

**EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026**

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

Student:

Final Grade: Satisfactory/Unsatisfactory

Semester: Spring

Date of Completion:

Faculty: Rachel Haynes, MSN, RN, CNE; Heather Schwerer, MSN, RN; Kelly Ammanniti, MSN, RN, CHSE;
Monica Dunbar, DNP, RN; Nick Simonovich, MSN, RN Dawn Wikel, MSN, RN, CNE;

Faculty eSignature:

Teaching Assistant: Stacia Atkins, BSN, RN

DIRECTIONS FOR USE:

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

METHODS OF EVALUATION:

- Skills Lab Competency Tool & Skills Checklists
- Simulation, Prebriefing, & Reflection Journals
- Nursing Care Map Rubric
- Meditech Documentation
- Clinical Debriefing
- Clinical Discussion Group Grading Rubric
- Evaluation of Clinical Performance Tool
- Lasater's Clinical Judgment Rubric & Scoring Sheet
- Virtual Simulation Scenarios

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make-up (/Date/Time)

Faculty's Name	Initials
Kelly Ammanniti	KA
Stacia Atkins	SA
Monica Dunbar	MD
Rachel Haynes	RH
Heather Schwerer	HS
Nick Simonovich	NS
Dawn Wikel	DW

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 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, 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 boxes do not need a student evaluation rating or faculty/teaching assistant initials.**

Week	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
3	Acute Pain	S/RH	N/A	N/A

Note: Students are required to submit two satisfactory care maps over the course of the semester. If the care map is not evaluated as satisfactory upon initial submission, the student must revise the care map based on instructor feedback/remediation and resubmit. A maximum of two remediation attempts will be provided for a single care map and if still unsatisfactory, the student will be required to start fresh and initiate a care map on a new patient. At least one care map must be submitted prior to midterm.

Objective

1. Illustrate correlations to demonstrate the pathophysiological alterations in adult patients with medical-surgical problems. (2,3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S													
a. Analyze the involved patho-physiology of the patient’s disease process. (Interpreting)			S	S													
b. Correlate patient’s symptoms with the patient’s disease process. (Interpreting)			S	S													
c. Correlate diagnostic tests with the patient’s disease process. (Interpreting)			S	S													
d. Correlate pharmacotherapy in relation to the patient’s disease process. (Interpreting)			S	S													
e. Correlate medical treatment in relation to the patient’s disease process. (Interpreting)			S	S													
f. Correlate the nutritional needs in relation to patient’s disease process. (Interpreting)			S	S													
g. Assess developmental stages of assigned patients. (Interpreting)			S	S													
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S													
	Indicate your clinical site as well as your patient’s age and primary medical diagnosis in this box weekly.	Meditech, FSBS, IV Pump Sessions	Rehab, 88yo, SP ORIF – R Hip	3T, 77yo, Respiratory Failure													
Instructors Initials	HS		RH														

**Evaluate these competencies for the offsite clinicals:

DH: 1h

IC: 1h.

ECSC: 1g, h

OR: All

*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

Comments: Week 1 (1h)- During week 1, the Meditech, FSBS and IV pump sessions were all considered clinical hours. You came prepared to each of them and demonstrated competency accordingly. For this reason, you have earned an S for this competency. NS/SA/DW/HS
Week 3 (1a-h): This week you were able to correlate the patient's symptoms, diagnostic tests, pharmacotherapy, treatment, and nutritional needs based on their reason for being on the Rehab floor and their past medical history. You were able to bring these needs to light in your satisfactory care map of this patient as well. RH

Objective

2. Perform physical assessments as a method for determining deviations from normal. (3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S													
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	S													
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	S													
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	S													
d. Communicate physical assessment. (Responding)			S	S													
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	S													
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S													
	HS		RH														

**Evaluate these competencies for the offsite clinicals: DH: N/A IC: 2f ECSC: N/A OR:2a,b,c,d,e

Comments:

