

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

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

**Student:** Jackson Beatty

**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:** Chandra Barnes, MSN, 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                    | Faculty Feedback    |
| Care Map Grading Rubric                  | Documentation       |
| Administration of Medications            | Clinical Reflection |
| Simulation Scenarios                     |                     |
| Skills Demonstration                     |                     |
| Evaluation of Clinical Performance Tool  |                     |
| Clinical Discussion Group Grading Rubric |                     |
| Lasater Clinical Judgment Rubric         |                     |

**ABSENCE (Refer to Attendance Policy)**

Date	Number of Hours	Comments	Make Up (Date/Time)
10/17/2025	1 H	Late CDG submission	10/17/2025 1H
11/14/2025	1 H	Incomplete CDG	11/17/2025 1H
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.**

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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
<b>Competencies:</b>																
a. Identify spiritual needs of patient (Noticing).										S	N/A	S	N/A	S	N/A	S
b. Identify cultural factors that influence healthcare (Noticing).										S	N/A	S	N/A	S	N/A	S
c. Coordinate care based on respect for patient's preferences, values, and needs (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
d. Use Maslow's Hierarchy of needs to determine the care needs of the assigned patient (Interpreting).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
<b>Faculty/TA Initials</b>		NS					BL	CB	CB	CB	CB	CB	CB	CB	CB	CB
<b>Clinical Location; Patient age**</b>		Meditech Orientation					3T 52	N/A	N/A	4N 62	N/A	4N 82	N/A	4N 70	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 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): Great job this week coordinating care around your patient's needs and preferences. CB

Week 11(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

**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
<b>Competencies:</b>																
a. Perform head to toe assessment utilizing techniques of inspection, palpation and auscultation (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
b. Use correct technique for vital sign measurement (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
c. Conduct a fall/safety assessment and institute appropriate precautions (Responding).										S	N/A	S	N/A	S	N/A	S
d. Conduct a skin risk assessment and institute appropriate precautions (Responding).										N/A	N/A	S	N/A	S	N/A	S
e. Collect the nutritional data of assigned patient (Noticing).										S	N/A	S	N/A	S	N/A	S
f. Demonstrates appropriate insertion, maintenance, and/or removal of NG tube (Responding).										N/A	N/A	N/A	N/A	S NA	N/A	N/A
g. Describe the findings and the rationale for diagnostic studies with the nursing implications for assigned patient (Interpreting).										S	N/A	S	N/A	S	N/A	S
<b>Faculty/TA Initials</b>		NS					BL	CB	CB	CB	CB	CB	CB	CB	CB	CB

Week 13(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

\* 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 this week using correct techniques for measuring vital signs and completing a systematic head to toe assessment on your assigned patient. Your assessment was thorough and completed in a timely manner. BL

Week 9(2a,b,c,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. 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 11(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 physical mobility. CB

Week 13(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**

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
<b>Competencies:</b>							S	N/A	S	S	N/A	S	N/A	S	N/A	S
a. Receive report at beginning of shift from assigned nurse (Noticing).									S		N/A	S	N/A	S	N/A	S
b. Hand off (report) pertinent, current information to the next provider of care (Responding).										S	N/A	S	N/A	S	N/A	S
c. Use appropriate medical terminology in verbal and written communication (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
d. Report promptly and accurately any change in the status of the patient (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
e. Communicate effectively with patients and families (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S

f. Participate as an accountable health care team member in the provision of patient centered care (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
		NS					BL	CB	CB	CB	CB	CB	CB	CB	CB	CB
<b>Faculty/TA Initials</b>																

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

**Comments:**

Week 7-3(e) Excellent job communicating with your patient during clinical this week. You also did a great job reflecting on and discussing your communication in your CDG as well. BL

Week 9(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 11(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 13(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**

