EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Jessica Seciliot

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)
1/28/2026	6	Missed Rehab Clinical	TBD (April 1 4N)
2/9/2026	1	Shadow health DCE score 74.2%	2/9/2026 94.9% (1hr)

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 5	Inability to care for self	NI/HS	S/HS	NA
Week 6	Impaired Physical Mobility	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	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)			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		N/A	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		N/A- No clinical	94 Y/O 5-TOWER REHAB	101 F, 73 M- 3 Tower	84 y/o F 5 Tower- Rehab	72 y/o F- 5 Tower Rehab										
Instructors Initials	**DW**		**DW**	**MD**	**HS**	**RH**	**SA**										

****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 4 Rehab Objective 1 A-E: This week you were able to analyze your patient's pathophysiology, correlate symptoms, diagnostic testing, pharmacotherapy, and medical treatment with their diagnosis of CHF exacerbation! You did a great job with discussing how these all related together to provide the patient with appropriate nursing care! Great job! MD

Week 5- (1 a, b, c, d, e, f)-Great job this week! This week you did a great job discussing your patient's pathophysiology of 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

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

Week 7 (1a-h)- This week you were able to correlate the patient's medications, treatment, and nutritional needs based on their reason for being on the Rehab floor and their past medical history. You also did an excellent job correlating this with your CDG as well. Great job! SA

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	S	S	S	S										
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			N/A	S	S	S	S										
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			N/A	S	S	S	S										
d. Communicate physical assessment. (Responding)			N/A	S	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	S	S	S	S										
	DW		**DW**	**MD**	**HS**	**RH**	**SA**										

****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 4 Rehab Objective 2 D, F: Great job communicating your physical assessment and accessing the electronic information/documentation of patient care! Keep working hard to continue gaining more confidence and skill with communicating and documenting as a nurse! MD

Week 5 (2a-f)- You did a nice job with your assessment this week. You also did a nice job communicating your findings to the RN. You were also able to discuss your focused assessment and the reasoning behind your decision of focus on each patient both days of clinical. HS

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. RH

Week 7 (2a-f)- While you were on clinical you performed a satisfactory physical assessment, communicated to me and to the primary nurse appropriately, and you were able to satisfactorily document all information to Meditech documentation. SA

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		N/A	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~~ NI	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	S	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	N/A	N/A										
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										
	DW		**DW**	**MD**	**HS**	**RH**	**SA**										

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

Comments:

Week 4 Rehab Objective 3 B, D, J: This week your patient had a very sensitive blood pressure when her antihypertensives were administered. You demonstrated skillful and safe practice for taking her blood pressure and identifying the limits to her antihypertensive medication to be administered. You collaborated with the nurse to ensure

proper care of the patient's blood pressure is prioritized. You also discussed with faculty that you were continually assessing for signs and symptoms of hypotension. Great job! MD

Week 5 (3 c, d, e)- You were able to prioritize your care for the day and adjust your plans when necessary, based on changes that occurred during the day. You were available to help others when needed and answer call lights to help others. Your patient on the second day needed her rest and you were able to re-arrange care to minimally disrupt her rest. (g) You were able to remove the Foley catheter, and follow the proper procedure. HS

Week 6 (3a-f, i-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. 3c was changed to "NI" because when it was time for you to administer the IV antibiotic for your patient you were sitting in the breakroom and unable to be found by the clinical instructor. The nursing staff stated "She is in the break room on her phone." I understand you were working on your care map, but that is not an acceptable time to be doing so when you had meds due. Please be aware of what you are doing and how it looks to others. The nursing staff thought you were just browsing on your phone, which also seems unprofessional. RH
I was in the breakroom looking up medications, which I had been looking up in an empty patient room the only reason I went to the breakroom this time was because I had to use the restroom. Moving forward I will be more aware of when my medications are due, and really work on my time management better to avoid not being ready when it is time for a medication administration.

