

**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)
1/29/2026	7 hours	Missed clinical and debriefing	

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	Impaired Skin Integrity	S/RH	N/A	N/A
4	Impaired Mobility	S/HS	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	NA										S		
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	S	NA										S		
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	NA										S		
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	NA										S		
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	S	NA										S		
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	S	NA										S		
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	S	NA										S		
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S										S		
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	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: 81. Bowel Obstruction – Post-ostomy	3T: 83. Syncope – Orthostatic Hypotension	ECSC.										4N: 77. BPH w/ obstruction		
Instructors Initials	NS	NS	RH	HS													

**Evaluate these competencies for the offsite clinicals:

DH: 1h

IC: 1h.

ECSC: 1g, h

OR: All

Comments:

*End-of-Program Student Learning Outcomes

Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

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

Week 4- (1 a, b, c, d, e)-Great job this week! This week you did a great job discussing your patient's pathophysiology of his illness. You were also able to review the diagnostics and discuss how they correlated with the patient's diagnosis. You were able to discuss the importance of the medications that your patient was taking and how they impacted the plan of care. HS

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	NA										S		
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	S	NA										S		
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	S	NA										S		
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	S	NA										S		
d. Communicate physical assessment. (Responding)			S	S	NA										S		
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	S	NA										S		
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	s		S	S	NA										S		
	NS	NS	RH	HS													

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 complete all assessments on your patient and charted your findings appropriately in meditech. You were able to communicate your findings to the nurse caring for your patient in a timely manner. You were able to perform a skin assessment before and after staples were removed from a wound. You were able to remove the staples and did a GREAT job! RH

Week 4 (2a-f)- You did a nice job with your assessment this week. You also did a nice job communicating your findings to the RN especially your concerns with your patient's bladder being distended and the fact that he had not voided or had anything out from his external catheter. You were also able to discuss your focused assessment and the reasoning behind your decision of focus. HS

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	S										S		
a. Perform standard precautions. (Responding)	s		S	S	NA										S		
b. Demonstrate nursing measures skillfully and safely. (Responding)			S	S	NA										S		
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S	NA										S		
d. Appropriately prioritizes nursing care. (Responding)			S	S	NA										S		
e. Recognize the need for assistance. (Reflecting)			S	S	NA										S		
f. Apply the principles of asepsis where indicated. (Responding)	s		S	S	NA										S		
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA	NA										NA		
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	S	NA										S		
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	s		S	S	NA										S		
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S										S		
	NS	NS	RH	HS													

**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 as appropriate throughout both days of clinical. You were able to organize your nursing care and assessments around the therapy schedule and still got everything done in a timely manner. You were able to ask for assistance when needed. You were able to promote DVT prophylaxis. RH

Week 4 (3 c, d, e)- You were able to prioritize your care for the day and adjust your plans when necessary, based on changes that occurred during the day. You were available to help others when needed, and ask for assistance when needed. (3j)- Great job collaborating with the primary nurse on the patient's genitourinary assessment.
HS

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	NA										S		
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	S	NA										S		
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	S	NA										S		
m. Calculate medication doses accurately. (Responding)			S	S	NA										NA		
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			NA	NA	NA										NA		
o. Regulate IV flow rate. (Responding)	s		NA	NA	NA										NA		
p. Flush saline lock. (Responding)			S	NA	NA										NA		
q. Monitor and/or discontinue an IV. (Noticing/Responding)			S	S	NA										S		
r. Perform FSBS with appropriate interventions. (Responding)	s		NA	NA	NA										S		
	NS	NS	RH	HS													

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, p, q): You were able to perform medication administration this week. You performed all checks and rights of medication pass. You were very prepared with all medication information to review with me prior to administering. You were able to administer PO medications and flush an IV. Remember when flushing the IV to aspirate prior to flushing to see if you get blood return. You were able to discontinue an IV, and did so with great technique. RH