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
<b>Competencies:</b>									S							
a. Document vital signs and head to toe assessment according to policy (Responding).							S	N/A	S	N/A	S	N/A	S	N/A	S	S
b. Document the patient response to nursing care provided (Responding).							S	N/A	S	N/A	S	N/A	S	N/A	S	S
c. Access medical information of assigned patient in Electronic Medical Record (Responding).*		S					S	N/A	S	N/A	S	N/A	S	N/A	S	S
d. Demonstrate beginning skill in accessing patient education material on intranet (Responding).*		S							S	N/A	N/A	N/A	N/A	S	N/A	S
e. Provide basic patient education with accurate electronic documentation (Responding).										S	N/A	S	N/A	S	N/A	S
f. Consistently and appropriately post comments for clinical discussion groups on Edvance360 website (Reflection).							S	N/A	S	S	N/A	S	N/A	S	S	S
<b>*Week 2 –Meditech Orientation</b>		NS					BL	CB	CB	CB	CB	CB	CB	CB	CB	CB
<b>Faculty/TA Initials</b>																

\* 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 to look for trends and identify any changes. 4(f) Satisfactory completion of your CDG this week. Keep up all your hard work! BL

Week 9(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. Competency 4f was changed to an "U" because after submission of your original CDG at 2131, you modified it at 2220 which is after the due date and time. It does not show separate postings, so therefore I am unable to see what was modified. This results in 1 hour of missed clinical time, which was made up with a completed submission. 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. Please reach out if you have any questions. CB

Week 9 (4f): I received a U for modifying my CDG post after the due date. I modified my post because I forgot to include my source citation at the bottom of my posting. I realized this mistake after the 2200 due date and time had passed. I will prevent this from happening in the future by ensuring all parts of the CDG requirements are met before I Submit my post. Jackson, thank you for addressing this competency and having a plan to ensure that all information is included. CB

Week 11(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 13(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. You received a "U" for your cdg because you did not answer all of the questions. CB

Week 13 (4f): I received a U for not completing all parts of my CDG post. I have gone back and added the missing question that I did not answer and resubmitted my CDG. In the future I will double check the directions to make sure I have answered all questions. Thank you for addressing this competency. CB

**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
<b>Competencies:</b>																
a. Demonstrate correct body mechanics and practices safety measures during the provision of patient care (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
b. Apply the principles of asepsis and standard/infection control precautions (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
c. Demonstrates appropriate skill with foley catheter insertion, maintenance, and removal (Responding).										N/A S	N/A	N/A	N/A	N/A	N/A	S
d. Manage basic patient care situations with evidence of preparation and beginning dexterity (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
e. Organize time providing patient care efficiently and safely (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
f. Manages hygiene needs of assigned patient (Responding).										S	N/A	S	N/A	S	N/A	S
g. Demonstrate appropriate skill with wound care (Responding).											N/A	N/A	N/A	S	N/A	S

<b>h. Document the location of fire pull stations and fire extinguishers. ** (Interpreting).</b>							S	N/A	S							S	
<b>Faculty/TA Initials</b>		NS					BL	CB	CB	CB	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 7 5h: There is a pull station in between rooms 3020 and 3021. There is a fire extinguisher in between rooms 3018 and 3019. Great job! BL

Week 9(5c,d,f): Great job managing basic patient care needs and providing hygiene needs for your patient. Competency 5c was changed to “S” because you were able to straight cath your patient with proper technique. CB

Week 11(5a,d): 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. CB

Week 13(5e): 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







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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 11(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 physical mobility. Great job correlating findings to your priority. CB

Week 13(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): Great job with completing your first nursing care map. You were satisfactory per the care map grading rubric. Please see the attached rubric below for feedback. CB