Week 7 (3a-j)- You were able to identify all of the priority needs for your patient based on their condition. You were able to communicate your priority assessments for the day and accommodate them around the therapy schedule. You also assisted a nurse with a bladder scan this week, nice job! SA

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

****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
(3o,r)- Unfortunately, these competencies are being evaluated as unsatisfactory due to omitting a self-rating. In the future, please be sure to rate yourself in all competencies with a white box. There may be times in the future that a competency does not apply. In this case, you will evaluate with NA. Take a moment to review the directions on page one of this tool for next steps on resolving these U's. When you submit the tool for week 3, please be sure to include comments for each U describing how you will prevent this from happening in the future. Failure to do so will result in a continued U rating. Let me know if you have any questions or need assistance. DW

Week 3 (3o,r)- Copied from Objective 7- And area of weakness is that I missed several self evaluation boxes in week 1. This being the first week I guess I just didn't realize there were so many! Moving forward I need to make time to fully read over this tool and not rush, rushing leads to missed steps and I want to prevent that from happening in the future. I'm not sure if I need to address each U individually because they were all marked U for the same reason.. missing the box. I've taken my time filling out this tool, and have double and triple checked it so that doesn't happen again. See my feedback in the objective 7 comments. DW

Week 3 Rehab Objective 3 K, L, M: While administering medications, you were able to identify the rights of medication administration as patient, medication, time, dosage, route, and documentation. You were able to discuss your patient's medications in correlation to why they are taking them, side effects, and nursing interventions to perform for each. This week, you administered oral medications and one subcutaneous medication. You were able to obtain your patient's blood pressure, interpret that the result was too low to administer the antihypertensives, and respond by discussing this with the patient and the primary nurse. You did an awesome job providing step by step instruction on how to administer the subcutaneous medication and performing the administration! Overall, you did an excellent job! Please be sure to slow down during the administration process so you can continue to satisfactorily administer medications. MD

Week 5 (3k- q)- You did a nice job with medication administration this week! You were able to administer PO, SQ, and IV medications. You followed the rights of medication administration and completed all checks prior to administering. You monitored the IV site before during and after the administration of the IV medications. You were able to research each medication and answer all questions related to the medications. HS

Week 6 (3k-q): 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 looked up medications to be prepared. You administered PO and IV 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. 3l was changed to "NI" because you need to slow down while scanning medications. You were reminded to do your final check of your medications while scanning and you were scanning them so fast that you missed a notification box that appeared and then just continued scanning the medications. This tells me that you were NOT performing your final check on some of these medications and you were just scanning them to get it done. Please slow down and pay attention to the medication/dose/route/etc while scanning. The computer prompts these pop ups for a reason and it should make you look at what you are doing. 3q was changed to "S" because you were able to discontinue the IV on your patient this week. RH
Yes I wasn't aware that during scanning medications pop ups come up that was the first time that happened. During medication administration I will slow down while scanning medications and look at the screen between each scan to make sure it scanned correctly and nothing popped up, which I focused on this week while scanning medications.

Week 7 (3k-r)- You did a nice job administering PO medications this week. You observed the rights of medication administration and were able to discuss appropriate information about your medications as they correlated to your patient with me and the primary nurse as well as your patient. Nice job! SA

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

****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	Week 7	SA
Patient Education: Identifying and Intervening on Knowledge Deficit		
Safety: Restorative Care and Managing Potential Complications	1/28-29/2026	MD

Comments:

Week 4 Rehab Objective 4 A-F: Unfortunately, you did not self-evaluate these competencies prior to submitting your clinical tool. These competencies are critical to evaluate with every submission of this document. **Please be sure to respond to these unsatisfactory ratings and how you will prevent this from occurring in the future. MD**

Week 4 Rehab Objective 4 E: This week you completed the Restorative Care and Managing Potential Complications CDG. The potential complication for your patient was the possibility of orthostatic hypotension and an increased risk for falls related to her antihypertension medications. You discussed assessing the patient's blood pressure and heart rate prior to medication administration of antihypertensives along with before and after activity to ensure she is not having symptoms of hypotension. Some intervention examples you provided your patient included encouraging slow position changes and using a cane/walker for assistance. You also noted that the patient's baseline was very independent prior to being admitted in the hospital, so the restorative care you provided promoted mobility and independence with PT and ADLs. Barriers you noted would be the challenge of her fluctuating blood pressure along with her decreased endurance. You provided a great reference and in-text citation with a satisfactory word count. This CDG is satisfactory. Great job! MD
I really need to slow down when submitting. So I submitted my Tool and came back to re-open it after submission and realized I did NOT respond to these U's so it was a good thing I slowed down and came back to re-check. I will continue to do that throughout the course, so to not miss something again. HS