Week 4 (3k, l, m, q)- You did a nice job with medication administration this week! You were able to administer several PO medications. You followed the rights of medication administration and completed all checks prior to administering. You were able to research each medication and answer all questions related to the medications.
HS

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	S										S		
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	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	S										S		
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	S	NA										S		
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S										S		
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S N/A	NA	S										NA		
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S	NA										S		
	NS	NS	RH	HS													

**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): you communicated with the members of the healthcare team professionally and when reporting your assessment findings to the nurse, did so in an organized manner. I changed 4e to "N/A" because your care map is not a CDG. RH

Week 3 (4a,b) You did a nice job this week communicating with your patient, his daughter and his wife. You were professional and therapeutic in your conversations; you also provided education to the family on medications and the need for a bladder scan and possible fecal impaction. Great job! HS

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	NA										S		
a. Describe a teaching need of your patient. ** (Reflecting)			S	S	NA										S		
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			NA U	S	NA										S		
	NS	NS	RH	HS													

****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: 5(a/b) – Education provided to my patient related to shortness of breath on exertion, my patient relayed to me that he starts to panic when becoming short of breath (from exertion) and it causes him to increase work of breathing. I educated my patient how panicking increasing breathing making it shallow, which in turn blows off too much CO2 making oxygen exchange less efficient. I provided information on purse-lip breathing (breathe in through nose slowly, puckering lips while breathing out slowly) to improve oxygen and slowing heart rate. This was important information so the patient remains calm, as panicking while SOB on exertion can create safety issues with increased dizziness or lightheadedness. I did not provide a patient education sheet as my patient effectively demonstrated education after ambulation in the hallways when back in room (teach-back method). **You do not need to provide the patient with a printout if they do not want one, but you still must list your source of where you got the information from, even if it is your textbook or skyscape. RH**

Week 3 (5b) This is a “U” because it is required that you use a resource to support your teaching. Please address this “U” and state what you will do to prevent getting another “U” in the future. This will remain a “U” until it is addressed. RH

Week 4: 5(b) U – Education regarding my week 3 patient was sought from my resource Skyscape –Taber’s Cyclopedic Medical Dictionary. My goal to prevent getting another “U” in this objective is to make sure I accurately list my supporting education information’s resource on future clinical weeks. **HS**

Week 4 5(ab) -- Education provided to my patient included the importance of skin integrity and prevention with turning and repositioning every two hours, since my patient’s mobility was low. I thought education regarding the prevention of skin breakdown was beneficial since my patient’s coccyx was red with a slight ulcer on the right buttock. I educated my patient and his wife that he is at high risk because of sensory and physiological factors which could increase risk of pressure injuries, skin breakdown and sores. I included on the importance of repositioning every two hours with pressure relieving devices (pillows) to encourage blood circulation. My patient’s wife and POA (daughter), understood prevention and explained back to me the importance of frequent position changes, as they are sole caregivers. The family helped me to reposition my

patient, displaying understanding in repositioning. I utilized my education from Skyscape resource – Davis’s Disease & Disorders: A nursing therapeutics Manual, 7th edition, (skin integrity – skin – pressure injury). **Great job not only educating the patient about what you were doing but including the family members as well in the plan of care. HS**

Week 5 (a,b) – Erie County Senior Center Experience.

Week 5 (a,b) makeup – A teaching need for my patient consisted of education regarding complications such as infection over a new CBI (continuous bladder irrigation) placed due to a revision and stent placement after a ureter obstruction. This is the first time my patient has had a catheter, so he was unsure of the infection risk/complications associated with them. Education to my patient included how normally the catheter is a closed drainage system, which helps to prevent the addition of bacteria. However, since the bags have been changed, the system is now considered “open” and adds risk of adding bacteria and can potentially become a CAUTI (catheter-associated urinary tract infection). I educated my patient and his granddaughter on complications to monitor such as chills, increased pain, fever, foul-smelling urine, worsening hematuria and clots can indicate infection. I also educated my patient on keeping the catheter bag below waist to prevent backflow of urine, to keep the urethral meatus clean, proper hand hygiene before emptying, and using an alcohol wipe to clean off the port of the catheter when switching bags. In doing so, I educated my patient and family on the importance of cleanliness to help prevent infections. I gathered my information from Lexicomp and also printed the leaflet out to provide information directly to my patient to take home in case of further questions.