**Objective**

2. 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
<b>Competencies:</b>																
a. Identify the action, rationale, dosage, side effects and the nursing implications of medications (Interpreting).													N/A	S	N/A	S
b. Recognize patient drug allergies (Interpreting).													N/A	S	N/A	S
c. Practice the rights of medication administration and safety checks prior to medication administration (Responding).													N/A	S	N/A	S
d. Administer oral, intra-muscular, subcutaneous, and intradermal medications using correct techniques (Responding).													N/A	S	N/A	S
e. Review the patient record for time of last dose before giving PRN medication (Interpreting).													N/A	S	N/A	S
f. Assess the patient response to PRN medications (Responding).													N/A	S	N/A	S
g. Demonstrate medication administration documentation appropriately using BMV (Responding).												N/A S	N/A	S	N/A	S
<b>*Week 11: BMV</b>																
<b>Faculty/TA Initials</b>		NS							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 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 13(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. CB

<b>Objective</b>																
3. 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
<b>Competencies:</b>																
a. Reflect on areas of strength** (Reflecting)							S	N/A	S	S	N/A	S	N/A	S	N/A	S
b. Reflect on areas for self-growth with a plan for improvement. ** (Reflecting)							S	N/A	S	S	N/A	S	N/A	S	N/A	S
c. Incorporate instructor feedback for improvement and growth (Reflecting).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
d. Follow the standards outlined in the FRMCSN policy, "Student Code of Conduct" (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
g. Comply with patient's Bill of Rights (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
h. Respect the privacy of patient health and medical information as required by federal HIPAA regulations (Responding).							S	N/A	S	S	N/A	S	N/A	S	N/A	S
i. Actively engage in self-reflection. (Reflecting)							S	N/A	S	S	N/A	S	N/A	S	N/A	S
<b>Faculty/TA Initials</b>		NS					BL	CB	CB	CB	CB	CB	CB	CB	CB	CB

\* 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 8a: I am confident when entering patient rooms and communicating with patients. I speak in a clear voice, and I am loud enough for patients to hear me and understand what I am saying. **Excellent job! Communicating with patients for the first time in the hospital setting can definitely feel nerve-wracking, but you handled it with confidence and professionalism. I’m glad you felt comfortable engaging your patient in conversation while performing vital signs and a head to toe assessment. Building trust and rapport is essential for effective nursing care, and you’re already developing that important skill—keep up the great work! BL**

Week 7 8b: I need to improve on my head-to-toe assessment by making sure I complete all parts of my assessment. I forgot to auscultate and palpate my patient’s abdomen today. To improve on this, I will make sure to practice going through all the steps of a head-to-toe assessment with my family members this week to ensure that I do not miss any steps in the future. **Great job taking time to reflect on an area of improvement for future clinical experiences. Self-awareness is an important part of learning. It’s completely normal to miss small things early on. As you gain more experience and spend more time at the bedside, you’ll continue to grow in both confidence and competence. Keep up all your hard work! BL**

Week 7-8(i) **You did a wonderful job reflecting on your first clinical experience in your CDG this week. You provided a nice description of your thoughts and feelings before and after the experience. Keep up all your great work! BL**

Week 9 8a: I improved on my head-to-toe assessment and did not forget anything when assessing my patient. I went through the assessment on Meditech and made sure that I assessed everything that I needed to. I also inserted a straight catheter using correct technique and maintained sterility. **Jackson you did a great job completing your head to toe assessment and used correct technique for inserting a straight catheter. CB**

Week 9 8b: I need to improve on auscultating the apical pulse. My patient had an irregular heart rate, and I needed to auscultate his apical pulse. I was able to find the pulse point and complete my vitals, but it took me a few tries. To improve on this, I will practice auscultating my family member’s apical pulse so that I can improve this skill.