Week 5 (4a,b) You did a nice job this week communicating with your patient, you were able to utilize different approaches to provide her care based on her dementia. You were professional and therapeutic in your conversations. You did a nice job answering a call light for another patient, then going and informing the nurse of the patient's needs. You then followed back up with the patient by going back and informing them that you told the nurse and she would be in to assist them with their needs. Great job! (4e)- You did a nursing care map this week, therefore this was changed to an NA. HS

(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. 4d was changed to "NI" due to some comments you made this week during clinical. You stated that you looked up your patient information on Wednesday night while you were at work. You then said you were logged in under your school ID and not your work ID. We discussed how if you looked up this information on your work ID that this would be a HIPAA violation and could be terms for dismissal from the program. Please be careful when looking up patient information outside of clinical hours. Looking up anything related to your patient for clinical under your work ID would absolutely be a HIPAA violation and we do not condone that. Also, if you did use your student ID while at work, you should only do so while you are on break as this would violate your work responsibilities. Let me know if you have questions related to this. RH
Moving forward I won't be looking up anything outside of clinical times. I know not to look anything up with my work badge because that's two different positions, and it was before I clocked in. Moving forward I will just avoid this all together, and only while at clinicals.

Week 7 (4e)- Nice job on your CDG this week. You were able to provide an article related to your patient based on her issues and diagnosis. Great job! SA

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	U	S	~~S~~ U	S										
b. Utilize appropriate termino-logy and resources (Lexicomp, UpToDate, Dynamic Health, Skyscape) when providing patient education. (Responding)			N/A	U	~~S~~ U	~~S~~ U	S										
			DW	**MD**	**HS**	**RH**	**SA**										

****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 Rehab Objective 5 A, B: Unfortunately, you did not self-evaluate these competencies prior to submitting your clinical tool. These competencies are critical to evaluate with every submission of this document. **Please be sure to respond to these unsatisfactory ratings with information on a teaching need for your patient and resources you utilized along with how you will prevent this from occurring in the future. MD**

Week 5-A teaching I discussed with my patient was the need to sit up for a few minutes before going directly from laying to standing to prevent falls from hypostatic hypertension. This is essential to prevent dizziness and falls while ambulating to different positions. I was able to have the patient teach back the importance of getting up slowly and sitting up for a few minutes before trying to ambulate from a sitting position. I believe you are referring to orthostatic hypotension based on the symptoms of dizziness upon rising and ambulating. (5b)- This was changed to a U because you did not list the resource you used for the teaching need of your patient. What resource did you utilize for the education that you provided? The text book or Skyscape? HS
Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. HS

A reoccurring theme I'm having is missing things on this tool because there are just so many sections. Heather did suggest this week that AFTER submitting the tool we go back into it and look to make sure everything saved correctly so I will be doing that from now on to make sure I don't miss anything else moving forward. HS

WEEK 5 U- 5B- I used the book to read about ambulation and that's what I educated my patient on. I educated her on the importance of taking a second before just jumping straight up from laying to standing. Yes the current term is orthostatic HYPOtension as well. Moving forward I know that not only do I need to slow down which I have been doing better but read carefully as well.

Week 6 (5a, b) I did not see anything about a teaching for your patient or what resource you used for this week, so both of these are changed to "U" Please address these "U" and state how you will prevent getting another in the future. These will remain "U" until they are addressed. RH

I missed this section on the clinical tool, I did speak with my patient about safety around her house, and fall precautions because she is living alone. We spoke about how her children live out of state and she stated her grandson was going to come stay with her. I spoke with her about a well balanced protein rich diet to help with healing. I got this information from Skyscape and our textbook.

