

EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Kaylee Altomare

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)
1/31/26	0.5 hours	Incomplete ECSC CDG	2/2/26, 0.5 hours

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
Week 3	Dysfunctional Gastrointestinal Motility	S/NS	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:																	
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			S	NI	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	N/A	S												
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	N/A	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		4N, 94 yrs, Bowel Obstruction	OR, ECSC	3T, 70, Stomach Cancer												
Instructors Initials	MD	MD	NS	DW	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 1(a,b) – You were able to research and discuss the pathophysiology involved with your patient’s primary disease process of a colon mass requiring an open colectomy. You identified the obstructing mass from the tumor leading to altered bowel elimination and abdominal pain. Through our discussions, you were able to identify the rationale for the procedure and need for a colostomy bag. You identified your patient’s hypoactive bowel sounds, stoma appearance, ostomy output, midline incision with staples, abdominal cramping, and anemia as symptoms of her newly identified colon cancer. NS

Week 3 1(c,e) – Good work reviewing your patient’s diagnostic testing results. You were able to identify the abdomen/pelvis CT results that demonstrated excess stool in the colon and an irregular wall thickening consistent with an obstructing mass. You also identified abnormal lab results, such as an elevated vit. B12 level and elevated carcinoembryonic antigen test which you correlated with her colon cancer diagnosis. You discussed the medical treatment required and researched an open laparotomy procedure to perform a colectomy and oophorectomy for an identified ovarian cyst. NS

Week 3 1(f) – You were able to identify the importance of adequate nutrition for healing following her significant abdominal surgery. You noticed that her appetite was well within normal limits and calculated her oral intake accurately. NS

Week 4 (1a)- Kaylee, I am curious to know why you gave yourself an NI for this competency. Overall, you did a nice job correlating, the patient’s medical history and assessment with the need for a surgical exploration (panendoscopy). DW

Week 5- (1 a, b, c, d, e, f)-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. You were able to identify your patients nutritional needs and that he was ordered Ensure with his meals yet he was not consuming it. You were able to discuss this with the patient and determine he was having problems drinking it and causing his hiccups. You then informed the nurse of his issue with the Ensure to determine a plan. 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:																	
a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	N/A S	S												
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			U NI	N/A S	S												
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	N/A S	S												
d. Communicate physical assessment. (Responding)			S	N/A S	S												
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	N/A S	S												
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	N/A	S												
	MD	MD	NS	DW	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 1 2(a) – Great job with your assessments this week! You were able to notice numerous deviations from normal. Upon assessment, you noticed missing teeth, +4 pitting edema, abdominal firmness, hypoactive bowel sounds, presence of a colostomy with normal appearance stoma and output, abdominal incision with the presence of 26 staples, scant amount of serosanguinous drainage, and back discomfort related to pressure on bony prominences. Good assessment skills this week! NS

Week 3 (2b) – I did not complete a falls assessment. I will complete a falls assessment on future patients. I changed this competency to “NI” because the assigned RN had already performed and documented this assessment. While it is still important to perform this assessment routinely, I don’t think it warrants a “U” because it had already completed. I love the you are holding yourself accountable and want to remind yourself to do this in the future. Just so you are aware, even if the RN completes the intervention, you can always perform and document your own safety assessment. NS

Week 3 2(c) - As a result of your thorough assessment, you were able to identify moisture under her breasts that causes blistering of the skin. You were able to intervene to prevent worsening skin breakdown by cleansing the skin and using theraworx products. You also noticed the use of Mepilex dressing on her bony prominences due to pressure injuries. NS

Week 4 (Obj. 2)- Please utilize the highlighted suggested competencies for evaluation above when attending the alternative clinical sites (DH, IC, ECSC, and OR). This will allow you to give full credit where it is due with every clinical experience. These competencies were not only demonstrated during clinical but also discussed in your CDG post. In terms of the adjusted evaluations above, you earned a S as your OR discussion post demonstrates understanding of the need for baseline assessment data, implementing safety measures associated with surgery, and patient-centered pain management. Well done! DW

Week 5 (2a-f)- You did a nice job with your assessment this week. You sought assistance when having issue obtaining the pedal pulse. You also did a nice job communicating your findings to the RN. 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:																	
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)			N/A	N/A	N/A												
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	N/A	N/A												
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)			N/A	N/A	S												
	MD	MD	NS	DW	HS												

