EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Keira Keoghan

Final Grade: **Satisfactory/Unsatisfactory**

Semester: **Spring**

Date of Completion:

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

Faculty eSignature:

Teaching Assistant: **Stacia Atkins,** BSN, RN

DIRECTIONS FOR USE:

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

METHODS OF EVALUATION:

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

ABSENCE (Refer to Attendance Policy)

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

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

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

Satisfactory (S): Safe, accurate each time, efficient, coordinated; confident, focuses on the patient; some expenditure of excess energy; within a reasonable time period; appropriate affective behavior; occasional supporting cues; minimal faculty feedback related to written clinical work.

UNSATISFACTORY CLINICAL PERFORMANCE

Needs Improvement (NI): Safe; accurate each time; skillful in parts of behavior; focuses more on the skill and self rather than the patient; inefficient, uncoordinated, anxious, worried, flustered at times; expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues; faculty feedback required in several areas of clinical written work.

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U," the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

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

Week	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
4	Acute pain R/T left hip fx and muscle spasm	S/RH	N/A	N/A

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

Objective

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

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies: a. Analyze the involved patho-physiology 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		OR, 48, total right shoulder replacement	5T, 81, left hip fracture s/p IMN	ECSC	3T, 80, COPD w/ exac. 84, epigastric pain N/V											
Instructors Initials	HS		DW	RH	DW												

****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 (Obj. 1)- Great job correlating, the patient's medical history, assessment, and intervention with the need for a shoulder replacement. DW

Week 4 (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

*End-of-Program Student Learning Outcomes
Clinical Judgment Terminology: Noticing, Interpreting, Responding, Reflecting

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)			~~NA~~ S	S	NA	S											
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			~~NA~~ S	S	NA	S											
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			~~NA~~ S	S	NA	S											
d. Communicate physical assessment. (Responding)			~~NA~~ 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		NA	S	NA	S											
	HS		**DW**	**RH**	**DW**												

****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 (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 validated understanding of the need for assessment, implementing safety measures associated with surgery, and patient-centered pain management. These measures were identified to be evidence-based. Well done! DW

Week 4 (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

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	S											
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		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)			NA	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											
	HS		**DW**	**RH**	**DW**												

****Evaluate these competencies for the offsite clinicals:** **DH: 3a** **IC: 3a, f** **ECSC: 3a, j** **OR: All**

Comments:

Week 4 (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.

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)			NA	~~S~~ NI	NA	S											
l. Ensure patient safety through proper use of EHR, IV flow sheet, and BMV. (Responding)			NA	S	NA	S											
m. Calculate medication doses accurately. (Responding)			NA	S	NA	S											
n. Administer IV therapy, piggybacks, IV push, and/or adding solution to a continuous infusion line. (Responding)			NA	NA	NA	S											
o. Regulate IV flow rate. (Responding)	S		NA	NA	NA	S											
p. Flush saline lock. (Responding)			NA	NA	NA	S											
q. Monitor and/or discontinue an IV. (Noticing/Responding)			NA	NA	NA	S											
r. Perform FSBS with appropriate interventions. (Responding)	S		S	NA	NA	NA											
	HS		**DW**	**RH**	**DW**												

****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 4 (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. I changed 3k to "NI" due to your SubQ injection. You seemed nervous (which is okay) and you dropped the needle onto the patient's bed after administration. I encourage you to build some confidence by practicing more in the skills lab. You did everything correct and it was very well done, so you are doing all the things you need to do, but I think your nerves got the best of you. Practice

will make this easier and less nerve wracking. 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

(NI) Addressed: To improve on competency 3k, I will be more slow when administering medications and be more aware of maintaining proper post-injection technique. DW

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	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	~~S~~ N/A	S	S											
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			NA	S	NA	S											
			DW	**RH**	**DW**												

