

**EVALUATION OF CLINICAL PERFORMANCE TOOL  
Medical Surgical Nursing – 2026**

**Firelands Regional Medical Center School of Nursing  
Sandusky, Ohio**

**Student:**

**Final Grade:** Satisfactory/Unsatisfactory

**Semester:** Spring

**Date of Completion:**

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

**Faculty eSignature:**

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

**DIRECTIONS FOR USE:**

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

**METHODS OF EVALUATION:**

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

**ABSENCE (Refer to Attendance Policy)**

Date	Number of Hours	Comments	Make-up (/Date/Time)
1/24/2026	1hr	Incomplete DH Survey	1/26/2026 1hr
2/10/2026	1hr	Simulation orientation	2/16/2026 1 hr

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 6	Impaired Gas Exchange	S/HS	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
<b>Competencies:</b>			N/A	S	S	S	S										
a. Analyze the involved pathophysiology of the patient's disease process. (Interpreting)			N/A	S	S	S	S										
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			N/A	S	S	S	S										
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			N/A	S	S	S	S										
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			N/A	S	S	S	S										
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			N/A	S	S	S	S										
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			N/A	S	S	S	S										
g. Assess developmental stages of assigned patients. (Interpreting)			N/A	S	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	Digestive Health; multiple patients	ECSC: OR- gallstone/ Cholecystectomy	Rehab, 85- Right Subarachnoid	3T, 83- aspiration pneumonia	4N, 83- Right Ankle Fracture										
Instructors Initials	NS	NS	SA	SA	SA	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 5: (1a-h) This week you did a 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 subarachnoid hemorrhage diagnosis. Your EBP article presented was appropriate to your client's medical history and provided supported guidance to aide them with their plan of care. SA

Week 6 (1 a, b, c, d, e, f)-Great job this week! This week you did a great job discussing your patient's pathophysiology of her illness. You were also able to review the diagnostics and discuss how they correlated with the patient's diagnosis. You were able to discuss the importance of the medications that your patient was taking and how they impacted the plan of care. HS

**Objective**

2. Perform physical assessments as a method for determining deviations from normal. (3,4,5)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>			N/A	N/A	S	S	S										
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	S	S	S	S										
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		N/A	N/A	S	S	S										
	NS	NS	SA	SA	SA	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 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 did a nice job with your assessment this week. You 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 on her respiratory system. 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
<b>Competencies:</b>	S		S	S	S	S	S										
a. Perform standard precautions. (Responding)	S		S	S	S	S	S										
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		N/A	S	S	S	S										
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			N/A	S	S	S	S										
d. Appropriately prioritizes nursing care. (Responding)			N/A	S	S	S	S										
e. Recognize the need for assistance. (Reflecting)			N/A	S	S	S	S										
f. Apply the principles of asepsis where indicated. (Responding)	S		N/A	S	S	S	S										
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			N/A	N/A	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)			N/A	S	S	S	S										
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		N/A	S	S	S	S										
j. Identify recommendations for change through team collaboration. (Reflecting)			N/A	S	S	S	S										
	NS	NS	SA	SA	SA	HS											

\*\*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.SA

Week 6 (3 c, d, e)- You were able to prioritize your care for the day and adjust your plans when necessary, based on changes that occurred during the day. You were available to help others when needed, and ask for assistance when needed. 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
<b>Competencies:</b>			N/A	N/A	S	S	S										
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	S	S										
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	S	S	S										
q. Monitor and/or discontinue an IV. (Noticing/Responding)			N/A	S	S	S	S										
r. Perform FSBS with appropriate interventions. (Responding)	S		N/A	N/A	N/A	N/A	N/A										
	NS	NS	SA	SA	SA	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 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 this week as well as flushed an IV correctly. Great job! SA

Week 6 (3k, l, m, n, p, q)- You did a nice job with medication administration this week! You were able to administer several PO, and an IV push medication. You followed the rights of medication administration and completed all checks prior to administering. You were able to research each medication and answer all questions related to the medications. HS

**Objective**

4. Use therapeutic communication techniques to establish a baseline for nursing decisions. (1,5,7)\*

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
<b>Competencies:</b>			S	S	S	S	S										
a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S	S	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	S	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	S	S NA	S										
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			N/A	N/A	S	S	S										
	NS	NS	SA	SA	SA	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	5	SA
Patient Education: Identifying and Intervening on Knowledge Deficit		
Safety: Restorative Care and Managing Potential Complications		