**With each experience your technique will get better and you will gain confidence in auscultating your patient’s apical pulse. Great plan to increase your knowledge. CB**

Week 11 8a: I was able to find all heart sounds without any difficulty after having practiced this skill. Another area of strength I had was noticing. While assisting my patient to the sink I noticed his left nephrostomy tube was filled with dark red blood. I informed the nurse of my finding, and she reported it to the charge nurse and alerted nephrology. **Great job noticing a change in your patient, relaying that information to the bedside nurse so that the healthcare provider could be notified. CB**

Week 11 8b: I need to improve on my time management. My head-to-toe assessment was delayed on the second day of clinical because my patient was in pain and wanted pain medication before I did my assessment. I had to work around this and had not had to do so previously. This led to me not having as much time to do my care map later in the day. I can improve on this by ensuring I am always spending my time wisely even when I am off schedule. **Time management is key and you will understand this more when we get into passing medications during the next clinical. Staying on task is not always possible, but being able to adapt is key. CB**

Week 13 8a: I improved my time management and did not fall behind at any point during my two clinical days. I was able to be organized and complete all tasks without needing to rush. I also gave my first subcutaneous injection smoothly and without error.

Week 13 8b: I need to improve on how I respond to unexpected situations with patients. During my second clinical day my patient refused to allow me to do a head-to-toe assessment. I was able to maintain calm and professional communication, but his refusal caught me by surprise, and I wasn’t sure how to explain to him why I needed to do my assessment without angering him. In the future I will explain that it is important for me to do a head-to-toe assessment every day to accurately monitor their condition and to ensure their condition has not worsened. **Sometimes things go unexpectedly and you just have to adjust to those situations. This is something that will get easier with more experience and situations like these. CB**

**Final comment: Jackson, 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. 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! CB

Date	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials
11/17/2025	Impaired Physical Mobility	*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: Jackson Beatty		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
<b>Noticing</b>	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. Remember to only list abnormal. For assessment findings, clear liquid diet could be included. Risk factors were accurate but due to your patient's situation I would have included history of falls.
	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	
<b>Interpreting</b>	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. When highlighting relevant data from the noticing boxes, only highlight what is related to your priority problem. I would also have highlighted bilateral nephrostomy tubes as I feel this might hinder your patient's mobility if they are not secured properly. Great job identifying potential complications and listing appropriate s/sx for them.
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
<b>Responding</b>	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 rationale for each. You need to ensure that there is a frequency for each intervention when completing the care map.
	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	2	

	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
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Criteria	3	2	1	0	Points Earned	Comments	
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	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, no extra data is needed. I agree that it is appropriate to continue the plan of care on your patient!
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	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: Jackson, 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:**  
44/45

**Faculty/Teaching Assistant Initials:**  
CB

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

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

\* Course Objectives

# Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Jackson Beatty (A), Kathleen Sibert (M)

GROUP #: 4

SCENARIO: NF #1

OBSERVATION DATE/TIME(S): 11/4/2025 1330-1430

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
<p><b>NOTICING: (1,2,4,6,7) *</b></p> <ul style="list-style-type: none"> <li>• Focused Observation:           E       A       D       B</li> <li>• Recognizing Deviations from Expected Patterns:           E       A       D       B</li> <li>• Information Seeking:           E       A       D       B</li> </ul>	<p><b><u>Focused observation</u></b>            Obtained vital signs.            Focused observation on patient’s pain level (0/10)            Noticed shortness of breath with Spo2 of 89%.            Focused observation on skin integrity when noticed reddened heels.            Focused observation on patient’s cough during assessment.            Focused observation on patient’s lung sounds and recognizes crackles.            Focused observation on sputum in tissues and asks history of cough.</p> <p><b><u>Recognizing deviations</u></b>            Notices low Spo2 (88%) initially due to performing assessment.            Noticed patient’s cough, encouraged deep breathing and incentive spirometer.            Noticed crackles upon auscultation of lung sounds.            Noticed shortness of breath.            Noticed redness to the heels during assessment.            Noticed Spo2 of 88% as abnormal.            Noticed tissues with yellow sputum in the bed.</p> <p><b><u>Information seeking</u></b>            Confirmed name and date of birth when entering the room. Compared with the wrist band.            Sought additional information related to cough.            Sought information related to patient’s pain (0/10).            Sought information related to medication administration (verified name and DOB), performed 7 rights of medication administration.            Asked patient on medications administration preference.            Remember to ask about allergies prior to medication administration.</p>
<p><b>INTERPRETING: (1,2,4,6,7) *</b></p> <ul style="list-style-type: none"> <li>• Prioritizing Data:           E       A       D       B</li> <li>• Making Sense of Data:       E       A       D       B</li> </ul>	<p><b><u>Prioritizing Data</u></b>            Prioritized vital signs.            Prioritized focused assessment of respiratory system, focusing on patient’s persistent cough.</p>