Week 1 (2f)- You satisfactorily completed the Meditech clinical update including documentation of IV solutions and the IV assessment. NS

Week 3 (2a-f): You were able to perform all assessments on your patient this week and chart appropriately in the electronic charting system. You identified a priority problem for your patient and performed a detailed focused assessment of this body system this week. You were able to perform a wound assessment before and after staples were removed. You were able to remove the staples and did a great job! RH

Objective

3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:	S		S	S													
a. Perform standard precautions. (Responding)	S		S	S													
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	S													
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S													
d. Appropriately prioritizes nursing care. (Responding)			S	S													
e. Recognize the need for assistance. (Reflecting)			S	s													
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S													
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	N/A													
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	S													
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S													
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S													
	HS		RH														

**Evaluate these competencies for the offsite clinicals:

DH: 3a

IC: 3a, f

ECSC: 3a, j

OR: All

Comments:

Week 3 (3a-f, h-j): You performed hand hygiene correctly throughout the clinical days. You were able to complete all nursing care and assessments while also working around the demanding therapy schedule. You were able to ask for assistance when needed. You promoted movement and the patient wearing ACE bandages for DVT prophylaxis. RH

Objective

3. Execute safety precautions in the implementation of quality, patient-centered care and evidence-based nursing interventions. (2,3,4,5,8)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S													
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	S													
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	S													
m. Calculate medication doses accurately. (Responding)			S	S													
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			NA	S													
o. Regulate IV flow rate. (Responding)	S		NA	N/A													
p. Flush saline lock. (Responding)			NA	S													
q. Monitor and/or discontinue an IV. (Noticing/Responding)			NA	N/A													
r. Perform FSBS with appropriate interventions. (Responding)	S		NA	N/A													
	HS		RH														

**Evaluate these competencies for the offsite clinicals:

DH: N/A

IC: N/A

ECSC: N/A

OR: All

Comments:

Week 1 (3o)- During the IV pump session, you actively participated in the programming and maintenance of the Alaris IV pump. Additionally, you accurately identified abnormal IV site assessment data with an IV site monitoring activity. HS/NS

(3r)- You satisfactorily performed a Quality Control check of the glucometer as well as demonstrate skills and knowledge required for proper fingerstick blood glucose measurement with the ACCU-CHEK Inform II glucometer. SA/DW

Week 3 (3k-m): This week you were able to perform medication administration. You followed the rights of medication administration as well as performed all safety checks prior to administration of medications. You were extremely thorough in your medication lookup prior to administration when reviewing medications with me. You were able to administer PO and SubQ medication this week. You also were able to look at a sliding scale for insulin to determine what the correct dose should be.

Objective

4. Use therapeutic communication techniques to establish a baseline for nursing decisions. (1,5,7)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S													
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S													
b. Communicate professionally and collaboratively with members of the healthcare team or next provider of care using clear, organized hand-off communication techniques. (SBAR) (Responding)			S	S													
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	S													
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S													
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S N/A	N/A													
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S													
			RH														

**Evaluate these competencies for the offsite clinicals: DH: 4a, b, d IC: 4b, d ECSC: 4a, b, d, e OR: 4a, b, c, d, e, f

CDG	Week Completed	Initials
EBP Article: Discussing Evidence in Nursing Research		
Patient Education: Identifying and Intervening on Knowledge Deficit		
Safety: Restorative Care and Managing Potential Complications		

Comments:

Week 3 (4a-f): this week you were able to communicate professionally with the nurse and healthcare team caring for your patient. You were able to communicate specific assessment findings to the nurse in a professional and organized manner. Your discussion post this week was your care map so 4e was changed to N/A. RH

Objective

5. Implement patient education based on teaching needs of patients and/or significant others. (1,6)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies:			S	S													
a. Describe a teaching need of your patient.** (Reflecting)			S	S													
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			S NI	S													
			RH														

****5a & b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab- describe the patient education you provided; be specific- include the topic, method of delivery, reason for teaching need, materials to support learning through above resources (if applicable), and method used to validate learning.**

Example: Education related to orthostatic hypotension (changing positions slowly by sitting at the side of the bed or chair for a few minutes before moving to another position, utilizing the walker when ambulating) was provided to my patient through discussion and demonstration. This was necessary to maintain patient safety as he/she was experiencing a drop-in blood pressure and dizziness when getting out of bed. A patient education sheet was printed from Lexicomp and given to the patient. The teach back method was used to validate learning.