**Comments:**

Week 4 (4e)- Nice job posting a discussion on your OR experience. I changed this competency to a “S” to show this discussion was graded as satisfactory. SA

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 great with your clinical discussion post and finding an evidence-based article that related to your client this week. SA

Week 6 (4a, b, c, d)- You did a nice job communicating with your patient, and her daughter this week about the plan of care and the medications she was receiving.  
(e) – This was changed to an NA because you completed a care map this week, not a CDG. 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
<b>Competencies:</b>			N/A	N/A	S	S	S										
<b>a. Describe a teaching need of your patient.** (Reflecting)</b>			N/A	N/A	S	S	S										
<b>b. Utilize appropriate terminology and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)</b>			N/A	N/A	S NI	S	S										
	NS	NS	SA	SA	SA	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:**

W5 (Rehab): A+B. Educated my patient on physical activity (getting up into the chair multiple times a day, utilizing the walker when ambulating, participating in PT) was provided via discussion and demonstration. This was necessary to maintain patient safety, to improve long-term health outcomes, and enhance rehabilitation as she was experiencing muscle weakness. The teach back method was used to validate learning. **This is a great topic for your client to prepare them for safe ambulation practices once they are home! I am changing (5b) to "NI" as we also need to know what resource you utilized for the information, Skyscape, textbook, etc. SA**

W6 (3T): A+B: My patient needs education on the importance of ambulation (getting up to the chair for meals and walking the halls) was provided via discussion and demonstration. This is necessary for the improvement of her health and her diagnosis of aspiration pneumonia. The teach back method was used to validate learning. I utilized skyscape and Lexicomp. **Great job! Yes, your patient has been hospitalized for several days and ambulation is important to prevent additional complications for her. HS**

W7: A+B. Educated my patient on the importance of non-weight bearing on her right foot and proper use of a walker (pushing off the bed and not pulling on the walker, using the walker for balance and support) was provided via discussion and demonstration. This was necessary for healing and safety, to improve outcomes. The teach back method was used to validate learning. I used skyscape and Lexicomp.

**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	N/A	S	N/A										
b. <b>Identify factors associated with Social Determinants of Health (SDOH) &amp;/or cultural elements that have the potential to influence patient care.**</b> (Noticing, Interpreting, Responding, Reflecting)			N/A	N/A	S	S	S										
	NS	NS	SA	SA	SA	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:**

W5 (Rehab): My patient’s main SDOH is her mental health and physical activity. My patient was diagnosed with both anxiety and depression. She also reported that she likes to sleep until 11 o’clock and tends to just sit and stare at her tablet everyday inhibiting her physical activity and strength. **Nice recognition of your client’s mental state. How does this affect her rehabilitation and what can nurses provide as education or resources to support their needs? SA**

W6 (3T): My patient’s main SDOH is her depression and anxiety. She is diagnosed with both. She has been in the hospital for over a week and is beginning to be tired of being at the hospital. She is starting to refuse activities. This can affect her healing process as she is not ambulating often which does not allow mucus secretions to mobilize. Nurses can provide education on the importance of ambulation and provide therapeutic communication to improve her mental health. **Can you think of anyone else that may be important to help encourage the patient to get up and move during the day, such as family members? Her daughter seemed to be there every day to visit so it seems that she has a good support system we must make sure to keep her involved in the plan of care since she will be there once the patient is discharged from the hospital. HS**

**(6a)- You received a satisfactory on the nursing care map. Please review the rubric at the bottom of the tool. HS**

W7: My patient’s SDOH was her history of smoking. My patient has a former history of smoking as well as COPD. This causes her to become short of breath more often which can lead to decrease tolerance of ambulation. She was unable to stand for a short period of time due to becoming dizzy and short of breath. Nurses can provide education and Physical Therapy can provide support to help improve her strength to get back to activities of daily living.