**Evaluate these competencies for the offsite clinicals:

DH: 3a

IC: 3a, f

ECSC: 3a, j

OR: All

Comments:

Week 3 (b,c,f) – You were able to perform several nursing skills during the care of your patient this week. In each instance, you demonstrated skill and safety to promote positive outcomes. You were able to perform a dressing change, perform a subQ injection, and a saline flush among your other routine nursing measures. With each skill,

you were organized, effective, and maintained asepsis as indicated. Throughout the week you were prompt with your nursing care which allowed you to participate in additional learning opportunities. Well done! NS

Week 3 3(h) – You effectively implemented DVT prophylaxis with the administration of subQ enoxaparin as prescribed by the healthcare provider. Good technique with your subQ injection! NS

Week 4 (Obj. 3)- Your OR discussion demonstrated solid observation and understanding of various safety measures utilized during the procedure you attended. Excellent job! DW

Week 5 (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 able to re-arrange the day since your patient needed to leave the floor both days for radiation therapy. 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 nutritional status. 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:																	
k. Administer PO, SQ, IM, or ID medications observing the rights of medication administration. (Responding)			S	N/A	N/A S												
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			S	N/A	S												
m. Calculate medication doses accurately. (Responding)			N/A S	N/A	S												
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			N/A	N/A	N/A												
o. Regulate IV flow rate. (Responding)	S		N/A	N/A	N/A												
p. Flush saline lock. (Responding)			S	N/A	N/A												
q. Monitor and/or discontinue an IV. (Noticing/Responding)			N/A S	S	N/A S												
r. Perform FSBS with appropriate interventions. (Responding)	S		N/A	N/A	N/A												
	MD	MD	NS	DW	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,l,m,p,q) – You did a nice job with medication administration this week. You were able to administer three PO medications, one subcutaneous injection, and performed a saline flush. With each medication, you observed the rights of administration and performed three safety checks. You effectively utilized the BMV scanning system for each medication, paying close attention to the alerts provided for safety. Competency “m” was changed to “S” because you calculated your medication accurately. You noticed that the prescribed spironolactone was 12.5mg; when dispensing from the pyxis you noticed that the pill was already split in half and packaged.

You confirmed that the correct dose removed and administered. Great job with your saline flush, utilizing aseptic technique. During the saline flush, you monitored the IV site closely for potential complications. NS

Week 5 (3k,l,m)- Competency K was changed to an S because you administered oral medications. 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. (q)- This was changed to an S because you monitored and documented on the patient's IV site. 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:																	
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	N/A	S												
c. Report promptly and accurately any change in the status of the patient. (Responding)			S	N/A	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)			N/A	S U	S												
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S	S												
	MD	MD	NS	DW	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	Week 5	HS
Safety: Restorative Care and Managing Potential Complications		

Comments:

Week 3 4(a,b) – You were strong with your communications this week with the patient, family members, peers, and members of the healthcare team. You were respectful of your patient’s visitors, allowing them time with your patient for prayer and comfort. You worked very well with the assigned RN, communicating frequently and learning through observation. Great job building a rapport with everyone you interacted with! NS

Week 4 (4e)- According to the CDG Grading Rubric, you earned an unsatisfactory for your participation online discussion this week. The OR/Surgery discussion met all criteria, was thoughtful and supported by evidence (Taber’s Cyclopedic Medical Dictionary). Additionally, your APA formatting is right on. Unfortunately, the Erie County Senior Center discussion addressed the first question but not the second, and was just under the word count. This will result in 30 min of missed clinical time and will require make up of this time by modifying your post to meet the above requirements. Please, also be sure to read page 1 of this document to ensure you address this U appropriately. You are required to comment on how you will improve in this area when you submit your clinical tool for week 5. Failure to do so will result in a continued U rating until addressed. Let me know if you have any questions. DW

Week 4 (4e) – I will improve this by answering the questions fully and resubmitting my CDG for week 4. Kaylee, you have now met the requirements for the ECSC CDG, this will be considered made up. HS