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	S	NA										NA		
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	NA										S		
	NS	NS	RH	HS													

****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 → 6(b) – My patient does not show signs of many factors associated with Social Determinants of Health. Using the CMS Social Determinants of Health Screening Tool, my patient had no negative factors in safety, utilities, transportation, housing, food, financials, and family support. He has a great support system with his family to provide any extra help or care around the house. Some factors that affect social determinants of health include substance abuse (chronic alcoholism) and decreased physical activity (mobility). Poor mobility can increase muscle weakness, decreasing oxygenation to tissues providing poor circulation, also leading to decreased lung expansion. Chronic alcohol use can weaken the immune system, delay healing, increase poor decision making, create dehydration issues and vitamin/electrolyte imbalances. **Social determinates of health can also be positive. If your patient has a great support system, that could be the SDOH you focus on. Great job listing multiple for your patient this week! RH**

Week 4 6(b) – I would say my patient does not show many factors associated with Social Determinants of Health using the CMS Social Determinants Screening Tool. My patient has no financial strain, no food/housing/transportation insecurities. My patient does have a wonderful support system, as his daughter is his main caregiver. My patient does not use any drugs, alcohol or smoking. The main social determinants I see that apply for my patient is how my patient struggles with immobility, requiring a hooyer lift; this impacts safety and self-dependence. Another factor would include dementia and round the clock care. My Patient is unable to make self-decisions, requiring the care of others to support him throughout the day with all activities. This affects Social Determinants of Health because my patient is unable to be independent, the increasing dependence on caregivers significantly impact his day-to-day safety. **Excellent job going through all of the SDOH related to your patient.**

Week 4 (6a)- Satisfactory on your care map, please refer to the rubric at the bottom of the tool. HS

Week 5 (6b) makeup –My patient demonstrates a couple areas of concern dealing with Social Determinants of Health using CMS Social Determinants Screening Tool. My patient has a good family support, with children and grandchildren helping if needed. Unfortunately, his wife died about a year ago which has caused him to become depressed. I feel as if being depressed can be worsened with social isolation or loneliness from losing his spouse, it can decrease mental wellbeing also. A social determinant of health can include his bilateral hearing aids, which could potentially create barriers in understanding medical information or communication. My patient does not require any mobility devices and currently still works as a carpenter, this suggests that he remains physically active (physically active is not a social determinant, as it is a good thing). However, his job occupation can potentially create occupational hazards. Overall, my patient is affected by several social determinants such as bilateral hearing aids (communication issues), loss of wife, and occupation. My patient does not experience housing instability, food insecurity, transportation issues or interpersonal safety violence.

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)	s		S	S	S										S		
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	s		S	S	S										S		
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	s		S	S	S										S		
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	s		S	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	S										S		
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	s		S	S	S										S		
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	s		S	S	S										S		
h. Actively engage in self-reflection. (Reflecting)	s		S	S	S										S		
	NS	NS	RH	HS													

**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 (7a and 7b) – An area of strength this week for me would include Accu-Chek FSBS. I was able to accurately complete quality control of the glucometer, while also successfully completing a finger stick without contaminating the sample and following the steps in order to achieve a blood sugar. I felt confident in completing the procedure without error. An area of weakness this week would include Trach care. I will review ATI, the lesson video, and documents with the steps to trach care and

suctioning to better understand and completely know the procedure steps in order. I will also practice trach care and suctioning three times before my clinical to fully prepare. **Good reflection, Kathleen! Great job with the FSBS competency, this will be something you will be able to apply in the clinical setting moving forward. Feeling comfortable with this process will allow you to better manage diabetes moving forward. As for trach lab, good plan for improvement! Great work during a busy first two weeks of the semester, keep up the hard work! NS**

