

**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)
1/9/26	3	Missed IV Lab	1/14/26

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 Physical Mobility	S KA	NA	NA

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	S												
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	S	S												
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	S												
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	S												
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	S	S												
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	S	S												
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	S	S												
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S												
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	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 5T, age 82 Total Knee Replacement	3T, age 75, Impaired mobility due to fall	Rehab 5T, age 89, Partial Hip replacement												
Instructors Initials	RH		RH	KA													

**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 – 1a-h – You did a nice job discussing on clinical and in debriefing your patient's pathophysiology, signs and symptoms, diagnostic studies, medications, medical treatments, and their current diet/nutritional needs and how it correlated to their admitting diagnosis. You were able to discuss your medications on clinical and researched their purpose, side effects, and related nursing interventions before administering medication to your patient. You came to clinical on time and prepared to care for your two patients, one diagnosed with back pain post fall and the other diagnosed with a UTI and new onset a fib. KA

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

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 them appropriately in meditech. You also were able to identify a priority problem with your patient and perform a detailed focused reassessment on your patient related to that problem. You communicated changes in your assessment to the proper healthcare team member. RH

Week 4 – 2 a-f – You did a nice job completing your physical assessment. You recognized abnormal assessment findings and documented them appropriately. You made sure your patient was on high risk fall precautions and ensured they were utilized throughout your day as you cared for them. You recognized your patient had a low SpO2 and worked with your instructor and nurse to initiate oxygen as well as ensure accuracy of the SpO2 reading. You completed a thorough wound assessment on your patient and was able to provide the prescribed treatment. You documented the wound as open to air in the wound assessment and monitored the site for any further complications. You utilized the EMR to research your patient and ensured your assessment findings were documented appropriately. You did a nice job documenting and made changes when needed promptly. KA

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												
a. Perform standard precautions. (Responding)	S		S	S	S												
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	S	S												
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S	S												
d. Appropriately prioritizes nursing care. (Responding)			S	S	S												
e. Recognize the need for assistance. (Reflecting)			S	S	S												
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S	S												
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			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	S												
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S	S												
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S												
	RH		RH	KA													

**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 appropriately throughout both clinical days. You were able to organize your day and perform all nursing tasks/assessments in a timely manner while working around the therapy schedule. You asked for help when needed. You were able to administer enoxaparin for DVT prophylaxis. RH

Week 4 – 3 a-f – You did a nice job ensuring standard precautions were utilized throughout your day when caring for your patient. You worked well with your classmates to assist one another when needed. You managed a patient on oxygen and monitored their SpO2 to ensure oxygen therapy was effective and still needed. You discontinued O2 therapy and documented it accurately in the EMR when the patient refused the NC later in the day. You were very independent and thorough with the care you provided on the first day of clinical and sought appropriate guidance on the second day of clinical when there was a question in the change in your patient’s status. You did a great job setting a goal for your patient related to ambulation and assisting them in achieving it to help them get closer to discharge. KA

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

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

Week 1 (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): You were able to perform medication administration this week. You were well prepared with all medication information to review with me prior to pulling medications. You had thoroughly looked up medications to be prepared. You administered PO and SubQ medications. You did great calculating medication dosages and scanning all meds correctly. You used the rights of medication administration and your three checks to ensure there were no medication errors. RH

Week 4 – 3 k-m – You did a nice job administering medications this week. You looked all medications up before administering and ensured the rights of medication administration were followed. You had the opportunity to administer PO, topical, and SubQ medications this week. You were prepared to administered IV medication as well but the patient’s IV infiltrated and healthcare provider determined the patient did not need the IV medication before discharge so it was discontinued instead of restarting the patient’s IV. You checked the patient’s labs and vital signs to ensure no medication needed to be held before administration. You made sure all medications were properly documented in the eMAR and updated your nurse when the process was complete. KA