Week 5 (4e)- You satisfactorily met the requirements for you CDG post this week. You were able to discuss the concerns about your patient’s tumor and his nutritional concerns, bowel concerns and his high fall risk score and refusal to be placed on fall precautions. 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:																	
a. Describe a teaching need of your patient.** (Reflecting)			S	N/A	S U												
b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			S	N/A	S U												
	MD	MD	NS	DW	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: My patient was experiencing a dry mouth and nose, so I educated them on the importance of drinking plenty of fluids, especially while on diuretics. After I explained the importance of drinking water, my patient asked for her water and chapstick. **Very good! You were able to correlate her use of diuretics with the risk of dehydration. You noticed in your assessment that her oral cavity was dry and lips were cracked. As a result, you identified an important educational need and confirmed understanding through the patient requesting water. One thing to consider, you noticed that she had pitting edema in the lower extremities and the prescription for a diuretic – would there be any concern if she drank too much water? NS**

Week 4-5: My patient wasn't drinking his Ensures so I was concerned as to why he wasn't drinking them. Simply, the liquid was too thick. I didn't provide any resources along with my teaching, but I was able to listen to what he had to say after my teaching was performed. **Kaylee, you have not listed anything about teaching the patient. You mention that you had a conversation about why the patient was not consuming his Ensure, but you have not mentioned anything in the above statement about educating him on anything or any resources utilized. HS**

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. HS

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	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	N/A	S NI												
	MD	MD	NS	DW	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(A) – Satisfactory care map submission with the priority problem of dysfunctional intestinal motility. See the attached rubric for more details. NS

Week 3: Some social determinants that may potentially affect patient care are that she has a son who helps care for her and that she is seemingly ready to learn whatever so that she can go home. Some cultural determinants may be that she is a faithful lady, and that seems to motivate her to want to get better. **It sounds like you were able to identify positive aspects of SDOH related to your patient care experience. SDOH can prevent patient's from achieving outcomes as a result of conditions within the environment they grew up in and/or live in. How does her readiness to learn, support of her son, and faith impact her health outcomes in a positive way? How could a lack of these factors negatively impact her health? Attached is a link to help better understand SDOH as you continue to learn. NS**
<https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health>

Week 4: Some social determinants that may potentially affect patient care are that he did not want to hear anything I had to say, and wanted to argue about whatever I had to say. He didn't have anyone visit him, but both days he had called (whom I believe was a family member), to talk for some time, and was seemingly happier after the conversations. **Kaylee, if you are unable to identify factors associated with SDOH that can influence care for your patient. Dig deeper into conversation with them, in an**

attempt to identify any concerns that may exist. It sounds like his support may be an issue upon discharge? Will he have transportation to and from appointments or to the store for food and will he be able to get his medications from the pharmacy? HS

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												
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		S	S	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												
	MD	MD	NS	DW	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: I feel good in the fact that I was able to recall most information from last semester. Something that I can improve is my confidence. Confidence comes in time, so there isn't much that I can do about it but to continue to do skills correctly and gain confidence as I go. I am so excited that you were able to recall information that you

have already learned! Confidence does come with time, but maybe a short-term goal could be to feel more confident in certain skills by spring break (assessments, IV skills, ect.). This will allow us to see progress. Great job! MD

Week 3: I felt confident in med pass this week, and it felt good to be proactive in my patient's health! Something that I can improve on is charting and finding what I want a little faster, and a way that I can do that is by practicing/going through my patient's chart as I have some free time on clinicals. Good, Kaylee! I am happy to hear that you were confident in your medication administration skills despite the long layoff since your last opportunity. I agree with your strength, as you seemed comfortable with the process and you were well-prepared to answer my questions related to medication administration. I especially appreciated you staying close by your patient as she swallowed her oral medications after she stated she might have a hard time swallowing the large Motrin pill. As for your area for improvement, keep practicing! Utilize the "down time" at clinical to dig through your patients' chart to learn more. You can always utilize the computer lab for more practice with documentation as well. Great job this week! NS