Week 7- This week I spoke with my patient about pain management and the importance of not getting up too quickly after taking her pain medication. We spoke about how it's important to eat before taking her medication to prevent dizziness. We also talked about how she should take her pain medication prior to doing any kind of PT/OT so it has time to start working. I got all of this information while looking up her medications in skyscape. Great topic for education! SA

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	U	S	S	N/A										
b. **Identify factors associated with Social Determinants of Health (SDOH) &/or cultural elements that have the potential to influence patient care.**** (Noticing, Interpreting, Responding, Reflecting)			N/A	U	S	~~S~~ U	S										
			DW	**MD**	**HS**	**RH**	**SA**										

****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 Rehab Objective 6 A, B: Unfortunately, you did not self-evaluate these competencies prior to submitting your clinical tool. These competencies are critical to evaluate with every submission of this document. **Please be sure to respond to these unsatisfactory ratings with information on your patient's SDOH along with how you will prevent this from occurring in the future. MD**
Some SDOH for this patient is her increased age, her decrease in mobility, transportation because she is no longer able to drive herself.

A reoccurring theme I'm having is missing things on this tool because there are just so many sections. Heather did suggest this week that AFTER submitting the tool we go back into it and look to make sure everything saved correctly so I will be doing that from now on to make sure I don't miss anything else moving forward. HS

Week 5- Some SDOH for my 101 year old patient are her age of 101 years old, Limited mobility, Inability to understand and manage her medications and self-care. The loneliness of her children and husband all passing away before her. It sounds like your patient did have several SDOH factors impacting her, that is probably why she needed to go to an extended care facility upon discharge from the hospital. Nice job looking into the multiple factors that may influence her care. HS

Week 6 (6b) I did not see anything about social determinates of health for your patient for this week, so both of these are changed to "U" Please address these "U" and state how you will prevent getting another in the future. These will remain "U" until they are addressed. RH
I completely missed this section this week, again I will focus on my time management and being able to really take my time on these clinical tools. Some of this patients SDOH are that she lives alone, which won't let her have immediate help if she were to fall, no help performing ADLs. Another is her age because she is 84 she will be at an increased risk for falls, slower recovery time, and with her diagnosis increased risk for confusion and delirium. Her glasses, and hearing aides limit her ability to see and

hear well. The fact that she has multiple chronic illnesses (A-fib, Cirrhosis, HTN, and OSA). Not a well balanced diet because her protein was low, but we did talk about this and she was educated on the importance of protein.

Week 7- Some of this patients SDOH could be that she lives alone, however she does have a friend that is staying with her temporarily. Her age because she is over the age of 65. Her economic stability because she is retired and probably on a fixed income. Health literacy given the fact that she is on multiple medications, she has complex diagnosis'. Her mobility given the fact that she uses a walker and wheelchair she has problems with her left foot drop, and will have issues getting in and out of the bathtub and using a shower chair is difficult for her because she has shower doors which make it more difficult to get in and out of the shower. Nice job recognizing your patient's SDOH. What are some resources the hospital departments can offer to help this patient? SA

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	U	S	S	~~S~~ U										
b. Reflect on an area for improvement and set a goal to meet this need.** (Reflecting)	S		S	U	S	~~S~~ NI	~~S~~ U										
c. Demonstrate evidence of growth, initiative, and self-confidence. (Responding)	U		N/A	U	S	S	S										
d. Follow the standards outlined in the FRMCSN Student Code of Conduct Policy. (Responding)	U		N/A	U	S	S	S										
e. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE"- attitude, commitment, and enthusiasm during all clinical interactions. (Responding)	U		N/A	U	S	S	S										
f. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (Responding)	U		N/A	U	S	~~S~~ NI	S										
g. Demonstrate the ability to give and receive constructive feedback. (Responding)	U		N/A	U	S	S	S										
h. Actively engage in self-reflection. (Reflecting)	U		N/A	U	S	S	S										
	DW		**DW**	**MD**	**HS**	**RH**	**SA**										

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

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

Comments:

Week 1- An area of strength I would say was the lab skills, and the Trach lab I always think I'm better working with my hands and better able to learn that way. Hands-on experience is extremely crucial to your group, so this makes sense. Any skill in particular that seemed to be your greatest strength, and why? Curious! DW An area of weakness is the quizzes, I've yet to get a 85 or higher on any quiz. I spend a lot of time studying, but tests give me anxiety to begin with and I feel like as soon as I start

taking it I forget everything. So that's absolutely an area I need to work on. Jessica this is quite understandable and I am glad you are recognizing it as an opportunity and not just hoping for the best in the future. Keep in mind, 7b asks you to set a goal for improvement. Identifying an issue only gets you so far. You have to make adjustments to see improvements and that's where the goal comes in. Luckily for you, you are doing something about it. You reached out to me and also requested a LAP referral. This is great, as they will be able to evaluate your current practices and offer opportunities to make changes for positive outcomes. In the future, please be sure to include your goal (what you will do, how often you will do it, and when you will do it by) in order to avoid a U for this competency. I am happy to help with goal setting if you need it. Also, keep in mind that this tool focuses on clinical. Please make sure that future strengths and goals for improvement focus on clinical. Once you start clinical in the weeks to come, this will be easier to identify and focus on clinical. DW
Week 1 (7c-h) Unfortunately, these competencies are being evaluated as unsatisfactory due to omitting a self-rating. In the future, please be sure to rate yourself in all competencies with a white box. There may be times in the future that a competency does not apply. In this case, you will evaluate with NA. Take a moment to review the directions on page one of this tool for next steps on resolving these U's. When you submit the tool for week 3, please be sure to include comments for each U describing how you will prevent this from happening in the future. Failure to do so will result in a continued U rating. Let me know if you have any questions or need assistance. DW

Week 3- I think an area of strength I had this week is my schedule and focusing on studying and making time to study I feel like I did really good at that this week and in turn feel better prepared for the quiz on Monday. Excellent! DW
And area of weakness is that I missed several self evaluation boxes in week 1. This being the first week I guess I just didn't realize there were so many! Moving forward I need to make time to fully read over this tool and not rush, rushing leads to missed steps and I want to prevent that from happening in the future. I'm not sure if I need to address each U individually because they were all marked U for the same reason.. missing the box. I've taken my time filling out this tool, and have double and triple checked it so that doesn't happen again. Thank you for being so diligent and wanting to improve each week. It is greatly appreciated. As for your uncertainty, in the future, if the U's are for the same reason, you do not need multiple separate comments. With that said, you must provide a comment for each objective that has a U (ex. objective 3 and 7 should each be addressed in the comments for week 1). We will make this work this week and I will copy and paste your comment under objective 3 as well. In the future, if you get a U, comment under any and all objectives that apply. You've got this! DW – THANK YOU for explaining Dawn that makes more sense now!

Week 4- An area of strength I feel like I continue to have is connecting with my patients. I feel because I've worked in the medical field for so many years talking and interacting with patients always comes natural to me. You definitely were natural with talking to your patient! Great job! MD
Area of IMPROVEMENT YES!!!! (because Monica HATES weakness ABSOLUTELY!!! 😊)- Is my time management and setting alarms. I didn't double check my alarms for Wednesday morning and ended up oversleeping and missing clinicals because I set my alarms for 6 PM instead of AM. Now I make sure to double check my alarms are set for the correct time so this doesn't help again. This is a great goal! MD

Week 4 Rehab Objective 7 A-H: Unfortunately, you did not self-evaluate these competencies prior to submitting your clinical tool. These competencies are critical to evaluate with every submission of this document. **Please be sure to respond to these unsatisfactory ratings and how you will prevent this from occurring in the future. MD**
A reoccurring theme I'm having is missing things on this tool because there are just so many sections. Heather did suggest this week that AFTER submitting the tool we go back into it and look to make sure everything saved correctly so I will be doing that from now on to make sure I don't miss anything else moving forward. This is funny because I came down here and responded to the strengths and areas of IMPROVEMENT! Maybe when I clicked the S's removed or something, but either way after I submit this week I'm going to go back through to make sure everything is still correct. HS