****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 (Obj. 4)- You were able to identify the importance of effective communication in the surgical department. Great job! The goal will then be to find ways to utilize this effective communication in your own practice as a nurse. DW
Week 3 (4e)- According to the CDG Grading Rubric, you have earned a satisfactory for your participation in the OR/Surgery discussion this week. Your post was thoughtful and supported by evidence (Lewis- surgical safety). Additionally, your APA formatting is right on track for the citation. Some slight adjustments will need to be made for future references. Here is the correct reference for the Lewis textbook:
Harding, M., Kwong, J., Hagler, D., & Reinisch, C. (2023). *Lewis's medical-surgical nursing: Assessment and management of clinical problems* (12th ed). Elsevier, Inc.
Notice the usage of authors last names and first initials, placement of the publication year, italics of the book title, and only capitalizing the first word of the title and again if the title includes a colon. These finer details are important, and while tricky, can be developed over time. Please consider utilizing the APA Formatting Examples document available in the Clinical Resources on Edv360. It assists you with formatting and also gives you the correct formatting for several of our commonly used resources. Additionally, the Purdue Owl website is amazingly helpful as well. The website is
https://owl.purdue.edu/research_and_citation/apa_style/apa_formatting_and_style_guide. DW

Week 4 (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. 4e was changed to "N/A" due to you having a care map this week and not a CDG. RH

Week 5 (4e)- According to the CDG Grading Rubric, you have earned a Satisfactory for your participation I the ECSC discussion this week. Your discussion was thorough and thoughtful. Keep up the good work. DW

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)			NA	S	NA	S											
b. Utilize appropriate termino-logy and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			NA	S	NA	S											
			DW	**RH**	**DW**												

****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 4:
(A): A teaching need for my patient would be to learn how to manage pain without the usage of medication and safely move the affected lower extremity to promote healing and further complications from occurring. I made sure my patient was using her assistive devices when ambulating and using an ice pack on the effected extremity to ease any discomfort or inflammation she was experiencing in the area. These were important to educate her on because they prevent further injury from happening and promotes further healing for my patient. This is a great education area for patients! RH
(B): I used the skyscape resource to provide effective education and care for my patient. The reinforcement method was used to confirm my patient's understanding of my teaching. Great job RH

Week 6:
(A): A teaching need for my patient who was experiencing COPD with exacerbation would be educating her more on managing her shortness of breath and understanding the purpose of her medications. She was experiencing chronic pain and emotional distress related to external factors with family members, this affected her mood and willingness to engage greatly. Teaching needed to be explained to my patient briefly with empathy. Reinforcement on recognizing early signs of worsening symptoms and when to seek medical attention was especially important to teach my patient.
(B): I used the teach-back method to make sure my patient was able to accurately restate the key points of the education I provided. Using terminology found within Lexicomp, I explained that COPD management requires proper inhaler technique, adherence to medication usage, and catching early symptoms of worsening respiratory symptoms.

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)			NA	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)			NA	S	NA	S											
			DW	**RH**	**DW**												

****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 4:
(B): A major factor associated with SDOH that influenced the care of my patient was that my patient has a history of chronic smoking and is known to drink a glass of wine daily. These factors greatly impact her health overall, increasing her risk of complications such as respiratory distress, delayed wound healing, and cardiovascular stress. These must be considered when planning pain management and mobility for a patient like mine, especially since it's more post-fracture-based care. This could definitely be an issue when the patient is discharged with narcotic type medication and is drinking alcohol with them. A lot of education should be done with the patient to ensure that they are aware they cannot drink alcohol with these pain medications. RH

Week 6:
(B): A factor associated with SDOH that influenced the care of my patient was the significant grief she experienced due to external factors within her family. This emotional stress likely impacted her mental well-being, mood, and overall ability to manage her COPD effectively. These factors can contribute to decreased motivation, nonadherence to medications, and respiratory symptoms that may worsen over time. This must be considered when planning care, as providing emotional support is important alongside managing the exacerbation she was experiencing.

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											
	HS		**DW**	**RH**	**DW**												

****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:

Weeks 1 & 2:

(A): I can confidently hang primary and secondary IV bags with proper preparation, as well as making sure the tubing is organized, and allowing IV pumps to be set up safely too. HS

(B): I am having difficulty with insulin administration at times, which slows down my workflow and requires extra checks. This can sometimes lead to delays in completing the task. To improve on this, I will continue to practice the administration of insulin when given the opportunity to do so and review the protocols for insulin to become more accurate with future administrations of this medication. This will become easier with more experience, which should occur during the clinical experience. HS