Week 4: I felt confident in communicating with my patient/individuals from the senior center. Was there anything in particular about this environment of patient population that made you feel comfortable with communication this week? I'm so happy for you, but also curious to learn more about your reflection on this strength. Either way, keep it up! DW Something that is kind of hard for me to do is think of what to say/empathize or what the right questions are to ask them that are appropriate for the situation. I can work on this in my everyday life situations. Kaylee, I would like to challenge you to be more thorough with your reflections on weekly strengths and opportunities for improvement. While you may be doing this internally, we as faculty would like to learn more about your growth, especially the internal stuff that we cannot physically observe on our own. I will share a little reflection of my own. I can totally relate to your inability to come up with things to say to people you don't know on the fly. For me, it's almost as if my mind goes completely blank and there is literally no options for reply in my brain. In the past, I would often find myself just standing there and smiling. Working on this in your everyday life will be helpful, but I will share that working in healthcare has helped me even more. Putting yourself out there is a great start. I also found it helpful to take some time and script a couple starter statements that I could keep in my back pocket when I went blank. Getting back to my challenge for you- in the future, please provide more detail in your responses to 7a and 7b...at least a couple sentences each. Additionally, be sure that your goal includes all of the necessary information (see highlighted information in green above). Future omission of any of these details will result in a U and we don't want that. The main things that are often missed include how often you will do something and when you will do it by. For example, how often will you take yourself out of your comfort zone in your daily life to practice appropriate communication (ex. 5 times) and when will you attempt to complete this goal by (ex. two weeks, before your IC and DH clinicals). Let me know if you have any questions or need assistance in any way. DW

Week 5: I felt confident in what I knew to do/what was right this week. For example, I knew that it wasn't right that he wasn't drinking his Ensure and communicated with Heather (you) on what I could do about it. HS Something that I could improve on is working on my communication with uncooperative patients. I can work on this by when I get into an argument with my brothers, how to de-escalate the conversation, and what is right to say. I may not have an exact number of times this happens in a day/week, but my goal is to have some better thoughts of what to say by March. You will definitely face many patients that are difficult to care for in the healthcare field. The challenge is that no two situations will be the same, it is helpful to embrace each instance individually and look at both verbal and non-verbal communication from both the patient and yourself during these situations. HS

Student Name: Kaylee Altomare				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 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	Twelve abnormal assessment findings are listed, all based on the findings during the patient care experience. Six abnormal diagnostic findings are listed based on results in the EHR. Several risk factors are identified,
	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	Seven top priority nursing problems are identified based on the patient’s current and past medical history. Based on the admitting diagnosis and nursing care required, dysfunctional GI motility is identified as the top priority problem.
	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	Most relevant data is appropriately highlighted as it pertains to the top priority problem. Consider including her family history of cancer, as this puts her at risk for the cancer that led to her dysfunctional GI motility. Three priority potential complications of dysfunctional GI motility are listed with specific signs and symptoms to monitor for.
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Respon	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	A list of ten nursing interventions is provided. Listed interventions are prioritized appropriately with assessment interventions taking highest priority. Consider including an intervention related
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

ding	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	2	to pain since you included pain relieving medications. Also, consider an intervention related to assessing the characteristics of her stool. You would also want to include an intervention related to changing the dressing per orders since you included an assessment of the incision. Just some things to consider!
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
							Interventions 7-10 did not include a frequency. Be sure to include a frequency with all interventions. For example, "ambulate the patient TID" or "Ensure the patient is drinking fluids q8h and PRN".

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	An appropriate rationale is provided for each listed intervention,
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	A list of re-assessment findings are provided to evaluate the effectiveness of the plan of care. Based on the results and the pending discharge to a SNF for continued healing, it was appropriately determined to continue the plan of care.
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete	3	

Reference

An in-text citation and reference are required.

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

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

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

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

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

Faculty/Teaching Assistant Comments: Kaylee, Great job with your care map submission for the priority problem of

Total Points: 43/45 – Satisfactory

Faculty/Teaching Assistant Initials: NS

dysfunctional gastrointestinal motility. You were able to apply what you learned in the clinical setting and identified important aspects of a nursing plan of care to consider. You have received 43/45 points for a satisfactory evaluation. Your 1 required care map submission prior to midterm is now complete. Remember, you will submit one more satisfactory care map before the end of the semester. Don't hesitate to reach out with any questions/concerns. Keep up the hard work! NS	
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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: - 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: Kaylee Altomare								
<u>Skills Lab Competency Evaluation</u>	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: 3/9/26
Performance Codes:								
S: Satisfactory								
U: Unsatisfactory								
Evaluation:	S	S	S	S	S	S	S	
Faculty/Teaching Assistant Initials	MD	MD	MD	MD	MD	MD	MD	
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 1/7/26 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. MD

Week 2

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. Great job keeping materials sterile and completing all care. RH

(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: Kaylee Altomare					
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	NS	NA
		DCE Score	97.7%		
Date: 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	S	HS	NA
		DCE Score	94.5%		
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