	<p>Prioritized interventions related to the low SpO2 of 88%.</p> <p>Prioritized skin assessment and interventions to reddened heels.</p> <p>Prioritized medication communication and prioritized oxygen placement.</p> <p><b><u>Making sense of Data</u></b></p> <p>Interpreted Spo2 of 88% as below normal. Made sense of shortness of breath and cough related to pneumonia.</p> <p>Made sense of guaifenesin medication PRN order for persistent or non-productive cough</p> <p>Made sense of prescribed oral medications.</p> <p>Made sense of crackles being related to pneumonia.</p> <p>Made sense of oxygen administration and elevating HOB.</p>
<p><b>RESPONDING: (1,2,3,4,5,6,7) *</b></p> <ul style="list-style-type: none"> <li>• Calm, Confident Manner:     E     A     D     B</li> <li>• Clear Communication:       E     A     D     B</li> <li>• Well-Planned Intervention/ Flexibility:                   E     A     D     B</li> <li>• Being Skillful:               E     A     D</li> </ul> <p style="padding-left: 40px;">B</p>	<p><b><u>Calm, confident manner</u></b></p> <p>Demonstrated confidence in nursing actions and communication with patient and team member.</p> <p>Answered patient’s questions appropriately.</p> <p>Was confident with reassurance with patient.</p> <p><b><u>Clear communication</u></b></p> <p>Introduced self and role when entering the room. Explained interventions to be performed.</p> <p>Good communication with the patient throughout. Good education on the need for oxygen related to Spo2 level.</p> <p>Provided education on incentive spirometer but unsure of use.</p> <p>Educated patient on medication, dosage, and indication.</p> <p>Excellent teamwork and collaboration on applying oxygen and reassessing patient, and reassurance to patient.</p> <p>Lacked knowledge on cause of crackles to patient.</p> <p><b><u>Well-planned intervention/flexibility</u></b></p> <p>Started vital signs.</p> <p>Focused assessment performed on patient’s cough and shortness of breath.</p> <p>Encouraged the patient to continue to cough and deep breath related to</p>

crackles. Encouraged incentive spirometer.

Applied nasal cannula as ordered by physician to maintain Spo2 >93%.

Focused re-assessment performed on the respiratory system. Noticed Spo2 at 94% on 2L.

Noticed reddened heels. Made attempt to elevate heels.

Elevated HOB when shortness of breath was noticed.

Administers guaifenesin PRN order for cough.

Educates on medication including side effects.

**Being skillful**

Did not assess oral cavity.

Assessed numbness and tingling, of lower extremity strength (push/pull).

Assessed some neuro assessment (eyebrows, smile, orientation questions, etc).

HEENT assessment performed partially.

Neuro assessment performed partially.

Respiratory assessment performed. Lung sounds auscultated skin to skin all locations.

Cardiovascular assessment performed.

Gastrointestinal assessment completed (looked, listened, felt). Asked about last BM.

Missed GU assessment.

Integumentary assessment completed.

Musculoskeletal assessment completed.

Circulation assessment completed.

Elevated bed for proper body mechanics.

Good hand hygiene.

Used BMV scanner for medication safety.

Did not ask or clarify allergies.