Week 3:
(A): I can accurately obtain my patient's blood glucose level while following proper safety and infection control measures. I ensured that the blood glucose was taken correctly and remained attentive to my patient's condition as I took it. Excellent! Did this feed comfortable to you, or was it your first official time in the clinical setting? Either way, keep up the great work! DW
(B): I had limited opportunities for hands-on skills during my OR clinical experience, this restricted my ability to actively participate beyond observation. To improve, I will take initiative to ask for more opportunities to assist when possible and continue to actively observe the abilities of nurses to strengthen my understanding of their practice. I love this attitude. Passive learning will only get you so far. I know it can be scaring to take initiative with your learning when you are surrounded by veteran healthcare professionals, but always default to the belief that they want to help you learn and that self-initiative will become easier. I encourage you to make a conscious effort to find at least one thing you can take initiative on every week, starting with your week 4 clinical experience. DW

Week 4:
(A): I can effectively communicate with patients during clinical settings, actively listening to their concerns, and adapting my communication style to meet the needs of each individual patient I work with. This allows me to build trust and promote better outcomes for my patient. RH
(B): I find myself feeling less confident with medication administration, particularly with giving injections and second-guessing whether I have the right medication or not. To improve on this, I plan to review the medication three times carefully before administration, practicing injection techniques under supervision, and following a checklist to build confidence and accuracy in future medication administrations. This is a great goal! If you ever want to practice in the skills lab, please let us know and we can open it up for you and provide some practice materials. RH

Week 5:
(A): I can recognize subtle changes in changes in my patients' conditions and behaviors. I pay close attention to their appetite, mood, pain levels, and ability to respond. Through this, I can report any concerns that may appear to my patients' nurse or clinical instructor. Excellent! Never underestimate the power of observation and how that can impact your clinical judgment. DW
(B): I am working on feeling hesitant when providing care to patients with complex needs, as I want to ensure I am doing everything right. To improve on this, I will review patient histories more thoroughly before providing care and make sure to ask questions in times I feel unsure. This will allow me to feel more prepared when providing care for my future patients. This is a great goal! Collecting valuable information about your patients will be quite helpful in determining expectations and possible complications to monitor for. As I mentioned above, all of this contributes to your development of clinical judgment as well. DW

Week 6:
(A): I stayed calm and respectful even though my patient was unhappy, allowing me to maintain a therapeutic and supportive interaction. I acknowledged her feelings and continued to provide care in a quiet, but patient-centered manner so that she felt heard and respected despite her emotional distress and frustration.
(B): I want to become more comfortable with respiratory assessments. Although I was able to complete the assessment, I sometimes second-guessed my interpretation of lung sounds and severity of shortness of breath my patient was experiencing. This had caused me to pause several times and think. Moving forward, I intend to review respiratory assessment findings more consistently and practice correlating clinical signs with the presentation of my patient to increase my clinical judgement.

Student Name: Keira Keoghan	**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: 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 providing detailed findings
	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. Great specific list of nursing priorities for your patient 7/8. Good list of potential complications as well as signs and symptoms 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. All interventions have rationale specific to patient. One intervention (number 2) does not have frequency, but all others do. (91%)
	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	For your re-evaluation, be sure to be specific. You listed that the patient had LLE non-pitting edema in your assessment and your reassessment but there were not specifics. Was it the same? Was it better? Was it worse? Include a little more detail so we can see the change/lack of change in the patient.
	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:
Great job with your care map this week! You were detailed and provided good findings throughout your care map. Be sure to review feedback listed above.
I would save this care map for your senior portfolio.

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)**		
	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: Kiera Keoghan								
Skills Lab Competency Evaluation	**Lab Skills**							
	Week 1	**Week 1**	**Week 1**	**Week 1**	**Week 1**	**Week 2**	**Week 2**	**Week 9**
Performance Codes: **S**: Satisfactory	**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)*
U:Unsatisfactory	**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**
Evaluation:	S	S	S	S	S	S	S	
Faculty/Teaching Assistant Initials	HS	HS	HS	HS	HS	HS	HS	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	

*Course Objectives

Comments:
Week 1
(IV Math)-You satisfactorily participated in the IV Math learning session on 1/6/26 as well as the assigned IV Math practice questions and the IV Math Application Lab on 1/7/26. 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. HS

Week 2
(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. One prompt needed for suctioning. Very aware of sterile field, great job! RH/DW/NS/HS

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

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

Student Name: Keira Keoghan					
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**	**DW**	**NA**
		DCE Score	89.2%		
Date: 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	**S**	**DW**	**NA**
		DCE Score	92.1%		
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