Week 3 → 7(a/b) – An area of strength for week 3 that I felt was accurately performed was medication administration. I was able to successfully look up all medications for classifications, indications, adverse effects and assessments associated to my patient. I felt confident in verifying medication, expiration date, dosage and patient with accuracy. I also felt confident in giving the medication (PO) to my patient. An area to improve on for week 3 would include IV saline flush. While I was able to check IV patency with a saline flush (noticing that the IV itself was not clamped before my administration), I did not release the air bubble in the push before administering. When injecting the saline and the syringe was inverted, I noticed the air bubble at the top of the syringe. While it did not get injected into the patient, I realized my mistake immediately. I plan on improving my saline flush procedure by reviewing the steps before my next clinical, why also practicing/applying with my instructor at next weeks (week 4) clinicals. **Great job with medication administration this week. You were very well prepared and it went very smoothly. Good goal to have with IV flush/IV med administration. You will (most likely) have more IV practice as the semester progresses. RH**

Week 4 7(a/b) – An area of strength during week 4, I believe would count for a strength includes patient advocacy. During my assessment, I found concerning findings related to urination. Throughout my clinical, I noticed my patient’s abdomen becoming extended more than normal, with no pain/tenderness. However, after multiple bladder scans showed fluid in the bladder with no urgency from my patient, I found it concerning with urinary retention. After reporting back to my instructor multiple times and her understanding my concern, we collaborated with the RN on multiple occasions to discuss assessment findings. I gathered additional information from my patient’s family, reporting that my patient is normally continent and urinates every 2-3 hours. My patient’s family brought up the concerns with myself due to my patient not emptying his bladder, I discussed how I would communicate this information back to the RN and push the issue further. Even though my patient did not report any discomfort, I continued to push and advocate for my patient for further evaluation. I think I used my clinical judgement and assessment findings to advocate for my patient when he could not fully advocate for himself. **Great job with your assessment skills and then following up on them and passing the information along. HS**

An area of improvement I think I would benefit from would include time-management, at times throughout my clinical day I felt rushed or that my documentation was not completed on time. I feel that moving forward for next week’s clinical, I will prioritize care from the start by making a plan to practice cluster care and document as soon as possible after patient care and assessments. I plan to improve my time-management skills following the next 2 weeks of clinicals to get my interventions structured and organized. **Great plan! HS**

Week 5 (7a,7b) – An area of strength during week 5 during ECSC can include recognizing a potential hazard in my group’s activity (balloon volleyball). While sitting in a group circle of chairs to play the game with pool noodles and balloons, I noticed that when a senior who used a rollator left it off to the side but seemed to sit bent forward in the chair. With the activity of the game causing range of motion of the arms/torso with hitting a balloon in the air, I took initiative to move the rollator in front of the senior to provide more stability and to prevent any accidents of falling forward. I think the individual liked the help, as they seemed more inclined to participate in the activity.

An area of improvement that I would benefit from would include “assessing” if any participants had any recent injuries. I think I would benefit from verifying every participant’s limitations to prevent any further injuries. I also think an area of improvement would improve verifying any allergies to latex, as our balloons for our ECSC activity were latex balloons. Even though, our idea was proposed to the center beforehand, information can be bypassed or forgotten. Overall, I think I would improve my clinical experiences in assessing and verifying allergies and limitations in further preventing injuries. To improve, if having any other experiences like this I will make a pre-activity list that can be used to screen participants for future activities.

Week 5 (7a, 7b) makeup – An area of strength during week 5 clinicals can include educating my patient on the risk of infection dealing with a new CBI catheter. Since my patient has never experienced a catheter before, he has never been educated on the importance of maintaining hygiene and cleanliness to prevent any infections. I looked up education material on Lexicomp and printed a leaflet, so my patient had a physical copy. I felt as I was confident in teaching him information on signs and symptoms to monitor in caution to any infections, and to call the HCP if manifestations occur. I do feel that my patient and his family understood the signs and risks associated with the

CBI catheter, as once I was finished, they repeated back to me the education provided. I did recognize the need for education on infection and prevention before discharge. I made the clinical decision to look up education material before I was asked to provide it.