## 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 U	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										
	NS	NS	SA	SA	SA	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:

W1: A. I felt confident with all things IV. I was confident when priming my primary and secondary tubing as well as any math incorporated with it. B. I need to work on my confidence when getting checked off in the skills lab. I need to feel confident in my decisions and abilities. I will practice my nursing skills at home at least once a day before the next clinical or checkoff. **Good reflection, Kacy. I am glad that you are feeling comfortable with the IV skills going into clinical this week. You should get plenty**

of opportunities to apply these skills throughout the semester. As for your confidence, this improves with more experience. You have a great plan for improvement. Remember to always celebrate your successes and strive to meet your goals. Great job during a busy first two weeks of the semester, keep up the hard work! NS

W3: A. I felt comfortable understanding the steps and importance of colonoscopy, endoscopy, and bronchoscopy. B: I would like to come prepared with more questions relating to my clinical setting to help me better understand the nurse's role in settings other than in medical surgical. I would research details and questions to remember for my next clinical setting that is not medical surgical. Thank you for contributing to your strengths and areas to improve. SA

Week 3 (7f)-You are receiving a "U" for failure to submit the survey for your digestive health experience. Failure to submit a survey will result in one hour missed clinical time and an unsatisfactory on their clinical evaluation tool. 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. SA

W4: I received a "U" in 4f, for not turning in my survey. This week is not an "U" because I turned surveys and CDGs. I had set multiple reminders to complete them and did the right after clinical or the day after. A. I felt confident in the OR by understanding sterile techniques, surgery procedures, and the importance of pre-operative and post-operative care. B. My weakness is studying. I tend to push off studying and only study for a day or two, and only for a few hours. I plan to set timers and a couple of hours each day to improve time spent on studying. I also plan to study using multiple styles to truly understand the content. Thank you for turning assignments in on time. Having a plan to be organized and study each day will be beneficial in the future. SA

W5: A. My strength this week is organized and prompt care. Great job! SA

B. I need to work on correctly identifying medications within the chart. I had written down too many meds and looked at the wrong times to give them, but still successfully gave correct medications. I plan to use the computer lab to practice looking at medications and reading when they are due at least 3 times before my next clinical. I also plan to take a couple of extra minutes and double check what time my meds are due. With this being your first onsite clinical since NF, it can be overwhelming to remember all the details of medication administration in addition to your other duties. Remember that we are only concerned with the medications you yourself will be administering during your clinical times. Nice job with your med administration this week! SA

W6: A. I successfully gave my first IV-push medication. Great job! HS B. I need to work on correlating and relating my patient's medications to the reasons they are getting it. I need to focus on using critical thinking and nursing judgment. I will take extra time reviewing my medications before giving them. I will practice relating medications to diagnosis using fake patients and medications. It is very important to fully understand why each medication is being given and what it is doing for the patient as well as what can happen or what side effects may occur. HS

W7: A. I felt confident in giving my patient all her medications as well as explaining what they were and were for. B. I need to increase the amount of sleep I am getting before clinical, as I am constantly feeling tired throughout clinical. To get more sleep, I will set a reminder to turn off electronics, stop studying, and organize my clinical material before I get to sleep. I will also implement this for nights before lectures.

Student Name: Kacy Leibacher		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)	2	You only listed 6 abnormal assessment findings. Others to include: wears glasses, hard of hearing, color and consistency of sputum. You listed 3 abnormal lab findings and an x-ray (no location listed) and a CT scan. You provided a list of 8 risk factors for the patient. HS
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)	3	
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	You listed 3 nursing priorities for the patient. Others to consider adding would include: risk for falls, risk for impaired skin integrity, knowledge deficit. You stated a goal, however in the future your goal should reflect your initial abnormal assessment findings and be specific. For example, patient will have an SpO2 of 96% on 2L nasal cannula. You highlighted appropriate abnormal findings. You listed 3 potential complications however they are essentially the same. Other potential complications to include, death, cardiac arrest. HS
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	1	
8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	2		
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	You provided a list of 13 nursing interventions that for the most part were relevant to the top priority problem. Some interventions were very vague and not specific such as educate on treatment plan, and collaborate with physician and family, be specific: educate on importance of ways to conserve energy and decrease dyspnea. Not all rationales were appropriate/ specific to the patient such as administer guaifenesin for intermittent coughing. HS
	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	2	

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	2	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	1	You did not re-evaluate several of the abnormal assessment, and lab/diagnostic findings (shortness of breath, X-ray, CT cough) You determined the plan of care should be continued. HS
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	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:

Kacy,

You have some important information in your care map however, it seems as if you rushed through it. For a patient that was hospitalized for 8 days there is a lot of information in the chart that could have been included within the care map. Be sure to take your time and review the chart and discuss with faculty prior to submitting the next care map. For the next care map, be sure to pull out the rubric and the guidelines so that you are meeting all of the requirements. You should also discuss it with your faculty member at clinical prior to submitting it so that you have a thorough understanding. Please reach out if you have any questions regarding my feedback above in each specific category. HS