Week 4 – 3n, o –You did a nice job attempting to administer an IV piggyback this week. You primed the tubing ensuring no bubbles and programed the pump for the correct medication. Unfortunately, when you checked patency of the patient’s IV you determined it was infiltrated and promptly notified your nurse. In the end the decision was to not restart the IV and administer the medication before discharge. You did a great job following direction and completing the process flawlessly even though you did not get to complete the administration. KA

Week 4 – 3p – You had the opportunity to flush your patient’s IV site before medication administration. You determined the patient’s IV was infiltrated and reported this finding to the nurse as well as documenting it in the patient’s EMR. Nice job! KA

Week 4 – 3q – You did a nice job monitoring your patient’s saline lock for complications and documenting your IV site assessment in the patient EMR correctly. You determined the patient’s IV was infiltrated and DC’s the patient’s IV with the catheter intact. You applied pressure to the site and a determined the site stopped bleeding before applying tape. Terrific job! KA

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

**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 professionally with all members of the healthcare team. You were able to communicate any changes with your assessment to the nurse caring for your patient in an organized manner. You did a care map this week, so 4e was changed to N/A. RH

Week 4 – 4 a-d, f – You worked well with classmates, assigned RN, and staff members to provide care for your assigned patient. You received report for your patient and asked questions as needed. You utilized the EMR to research information on your patient and ensured confidentiality was maintained. You provided an SBAR to your nurse when reporting off and made sure all pertinent information was passed on before leaving. KA

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

****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 3a and 3b- A teaching need that my patient needed was her hypertension. I utilized skyscape to teach her how to monitor her hypertension and follow up with her primary doctor after her stay at the hospital. Another teaching need was that she needed education on utilizing her walker and cane when she needed to. She was a very independent lady and was not fearful of anything. I just made sure to explain to her when she got home to utilize her resources. **Great job! Both are good education topics for patients. RH**

Week 4a and 4b- A teaching need that my patient needed was to encourage drinking water and the side effects of her medications that could cause her to lose her balance when walking. I used Skyscape to see the side effects of her antihypertensive medications that could cause orthostatic hypotension. **Nice job. KA**

Week 5a and 5b- A teaching need that my patient needed was to encourage protein intake and encourage to sue the incentive spirometry due to her shortness of breath. I used by information from the textbook to provide explanations of why you need extra protein to help with wound healing and the incentive spirometry to help with opening the lungs.

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												
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	S												
			RH	KA													

****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 6b- Some social determinants of health for my patient were her age. She was 82 years old, which increased her level of care with increased fall risk and impaired wound healing from her surgery. She also had lack of support due to being a caregiver for her own husband and not having any family nearby. **Good observations of your patient’s SDOH. RH**

Week 4 6b- Some social determinants of health for my patient were her age. She was 75-year-old, which increased her chance of falling and her living alone which led to her having a fall in the first place. **Great job identifying these SDOH factors. What resources are available to help address these concerns for the patient? KA**

Week 4 – 6a – You satisfactorily completed your second care map. Please see the rubric at the end of your clinical tool for details. KA

Week 5 6b- Some social determinants of health for my patient washer age. She was 89 years old and she was also a former smoker that both have a negative impact on the healing process of her wound from her surgery.

S

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

**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 Strength- For week one I was able to come prepared to all of the skills rotations and understand the content that I was learning. For my area of improvement is to be more confident in myself with my head-to-toe assessment. I doubt myself and overstress which makes me flustered. I will right before I perform a head-to-toe assessment is to take a breather and remind myself that I know what I am doing. **Great plan! RH**

