EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Lily Osborn

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
5	Impaired Physical Mobility	S/SA	NA	NA
6	Risk for Recurrent Adult Falls	S/RH	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	Mid term	9	10	11	12	13	Make Up	Make Up	Final
Competencies: a. Analyze the involved patho-physiology of the patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
g. Assess developmental stages of assigned patients. (Interpreting)			N/A	N/A	S	S	S										
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		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		Infection Control	Digestive Health	5T Rehab, 69 year old with thoracic myopathy	5T Rehab, &4 year old, with T12 L1 L2 Fx	3T, 84-year-old with a stroke and 65-year-old with hypocalcemia.										
Instructors Initials	MD	MD	SA	SA	SA	RH											

****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 5: (1a-h) Great job making correlations with your patient's diagnosis and their disease process. You were able to also discuss how each of their medications related to their diagnosis and how it would assist with their plan of care. Your Care Map was appropriate to your client's medical history and provided supported guidance to aide them with their plan of care. SA

Week 6 (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)			N/A	N/A	S	S	S										
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			N/A	N/A	S	S	S										
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			N/A	N/A	S	S	S										
d. Communicate physical assessment. (Responding)			N/A	N/A	S	S	S										
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			N/A	N/A	S	S	S										
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	N/A	S	S	S										
	MD	**MD**	**SA**	**SA**	**SA**	**RH**											

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

Comments:

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

Week 5: (2a-f) You performed a full head to toe assessment on your client as well as a fall, IV, safety, and wound assessments. You were able to communicate any abnormalities in your assessment to myself and the primary nurse. You charted all your findings in the EHR appropriately. SA

Week 6 (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. You did great with charting this week. There were minimal areas that needed corrected or changed. You also had all charting done by 0800 on both clinical days, that was fantastic! 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	S										
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		N/A	N/A	S	S	S										
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			N/A	N/A	S	S	S										
d. Appropriately prioritizes nursing care. (Responding)			N/A	N/A	S	S	S										
e. Recognize the need for assistance. (Reflecting)			N/A	N/A	S	S	S										
f. Apply the principles of asepsis where indicated. (Responding)	S		S	N/A	S	S	S										
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			N/A	N/A	S	S	N/A										
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			N/A	N/A	S	S	S										
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		N/A	N/A	S	S	S										
j. Identify recommendations for change through team collaboration. (Reflecting)			N/A	N/A	S	S	S										
	MD	**MD**	**SA**	**SA**	**SA**	**RH**											

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

Comments:

Week 5: (3a-f, h-j) You used proper hand hygiene throughout both clinical days. You were able to care and assist safely with therapy in helping your client with their ADLs. You did great working around and with all the various therapies and prioritizing assessments and tasks with your client this week. You were also able to provide foley catheter care. SA

Week 6 (3a-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. Your patient had a foley and you maintained the foley throughout your clinical. You asked for help when needed. You were able to administer enoxaparin for DVT prophylaxis. RH

Objective

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

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

****Evaluate these competencies for the offsite clinicals:** **DH: N/A** **IC: N/A** **ECSC: N/A** **OR: All**

Comments:

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

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

Week 5: (3k-n,p-r) This week you performed medication administration. You identified all medications and were able to provide an analysis of all medications administered including type of medication, side effects, and nursing care performed after administration. You also performed all checks prior to administration to ensure you were giving the correct dosages of each medication to the correct patient. You were able to scan all medications in the MAR and chart them appropriately. You administered PO

medications and followed protocol for giving PRN pain medication providing an appropriate pain assessment and re-assessment. You took your time assessing them with each pill assuring they safely swallowed all pills. You also successfully discontinued the client's IV and documented accordingly. Great job! SA

Week 6 (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. You were very confident with your medication administration this week, great job! RH

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)			N/A	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	S										
c. Report promptly and accurately any change in the status of the patient. (Responding)			N/A	N/A	S	S	S										
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S	S	S										
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			N/A	N/A	~~S~~ NA	N/A	S										
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			N/A	N/A	S	S	S										
	MD	**MD**	**SA**	**SA**	**SA**	**RH**											

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

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

Comments:

Week 5: (4-f) You did a good job staying in communication with the nurse caring for your client this week. You were able to use SBAR communication to keep the nurse informed of the care you provided and if there were any changes. You did a care map for this week so I changed (4e) to “NA”. SA

Week 6 (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. RH

Objective

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

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

****5a & b- You must address this competency in the comments below for all clinicals on 3T, 4N, or Rehab- describe the patient education you provided; be specific- include the topic, method of delivery, reason for teaching need, materials to support learning through above resources (if applicable), and method used to validate learning.**
Example: Education related to orthostatic hypotension (changing positions slowly by sitting at the side of the bed or chair for a few minutes before moving to another position, utilizing the walker when ambulating) was provided to my patient through discussion and demonstration. This was necessary to maintain patient safety as he/she was experiencing a drop-in blood pressure and dizziness when getting out of bed. A patient education sheet was printed from Lexicomp and given to the patient. The teach back method was used to validate learning.

Comments:

Week 5:
5a: My taught my patient that he can do ROM exercises while he is in his chair.
5b: On skyscape with impaired mobility I used that in order to teach him to keep moving, and have less opportunity to get other complications.
This is a great topic to continue educating your client to them so that they can continue these once they get home. SA
Week 6:
5a: I helped educate my patient on the right way to put on his back brace.
5b: I utilized what physical and occupational therapy taught as well as the directions given with the brace. Great job RH

Week 7:
5a: My first patient really needed taught about fall precautions and his safety while walking around in his room.
5b: I used skyscape in order to give my patient relative data, on why he should call before he gets up.