<p><b>REFLECTING: (1,2,4,5,6,8) *</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis: E A D B</li> <li>• Commitment to Improvement: E A D B</li> </ul>	<p><b>Evaluation/Self-Analysis</b></p> <p>Everyone participated well in debriefing. Each member of the team reflected on the experience and asked appropriate questions.</p> <p><b>Commitment to Improvement</b></p> <p>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.</p>
<p><b>SUMMARY COMMENTS: * = Course Objectives</b></p> <p><b>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</b></p> <p><b>E= Exemplary</b></p> <p><b>A= Accomplished</b></p> <p><b>D= Developing</b></p> <p><b>B= Beginning</b></p> <p><b>Scenario Objectives:</b></p> <ul style="list-style-type: none"> <li>• Demonstrate collaborative communication with patients and healthcare team members (1,3,8) *</li> <li>• Execute accurate and complete head to toe assessment (1,5,6,8) *</li> <li>• Select and administer prescribed oral medications following the six rights (1,4,5,7) *</li> <li>• Identify and provide accurate patient education (1,2,3,4,5,7) *</li> </ul>	<p>Lasater Clinical Judgement Rubric Comments:</p> <p><b>Noticing</b></p> <p><u>Focused Observation:</u> Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information</p> <p><u>Recognizing Deviations:</u> Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment</p> <p><u>Information Seeking:</u> Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads</p> <p><b>Interpreting</b></p> <p><u>Prioritizing Data:</u> Focuses on the most relevant and important data useful for explaining the patient’s condition</p> <p><u>Making Sense of Data:</u> 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><b>Responding</b></p> <p><u>Calm, Confident Manner:</u> Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families</p> <p><u>Clear Communication:</u> Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport</p> <p><u>Well-Planned Intervention/Flexibility:</u> Interventions are tailored for the individual patient; monitors patient progress closely and is able to adjust</p>

	<p>treatment as indicated by patient response</p> <p><u>Being Skillful</u>: Displays proficiency in the use of most nursing skills; could improve speed or accuracy</p> <p><b>Reflecting</b></p> <p><u>Evaluation/Self-Analysis</u>: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives</p> <p><u>Commitment to Improvement</u>: 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><b>Satisfactory Completion of NF Simulation #1.</b></p>
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**Student Roles: O=Observer**

STUDENT NAME(S) AND ROLE(S): Jackson Beatty (O), Kathleen Sibert (O)

GROUP #: 4

SCENARIO: NF #2

OBSERVATION DATE/TIME(S): 11/24/2025 1200-1300

<p><b>CLINICAL JUDGMENT COMPONENTS</b></p>	<p><b><u>OBSERVATION NOTES</u></b></p>
<p><b>NOTICING: (1,2,4,6,7) *</b></p> <ul style="list-style-type: none"> <li>• Focused Observation:            E            A            D            B</li> </ul>	<p>Noticed patients breathing was labored.                      Noticed prioritization related to low Spo2 and application of oxygen.                      Noticed a thorough focused respiratory and pain assessment should be performed before a thorough head to toe assessment.                      Noticed information seeking with medication administration.                      Noticed observation of the rights of medication administration.                      Noticed collaboration and teamwork among students performing in the scenario.                      Noticed education could have been given on smoking cessation.                      Noticed education on incentive spirometer was incorrect and need to clarify.                      Noticed medication nurse wasted morphine without a witness.                      Noticed good education on medication administration after patient prompting.</p>
<p><b>REFLECTING: (1,2,4,5,6,8) *</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis:        E            A            D            B</li> <li>• Commitment to Improvement: E            A            D            B</li> </ul>	<p>Observers did a great job actively paying attention to detail throughout scenario. Constructive feedback was provided during debriefing. Observers provided good insight on safe medication administration, including the rights of medication administration. Constructive feedback was provided related to areas for improvement. Good discussion and support amongst those performing in the scenario and the observers.</p>
<p><b>SUMMARY COMMENTS: * = Course Objectives</b></p> <p><b>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</b></p> <p><b>E= Exemplary</b>  <b>A= Accomplished</b>  <b>D= Developing</b>  <b>B= Beginning</b></p> <p><b>Scenario Objectives:</b></p> <ul style="list-style-type: none"> <li>• Demonstrate collaborative communication with patients and</li> </ul>	<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><b>Satisfactory completion of NF Simulation #2!</b></p>