Week 3 Strength and area of improvement- For my strength I did good on my medication administration and administering my first injection. I administer the enoxaparin to prevent DVT in her abdomen. My area of improvement is time management with my head-to-toe assessment. I take too much time talking to my patient and not enough time doing my assessment that I have to rush to get it done. Next time I have a patient I will make sure that I do my assessment first before I talk more to my patient. I will also practice my head-to-toe 3 times before next clinical to make sure that I do it in a timely manner as well as efficient. **You did GREAT with your medication administration. You were well prepared and knowledgeable about all meds prior to administration. Though you said it was the first time giving enoxaparin, you seemed confident and did a great job. For your area of improvement, sometimes having a conversation helps with the assessment of your patient. You can ask questions about them while you are watching them move their arms and legs or while they are talking you can assess their speech and facial movement. This can take some practice, but it is possible to do both with a purpose. RH**

Week 4 Strength and area of improvement- For my strength I did a good job of recognizing that my patient was experiencing infiltration when I was performing my saline flush. My area of improvement is to provide more education topics for my patient. I educated on the mobility and the side effects of medication, but I didn't educate on what can happen when you are not moving and the complications like pneumonia and constipation that can be resolved by coughing, deep breathing and performing range of motion exercise in bed. **Remember when recognizing your area for improvement to include a measurable goal for next time such as "I will write down all patient education needs the next time I am on clinical and check them off as they are taught to ensure more thorough education is provided." KA**

Week 5 strength and area of improvement- For my strength I did a good job of administering my medication especially with taking the time to let her due it at her own time and my area of improvement is to be more innovative with searching for ways to increase my patients' motivations. Next time I will look up more innovative areas after the first day of clinical on my patient to put them into practice on the next day of clinical.

Student Name: Katleyn Swingle		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	Good findings listed for all noticing boxes. You can always include more than the minimum amount required if it will help paint a better picture of what your patient looks like.
	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 of nursing problems. 5. Goal includes timeframe for measuring. 6. highlighted all supporting data 7/8. Good list of complications and s/sx of each complication.
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	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	All interventions are prioritized and personalized to patient. All interventions have frequency and rationale personalized to patient.
	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	I really like the smoking cessation intervention and how you relate it to delayed wound healing. Great connections!
	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:

Good job! This is a great care map. Be sure to try and include as many assessment findings/lab findings/diagnostic tests/risk factors. The more you include, the better we will “see” what your patient looks like and be able to make connections with you. I would definitely keep this for your senior portfolio. RH

Total Points: 45/45

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)	3	You did a nice job identifying all abnormal assessment findings, labs/diagnostics, and risk factors for you patient this week. KA
	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 did a nice job identifying all nursing priorities for your patient and highlighting the patient's highest nursing priority. You had the foundations for a realistic measurable goal for your nursing priority, but I think you meant to say improved instead of impaired. You highlighted associated information from the noticing section. I would consider highlighting PVD from the risk factors section as well. You identified 3 complication for you priority and signs and symptoms the nurse should assess the patient for. KA
	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 did a nice job listing all nursing interventions related to your nursing priority and ensuring they were prioritized, included a frequency, were individualized, realistic, and included a rationale. For the medication intervention some medications had a frequency and others did not. Make sure to place a frequency for all medications in the future. Nice job! KA
	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 did a nice job reassessing your highlighted information from the noticing section. You identified you would discontinue the plan of care since your patient was discharged. KA
	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 satisfactorily completing your second care map. Please see comments above on areas to consider in the future to make your care maps clearer, Overall you did a terrific job setting up this plan of care for your patient! KA

Total Points: 45/45

Faculty/Teaching Assistant Initials: KA

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

Student name:								
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: 1/7/26	Date: 1/7/26	Date: 1/9/26	Date: 1/14/26	Date: 1/14/26	Date: 3/9 or 3/10/26
	Evaluation:	S	S	S	S	U	S	S
Faculty/Teaching Assistant Initials	RH	RH	RH	RH	RH	RH	RH	
Remediation: Date/Evaluation/Initials	N/A	N/A	N/A	N/A	S 1/14/26 RH	N/A	N/A	

*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 1/7/26. 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. RH

Week 2

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. RH/DW/NS/HS well done! Sterility maintained. DW

(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	95.2%		
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