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)			N/A	N/A	S	S	S										
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)			N/A	N/A	S	S	S										
	MD	**MD**	**SA**	**SA**	**SA**	**RH**											

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

See Care Map Grading Rubrics below.

Comments:

Week 5:
6b: His potential to influence care is that he has been livening in rehab facilities for the last three months but when he gets home he does not have anyone living with him to give him the energy to keep going. Great recognition of the client's SDOH. What are some resources available to help them once they go home? SA
Week 5 (6a)- You were satisfactory with your first care map this week. Please see the rubric below for feedback. SA
Week 6:
6b: An element that could possible alter his care is that his wife and him are currently separated, going through a divorce, and selling the family home which may cause a lot of stress and some depression on his mind. I think with encouragement he will keep trying his best while everything else is going on. This is probably impacting his support system as well since his wife will no longer be a support person for him. RH

Week 7:
6b: My second patient's wife was very overbaring, when I was in there she would answer questions for him and not let him speak for himself, but when it was just him and I he knew a decent amount and was a totally different person. Which may alter his care if he is not able to speak up for himself.

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

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

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

Comments:

7a: My strength was doing the insulin injection and remembering how to perform it as well as with the IV math I understood it quickly. Amazing! I am so happy for you! MD

7b: The area of improvement would be reading the questions on the quiz thoroughly, on the first quiz I did not do that and had to retake the quiz. I will achieve this by making sure I read through the whole question before picking my answer every time that I take a quiz. Great goal! This will help so much! MD

Week 3:

7a: My area of strength was knowing the hospital, being able to go around and get what I needed to get done without feeling lost during the clinical, and also making a new friend in clinical.SA
7b: Something that I need to work on is my pharmacology, I can do this by changing my study method and starting to study a few each day and make sure I know them before I move on. Great plan! SA
Week 4:
7a: My area of strength this week was getting a good grade on my respiratory quizzing, and asking many questions at clinical instead of being shy. Great job! SA
7b: My area of improvement would be learning how to figure out what to focus on in the assessment chapters, which I can do this by asking questions and reading the book looking for nursing focused information. This is a great plan. Look at the course outline and this will also provide you information where to study as well. Keep up the good work! SA
Week 5:
7a: My area of strength this week is that I was able to stay on top of things with my badge not working, and having my med pass during the same time. Thank you for being adaptable to a crazy first part of the morning! SA
7b: My area of improvement is to get my papers more organized on clinical, I can do this by bringing a blank sheet of paper starting on that and transferring it to my SBAR if needed. Always a great plan to stay organized and prepare the night before so that you can focus on the client during your clinical experience! SA
Week 6:
7a: my area of strength was med pass, I felt very confident and it felt like I was able to understand most of everything without any hesitations.
7b: My area of improvement would be to get more rest and letting my mind have enough time to shut off. I can do this simply by trying to set a bedtime every night early enough to where I feel well rested before school. Sleep is so important, this is a great goal! RH
Week 7:
7a: My area of strength was when I was giving medications to my second patient he screamed as a joke while I was giving an subcut heparin shot and I kept it together and finished everything without poking somewhere I shouldn't of.
7b: My area of improvement for this week would be looking deeper into the charts, because my nurse found something on one of my patients that I wasn't able to find. I can do this by researching and trying to dive deeper into my patients charts.

Student Name: Lily Osborn	**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 5		

	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	Meets all requirements for identifying abnormal findings with assessment, labs, diagnostics, and risk factors. Please remember to be specific on the diagnostic testing/imaging results. What were the findings of the x-ray?
	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	Nursing priorities correctly listed with top one highlighted. Goal statement needs to show what the patient will be able to do with their understanding of those topics and by when. All relevant data is highlighted. Appropriate potential complications are listed with signs and symptoms included.
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	0	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Great job listing realistic interventions that correlate to your top nursing priority problem, listing them in order of priority, while incorporating a rationale for each. Missing frequencies to several interventions.
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	
	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	

	Criteria	3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	All highlighted findings are evaluated and appropriate statement is included.
	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:

Total Points:

41/45
Satisfactory

Faculty/Teaching Assistant Initials:

SA

Student Name: L. Osborn	**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 6		

	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 compilation of data for first three boxes.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	4. You provided priorities related to a variety of body systems, good job looking at the whole picture. 7/8. Good list of potential complications and signs/symptoms of the complications.
	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, personalized to the patient, have a frequency, and have a rationale.
	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	14. 14/16 highlighted items reassessed (88%) so no points lost here. 15. Put continue/terminate/modify plan of care. Which one are you choosing? Must pick one of the three.
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	0	

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: 42/45

Faculty/Teaching Assistant Initials: RH

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**
Performance Codes: **S**: Satisfactory **U**:Unsatisfactory	**Insulin** (2,3,5,7)*	**Assessment** (2,3,4,5,7)*	**IV Math Application** (3,7)*	**Lab Day** (1,2,3,4,5,6,7)*	**IV Skills** (2,3,5,7)*	**Trach** (1,2,3,4,5,6,7)*	**EBP** (3,7)*	**Lab Day** (1,2,3,4,5,6,7)*
	Date: 1/6/26	**Date: 1/6/26**	**Date: 1/8/26**	**Date: 1/8/26**	**Date: 1/9/26**	**Date: 1/16/26**	**Date: 1/16/26**	**Date: 3/9 or 3/10/26**
Evaluation:	S	S	S	S	S	S	S	
Faculty/Teaching Assistant Initials	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 1/8/26. 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! Very purposeful and thorough! 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: Lillian Osborn					
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**	**SA**	**NA**
		DCE Score	94.8		
Date: 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	**S**	**SA**	**NA**
		DCE Score	94		
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