**Total Points: 36/45**

**Faculty/Teaching Assistant Initials: HS**

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		
<b>Reflecting</b>	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: <ul style="list-style-type: none"> <li>• Continue plan of care</li> <li>• Modify plan of care</li> <li>• Terminate plan of care</li> </ul>	<b>Complete</b>			<b>Not complete</b>		

**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: <b>Kacy Leibacher</b>								
<b>Skills Lab Competency Evaluation</b>	<b>Lab Skills</b>							
	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 1</b>	<b>Week 2</b>	<b>Week 2</b>	<b>Week 9</b>
	<b>Insulin</b> (2,3,5,7)*	<b>Assessment</b> (2,3,4,5,7)*	<b>IV Math Application</b> (3,7)*	<b>Lab Day</b> (1,2,3,4,5,6,7)*	<b>IV Skills</b> (2,3,5,7)*	<b>Trach</b> (1,2,3,4,5,6,7)*	<b>EBP</b> (3,7)*	<b>Lab Day</b> (1,2,3,4,5,6,7)*
	<b>Date:</b> 1/6/26	<b>Date:</b> 1/6/26	<b>Date:</b> 1/8/26	<b>Date:</b> 1/8/26	<b>Date:</b> 1/9/26	<b>Date:</b> 1/16/26	<b>Date:</b> 1/16/26	<b>Date:</b> 3/9 or 3/10/26
Evaluation:	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	<b>S</b>	
Faculty/Teaching Assistant Initials	<b>MD</b>	<b>KA/RH</b>	<b>KA/DW/HS</b>	<b>MD/NS/RH</b>	<b>NS</b>	<b>HS</b>	<b>KA</b>	
<b>Remediation:</b> Date/Evaluation/Initials	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NA</b>	<b>NS</b>	

\*Course Objectives

**Comments:**

(IV Math)-You satisfactorily participated in the IV Math learning session on 1/6/26 as well as the assigned IV Math practice questions and the IV Math Application Lab on 1/8/26. KA/DW/HS

(Lab Day)- You satisfactorily completed the mandatory lab review of nursing foundational skills. This was achieved through simulating care for a patient in a scenario requiring competency in assessment, communication, medication administration (including PO and IM injection), nasogastric tube insertion and removal, patient mobility and hygiene, use of PPE for Contact Isolation, wound care, Foley insertion and removal, development of nursing notes, and providing SBAR hand-off report. NS/MD/RH

(IV Skills)- You have satisfactorily completed IV lab including a saline flush, IV push medication administration with reconstitution, priming and hanging a primary and secondary IV solution, adjusting a flow rate to run by gravity, discontinuing IV therapy, and monitoring the IV site for infiltration and signs of complications. NS

(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. Great job. 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

<b>Student Name: Kacy Leibacher</b>					
<b>Performance Codes: S: Satisfactory U: Unsatisfactory</b>			<b>Evaluation</b>	<b>Faculty Initials</b>	<b>Remediation Date/Evaluation/Initials</b>
<b>Date:</b> 1/26/26	Shadow Health (Respiratory Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	<b>S</b>	<b>SA</b>	<b>NA</b>
		DCE Score	93.8		
<b>Date:</b> 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	<b>S</b>	<b>SA</b>	<b>NA</b>
		DCE Score	91.1		
<b>Date:</b> 2/23/26	Shadow Health (Basic Patient Case: Pharmacology) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
<b>Date:</b> 2/25 or 2/26/26	Simulation #1 (Musculoskeletal & Resp) (*1, 2, 3, 4, 5, 6, 7)	Prebrief			
		Scenario			
		Reflection Journal			
		Survey			
<b>Date:</b> 3/24/26	Shadow Health (Perioperative Care Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
<b>Date:</b> 4/8 or 4/9/26	Simulation #2 (GI & Endocrine) (*1, 2, 3, 4, 5, 6, 7)	Prebrief			
		Scenario			
		Reflection Journal			
		Survey			
<b>Date:</b> 4/13/26	Shadow Health (Intermediate Patient Case: Pharmacology) (*1, 2, 3, 4, 5, 6)	Scenario			
		DCE Score			
<b>Date:</b> 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