Comments:

Week 3: I assisted in education/teaching with PT. The PT Jan and I demonstrated how to use a gait belt to assist the pt leg into bed. The gait belt had a loop at the bottom where the pt inserted her foot, she then put her good leg on the bed and used the end of the gait belt to pull her “bad” leg into the bed. This skill was taught to demonstrate safe transitional states as it promotes healing and prevents secondary complications such as injury and fatigue Pt demonstrated understanding by teach back method and demonstrating the skill as well. **This is a great thing to educate the patient on! Please note that for 5b you must include your resource. PT themselves are not a resource, but they have resources to give you (even if it is a handout they provide). Please include what resource you used in future weeks. RH**

Week 4: I provided my patient with education on how to maintain pulmonary hygiene. With her recent intubation and diagnosis of pneumonia it is crucial to maintain a patent airway to prevent further complications. I demonstrated effective techniques for the patient to try while she is sitting up in the chair throughout length of stay and post discharge. This included usage of an incentive spirometer, deep breathing exercises as well as effective coughing. I instructed the patient to demonstrate the items I educated her on to show validation of learning. Resource: Davis’s Diseases & Disorders: A Nursing Therapeutic Manual; Pneumonia

Objective

6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
a. Develop and implement a priority care map utilizing the nursing process and clinical judgment. (Noticing, Interpreting, Responding, Reflecting)			S	N/A													
b. Identify factors associated with Social Determinants of Health (SDOH) &/or cultural elements that have the potential to influence patient care.** (Noticing, Interpreting, Responding, Reflecting)			S	S													
			RH														

****6b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab. Refer to CMS Social Determinates of Health Screening Tool in the Resources folder for the course.**

See Care Map Grading Rubrics below.

Comments:

Week 3 A key factor once my pt gets discharged is her living environment. She does live alone so she needs to have the proper home safety installed prior to discharge. She also would need medical equipment such as a wheelchair/walker and raised toilet seat as well as equipment to help with ADL. She does have a very strong support system with lots of family that will help her out. She will also benefit from having HHC. Without these items it will be very difficult to promote successful healing. **Great observations! Living alone and having a good support system are important SDOH to take into consideration while doing discharge education. RH**

Week 4: My patient has a history of MR. This diagnosis can be a key factory that can put an influence on care due to a possible misunderstanding or not remembering correctly. Due to this condition, it is crucial to explain interventions and education is lament terms to improve understanding of information that is provided. After teaching I asked the patient to reflect on what she learned by demonstration.

Objective

7. Illustrate professional conduct including self-examination, responsibility for learning, and goal setting. (7)*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
a. Reflect on an area of strength. ** (Reflecting)	NH S		S	S													
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	NH S		S	S													
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	S		S	S													
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	S		S	S													
e. Incorporate the core values of caring, diversity, excellence, integrity, and “ACE”- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	S		S	S													
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	S		S	S													
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	S		S	S													
h. Actively engage in self-reflection. (Reflecting)	S		S	S													
	HS		RH														

**Evaluate these competencies for the offsite clinicals: DH: All IC: All ECSC: All OR: ALL

**7a and 7b: You must address these competencies in the comments section after each clinical experience. Please write a different comment each week. Remember that a goal includes what you will do to improve, how often you will do it, and when you will do it by (example- “I had trouble remembering to do the three checks of the six medication rights prior to administering medications. I will review the six rights and medication administration content in the textbook twice before the next clinical. Additionally, I will request to meet with my clinical faculty member to practice preparing and administering at least three medications before the next clinical.”