<p>healthcare team members (1,3,8) *</p> <ul style="list-style-type: none"><li>• Differentiate between need for complete head to toe versus focused assessment and execute accordingly (1,5,6,8) *</li><li>• Select and administer prescribed oral and intramuscular medications following the six rights (1,4,5,7) *</li><li>• Identify and provide accurate patient education (1,2,3,4,5,7) *</li><li>• Recognize patient oxygenation and pain control needs and provide appropriate interventions (2,4,5,6,7) *</li></ul>	
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### Skills Lab Competency Tool

Student Name: Jackson Beatty

<b>Skills Lab Competency Evaluation</b>  Performance Codes:  S: Satisfactory  U: Unsatisfactory	<b>Lab Skills</b>										
	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: 8/26/2025	Date: 9/2/2025	Date: 9/10/2025	Date: 9/17,18/ 2025	Date: 9/24/2025	Date: 9/29/2025	Date: 10/6,8/ 2025	Date: 10/15/2025	Date: 10/22/2025	Date: 10/28/2025
Evaluation:	S	S	S	S	S	S	S	S	S	S	S
Faculty Initials	HS	HS	NS	AR	AR	HS	NS	AR	AR	AR	AR
<b>Remediation:</b> Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
<b>Remediation:</b> 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 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 consecutive blood pressure results on the Vital Sim manikin for a satisfactory evaluation. The first blood pressure measurement was set at 134/78, and you identified it as 134/78, 100% accurate! The second measurement was set at 110/68 and you interpreted it as 110/68, again 100% accurate. Very well done! You were able to verbally discuss the following measurements: axillary and rectal temperature along with orthostatic vital sign assessments. You only required one prompt throughout the whole checkoff related to asking the patient if they have smoke chewed gum, or ingested any food/drink within 20 minutes of obtaining an oral temperature. You were able to remind yourself about raising the height of the bed and lowering the side rail for safety. You provided accurate detail in your communication with the “patient”. Your documentation was 100% accurate. Keep up the great work!! NS

**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 for urinary symptoms. The pain assessment you provided was excellent! You demonstrated friendly, professional, and informative communication. You were able to correctly identify the lung sounds as wheezes. Great job! AR

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 an excellent job, overall, with your Meditech documentation. You documented on the interventions listed below; however, some areas were inaccurate and omitted. Please review each area of documentation within the next two weeks so you can examine areas that were omitted. I want you to feel comfortable and confident with Meditech documentation.

- **Pain-** Documentation complete and accurate.
- **Vital signs-** Documentation complete and accurate.
- **Safety-** Documentation complete and accurate.
- **Physical reassessment-** HEENT – omitted trachea description of midline. Integumentary- omitted “no” for does patient have wounds. AR

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. AR

**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! HS

**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, well done! One prompt was required during irrigation related to injecting 10-20 ml of air in the blue port instead of the clear NG port. You did not require any prompts during removal, 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! NS

**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 throughout the procedure, nice work! You were able to remind yourself to label the drainage bag following insertion. During insertion, the 10 mL balloon syringe fell off the balloon port twice and you did an excellent job reattaching it with your sterile gloved hand. 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! 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. At one point you did contaminate the ABD at the edge however you recognized this and verbalized how you would correct it. After the sterile gloves were put on, you were able to remind yourself to pour the sterile saline over the gauze. 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! 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. 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:

Student eSignature & Date: \_\_\_\_\_ Jackson Beatty 12/2/25 \_\_\_\_\_