An area of improvement that I would benefit from for this week would include the head-to-toe assessment, in dealing with having the patient smile and lift the eyebrows to check for symmetry. I felt confident during my assessment, however looking back I realized I did not assess my patients smile or eyebrow raises. Moving on, I plan on practicing my head-to-toe assessment on a classmate 2 separate times to make sure I remember to assess smile/eyebrow symmetry. I can also review my procedure steps from my clinical lab folder in practicing the assessment by next clinical.

Student Name: Kathleen Sibert		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 and thorough list of findings for the noticing boxes!
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	4. Good list compiled of nursing priorities. 5. Goal includes timeframe for measuring purposes. 6. Highlighted all supported findings. 7. Great list of potential complications and s/sx of each one. Glad to see you did more than the minimum amount required! Good critical thinking.
	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	Interventions listed are personalized and all have rationale listed. Intervention number 6 is generalized "administer medications as ordered." Would be nice to know which medications you wanted to administer related to skin integrity. 4/11 interventions do not have frequency listed (64%) so one point lost here.
	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	

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:

Great job with this care map. It is very detailed and shows that you were using critical thinking while caring for your patient. You went above the requirements to add detailed information to help show what your patient looked like with just a care map. Remember to include frequency with ALL interventions, including educational interventions so you do not lose points. I would definitely keep this for your senior portfolio. RH

Total Points: 44/45

Faculty/Teaching Assistant Initials: RH

Student Name: Kathleen Sibert		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: Week 4							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	3	Great job, you listed many abnormal assessment findings for your patient. You did have some duplications: decreased mobility, weak upper and lower extremities, limited ROM could all be combined into weakness in upper and lower extremities would cover all of them. Be sure when using leg discomfort on exertion to use the pain scale. Great job on your abnormal lab/diagnostic findings. Excellent job on your list of risk factors for your patient. HS
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	You provided a list of 8 nursing priorities for your patient and selected the appropriate top priority problem. You stated an appropriate goal for the patient. You were able to highlight all of the related data to support the top priority problem. You were able to identify 6 potential complications related to the top priority problem. You listed all of the appropriate signs and symptoms that you would monitor the patient for with 4-5 under each potential complication. HS
	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	You provided a list of 11 interventions appropriate for your patient and specific to the priority problem. All interventions included a frequency, rationale and were prioritized appropriately. One suggestion for future care maps would be to include the medication as ordered in the MAR (acetaminophen 650mg PO Q6 prn pain.)
	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	You reassessed all of the abnormal findings from the assessment and lab/diagnostic categories. HS
	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:
Kathleen,
You did an excellent job on your nursing care map. You provided all of the details to present a clear picture of the patient and the nursing care to be provided based on your findings. HS

Total Points: 45/45

Faculty/Teaching Assistant Initials: HS

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

Student name: Kathleen Sibert								
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	
Faculty/Teaching Assistant Initials	MD	KA/RH	KA/DW/HS	MD/NS/RH	NS	NS	KA	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NS	

*Course Objectives

Comments:

(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 1/7/26. KA/DW/HS

(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. NS

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrated competence with tracheostomy care and tracheostomy suctioning, great job! You were able to maintain sterility throughout both procedures and were conscientious of your sterile field. During trach suctioning, you required one prompt related to returning the oxygen to previous settings after hyper oxygenating the patient prior to leaving the room. Otherwise, no additional prompts were needed for trach suctioning. During trach care, you did not require any prompts, well done. You were efficient, confident, and communicated well with your “patient” throughout. Keep up the hard work! NS

(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: Kathleen Sibert					
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	83.2%		
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