Comments:

Week 1 & 2 : An area of strength that I have identified this week is being able to come to lab fully prepared with all information needed prior, retained. I changed this to an S because we were able to reflect on an area of strength for yourself. HS

An area for improvement will be proper time management for all assignments and learning modules to be completed in a timely manner. I will set aside time to adequately take notes on information that is learned to be able to effectively apply it in the clinical aspect. I will also set aside time to work on all clinical documents required throughout each week to submit materials on time. I changed this to an S because you were able to identify an area of improvement and set a goal to achieve. HS

Week 3: An area of strength I identified this week was my medication pass. I feel as if it went very well for not passing medications since my previous program in May. I completed all 3 med checks as well as completed the correct math associated with providing the correct dosage of medication. I also correctly administered insulin using the insulin pen. You did AMAZING with med pass this week. You were very prepared before with detailed medication information. You took your time and performed all checks throughout the process of med administration. RH

An area for improvement that I identified this week is learning to improve my charting as well as in a timely manner. Meditech is completely new to me as I am used to Epic, Cerner and Pinpoint. I felt as if there were a lot of areas that could have had more charting, but I wasn't sure. Next week I will take more time out to sit down and look at all the areas that need more charting to make sure the correct information is documented. Learning a new charting system can be difficult, so this is a great goal to have! Remember when writing a goal you must include what you are going to do, how many times you will do it, and when you will have it done by. I have highlighted the goal requirements in green so you can reference them for next week. RH

Week 4: An area of strength this week was being able to identify additional complications that could arise from my pt recent diagnosis w/ intubation. I feel as if I educated my patient properly and she retained some information despite her learning disability.

An area for improvement this week would be able to pass my meds in a faster timelier fashion. It took a lot of time to scan each med and administer them to the patient. Each clinical that I have to pass meds I will have all of my medications looked up and identified within 30 minutes as well as be able to pull, pass and educate my patient all within 30 minutes, therefore only an hour is spent on medication pass for 1 patient so I can focus on other lengthy processes with my patients care everyday throughout my nursing career.

Student Name: Shamura' Taylor		Course Objective: 6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)*					
Date or Clinical Week: 3							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	3	Great collection of assessment findings, lab/diagnostics, and risk factors. You can have more than the minimum requirements for these areas, it might help create a better
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	4. are there any other potential priorities? Risk for infection, impaired skin integrity, impaired healing r/t history of diabetes. (50%) 5. A goal should have a timeframe included (by discharge, by a certain date, etc) 6. Does diabetes contribute to the patient's acute pain? If the patient has no risk factors contributing that is ok. Not sure how elevated glucose is related to acute pain but if you can relate it for me that's fine.
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Great list of interventions. They are prioritized appropriately. All interventions had frequency listed For your next care map I would separate the rationale from the intervention.
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> Continue plan of care Modify plan of care Terminate plan of care 	Complete			Not complete	3	

Reference

An in-text citation and reference are required.

The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.

The care map will be graded “unsatisfactory” if both in-text citation and reference are not included.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

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

Faculty/Teaching Assistant Comments:

This is a great first care map. Feel free to list more than the minimum requirements as this may help you have more supporting data for your priority problem. It might also help create more potential priority problems.

