (cholesterol). Educated on multivitamin. Educated on guaifenesin. Educated not to chew guaifenesin. Educated on potential side effects. Interrupted med administration for fall/safety questions. Assessed room for safety. Re-assessed lung sounds after interventions performed for low SpO2. Water provided for medication administration, elevated HOB for med administration. Good rapport with the patient. Educated on water intake for cough and secretions.
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: Attempts to monitor a variety of subjective and objective data but is overwhelmed by the array of data; focuses on the most obvious data, missing some important information. Identifies obvious patterns and deviations, missing some important information. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In simple, common, or familiar situations, is able to compare the patient's data patterns with those known and to develop or explain intervention plans. 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 the most obvious data; monitors progress but is unable to make adjustments as indicated by the patient's response. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses.

	Satisfactory completion of NF Simulation #1.

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: O=Observer

STUDENT NAME(S) AND ROLE(S): Karsyn Brewer (O), Thomas Dendinger (O)
GROUP #: 6
SCENARIO: NF #2
OBSERVATION DATE/TIME(S): 11/25/2025 0800-0900

CLINICAL JUDGMENT COMPONENTS	**OBSERVATION NOTES**
NOTICING: (1,2,4,6,7) * • Focused Observation: **E** A D B	Noticed several observations in students' performance, both positive and negative. Noticed several abnormal assessment findings. Noticed numerous important interventions performed. Noticed the need for better hand hygiene. Noticed the need to prioritize applying oxygen to the patient sooner. Noticed the need to improve communication when providing education. Noticed the importance of verifying the patient's allergies before administering medications. Noticed the need to aspirate for the IM injection. Noticed the importance of collaboration amongst team members.
REFLECTING: (1,2,4,5,6,8) * • Evaluation/Self-Analysis: **E** A D B • Commitment to Improvement: **E** A D B	Observers 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 observers.
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) * • Differentiate between need for complete head to toe versus	Lasater Clinical Judgement Rubric Comments: Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. **Satisfactory completion of NF Simulation #2.**

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) *	

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:** 8/25/2025	**Date:** 9/3/2025	**Date:** 9/8/2025	**Date:** 9/15/2025	**Date:** 9/22/2025	**Date:** 9/29/2025	**Date:** 10/6,8/ 2025	**Date:** 10/13/2025	**Date:** 10/20/2025	**Date:** 10/28/2025
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	HS	HS	AR	AR	FB	AR	FB	AR	AR	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**

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

Student Name: Thomas Dendinger

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):

Excellent work in the lab this week! You satisfactorily completed the vital sign check off during 1:1 observation, including oral temperature, radial pulse, respiratory rate, pulse oximetry, and blood pressure measurement. During the blood pressure measurement, you accurately obtained two out of three blood pressure results on the Vital Sim manikin. The first blood pressure measurement was set at 158/72 and you identified it as 156/70. The second measurement was set at 124/68 and you interpreted it as 150/68 which was not in the parameter. The third measurement was set at 118/60 and your interpreted it as 116/58. Great job! You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. Two prompts were given following your observation: When obtaining a rectal temperature, you will angle the thermometer towards the umbilicus, and always remember to lower the bed and raise the siderail when you have completed care for your patient. As a reminder, always verify with the ID band as the patient states their name and date of birth. You did a great job with your first Meditech documentation; all areas were accurate and complete. Keep up the great work!! AR

Week 4 (Assessment):

Satisfactory with head to toe assessment guided practice, hand-off report activity, Lexicomp/Intranet navigation activity, and the assessment/safety activity utilizing your clinical judgment skills. Great job! You will be observed 1:1 for Head to Toe Assessment competency during Week 5. AR

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 assessing the patient for pain. A second prompt was required for the use of an ambulatory aid. 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**- omitted documentation that physician was already aware of pain.
- **Vital signs**- Documentation complete and accurate.
- **Safety**- Documentation complete and accurate.

Physical reassessment- HEENT (eye)- omitted clear eye discharge color; omitted right ear hearing difficulty; omitted no throat complaints or tracheal deviation (midline). Cardiovascular- omitted edema note- toes to knee bil. and the entire left upper extremity.

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

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. During insertion you did not require any prompts. You did require two prompts during irrigation, if you are unable to irrigate check for kinks, if none are present place the patient on their left side and attempt to irrigate. The second prompt was making sure to rinse equipment after use especially if the equipment is to be reused. Excellent patient education provided! Great job! You were able to verbalize understanding of the difference between irrigation and flushing. 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! FB

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 removal related to pulling back the 10 mL syringe plunger to 0.5 mL prior to attaching to the balloon port for deflation of the balloon. As a reminder, when putting on sterile gloves hold your hands/sterile glove higher so the glove doesn't touch the package (you did not contaminate the glove but were close as your hand/glove were too low and close to the package). 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! AR

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! AR

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 require two prompts related to only touching the outer edges of the 4X4 when patting the wound dry, and remembering to open the cotton tipped applicators prior to putting on the sterile gloves. When putting on the sterile gloves be careful that the edges of the package don't touch the opened dressing supplies. You had good communication with the patient throughout the procedure. 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! AR

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: Thomas Dendinger 12/1/2025