Total Points: 44/45

Faculty/Teaching Assistant Initials: RH

Student Name:		Course Objective: 6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)*					
Date or Clinical Week:							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)		
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)		
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)		
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	5. State the goal for the top nursing priority.	Complete			Not complete		
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)		
8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)			
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete		
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete		
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete		

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete		
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete		
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> • Continue plan of care • Modify plan of care • Terminate plan of care 	Complete			Not complete		

Reference

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

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

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

Faculty/Teaching Assistant Comments:

Total Points:
Faculty/Teaching Assistant Initials:

Firelands Regional Medical Center School of Nursing
Medical Surgical Nursing 2026
Skills Lab Competency Tool

Student name: Shamura' Taylor								
Skills Lab Competency Evaluation	Lab Skills							
	Week 1	Week 1	Week 1	Week 1	Week 1	Week 2	Week 2	Week 9
	Insulin (2,3,5,7)*	Assessment (2,3,4,5,7)*	IV Math Application (3,7)*	Lab Day (1,2,3,4,5,6,7)*	IV Skills (2,3,5,7)*	Trach (1,2,3,4,5,6,7)*	EBP (3,7)*	Lab Day (1,2,3,4,5,6,7)*
	Date: 1/6/26	Date: 1/6/26	Date: 1/8/26	Date: 1/8/26	Date: 1/9/26	Date: 1/16/26	Date: 1/16/26	Date: 3/9 or 3/10/26
	Evaluation:	S	S	S	S	S	S	S
Faculty/Teaching Assistant Initials	HS	HS	HS	HS	HS	HS	HS	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	

*Course Objectives

Comments:

Week 1

(IV Math)-You satisfactorily participated in the IV Math learning session on 1/6/26 as well as the assigned IV Math practice questions and the IV Math Application Lab on 1/8/2026. KA/DW/HS

(Assessment)- You were able to satisfactorily demonstrate the Basic Head to Toe Assessment during lab. KA/RH (Insulin)- You were able to correctly prepare an insulin pen and administer subcutaneous insulin. Insulin requirements were accurately identified and calculated through the corrective scale and carbohydrate coverage orders. MD

(Lab Day)- You satisfactorily completed the mandatory lab review of nursing foundational skills. This was achieved through simulating care for a patient in a scenario requiring competency in assessment, communication, medication administration (including PO and IM injection), nasogastric tube insertion and removal, patient mobility and hygiene, use of PPE for Contact Isolation, wound care, Foley insertion and removal, development of nursing notes, and providing SBAR hand-off report. NS/MD/RH (IV Skills)- You have satisfactorily completed IV lab including a saline flush, IV push medication administration with reconstitution, priming and hanging a primary and secondary IV solution, adjusting a flow rate to run by gravity, discontinuing IV therapy, and monitoring the IV site for infiltration and signs of complications. HS

Week 2

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. Caught yourself opening the water after you were sterile and stated how to fix it in the clinical setting. One prompt for trach care. Good job maintaining sterility throughout the procedure. RH RH/DW/NS/HS

(EBP Lab)- You actively participated in the online searching process for evidence-based practice literature, as well as reviewing example articles to determine appropriate selection and information needed when summarizing a research article. KA/SA/LK

Firelands Regional Medical Center School of Nursing
 Medical Surgical Nursing 2026
 Simulation Evaluations

Student Name:					
Performance Codes: S: Satisfactory U: Unsatisfactory			Evaluation	Faculty Initials	Remediation Date/Evaluation/Initials
Date: 1/26/26	Shadow Health (Respiratory Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	S	RH	N/A
		DCE Score	84.8%		
Date: 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
Date: 2/23/26	Shadow Health (Basic Patient Case: Pharmacology) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
Date: 2/25 or 2/26/26	Simulation #1 (Musculoskeletal & Resp) (*1, 2, 3, 4, 5, 6, 7)	Prebrief			
		Scenario			
		Reflection Journal			
		Survey			
Date: 3/24/26	Shadow Health (Perioperative Care Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
Date: 4/8 or 4/9/26	Simulation #2 (GI & Endocrine) (*1, 2, 3, 4, 5, 6, 7)	Prebrief			
		Scenario			
		Reflection Journal			
		Survey			
Date: 4/13/26	Shadow Health (Intermediate Patient Case: Pharmacology) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
Date: 4/23/26	Shadow Health (Renal Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			

* Course Objectives

Comments:

EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026

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 and Date:

12/19/25