Week 4 Rehab Objective 7 C-H: Jessica, this week has been a great experience witnessing your first week in the inpatient clinical setting for MSN! You really showed self-confidence in the care of your patient and interactions with peers while maintaining the Student Code of Conduct, ACE attitude, and positive professional behavior! You also were able to give and receive constructive feedback from your peers and myself as well as engage in reflection on your clinical week! I cannot wait to watch you grow this semester! MD

Week 5- An area of strength I would say was connecting with my patient this week being confident in their care, rolling with the punches for example while going to take out the patients catheter and finding she had a BM too I didn't worry I just realized plans were changed and we were just going to focus on one thing at a time and it would get done, even if we had to go to lunch late. In nursing that happens things don't go as planned and I think a strength is rolling with that. Very true! HS

An area of growth or improvement would be me rushing to complete things and making small errors. There were a few small errors I made while charting my Wednesday patient that I remembered and didn't repeat for my Thursday patient. So I just have to remind myself it's not a race, and everything will get done, but it's better to 1. Slow down and 2. Double check for accuracy. Good plan, slow down and double check your work. HS

Week 6- Strength is the amount of time I've been studying this week, I have really focused on studying more then other weeks and I'm really praying that I can get a good grade on Monday's test. RH

Area of growth- Getting more sleep I think because I work a lot to be able to afford all my bills and things and it's just a lot with school too. So I definitely need to get more rest. This is a good goal because sleep is so important. Please refer to the directions for what your goal should include in order to get a satisfactory rating. I changed it to NI for this week, but in future weeks it will be changed to a U if not all criteria are met. I highlighted the directions in green above. RH I think you are talking about because I didn't state how I would change this area of growth. I have since changed my work schedule and am not working such long hours on school and clinicals days, so that is how I will work to focus on getting more sleep.

Week 6 (7f) This was changed to "NI" due to the comments from the nurses saying you were on your phone, the need to slow down while performing medication administration, and some of the comments you said about looking in your patient's chart while at work. You also made some comments to your peers about sleeping in the hospital while in the hallways. We want to present ourselves as professionals by our actions and our words. Please be aware of what you are saying and where you are when saying things. The family members of our patients do not need to know you slept at the hospital prior to a clinical, no do the nurses on the floor. RH
I've addressed the first two above already about being in the break room during medication administration, and looking at the patients chart. I did not say anything about sleeping in the hallways. There was a night that I worked from 3p-3a and instead of going home and rushing back I stayed at the hospital in a call room on 3N which was approved ahead of time by the nursing supervisor that night. Sleeping in the hallways would absolutely be inappropriate and unprofessional, but that is not what happened. Moving forward I changed my schedule and am not working anymore 3p-3a shifts so I won't have to worry about the limited hours between work and school.

Week 7 (7a,b)- You did a great job with your patient this week, however, you are receiving "U's" for competency a and b as you did not provide your strength's and areas for improvement for week 7. 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. SA

Student Name: Jessica Seciliot	**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)**	2	The list of assessment findings were not all necessarily assessment findings. For example, malnourished you should be more specific what did you see during your assessment: dry pale skin, bony prominences present. You listed bruising but no specific sites. You listed inability to care for self but then put that as the priority problem, be specific if the patient is unable to dress self or what they are unable to do. You put an SpO2 of 95% which is a normal finding. Other things to include would've been Foley, incontinence, uses a walker. You listed several abnormal lab/diagnostic findings. I am confused because you put colon cancer but did not state if that was from a CT scan or what type of test. Also, you put CHF impaction I am not sure what that is (I believe it is a mistype). You also put a glucose of 12.1? For the risk factors the patient also had a history of DVT which could be included.
	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**	1	You provided a list of 3 nursing priorities. I can think of several other problems for the patient such as: risk for falls, risk of injury, knowledge deficit, Impaired nutritional intake. You stated a goal for the patient. In the future, be sure to make it specific to the patient. You did not highlight all of the abnormal findings that would corelate with the inability to care for self, such as hearing aids, and vision loss. You listed 3 potential complications for the top priority with 3 signs and symptoms to monitor for each one.
	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**	2	
	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	
Res	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	You listed 15 nursing interventions specific to the top priority. You prioritized the interventions.

ponding	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Be sure to include a frequency for each intervention 2 of them were missing. The interventions were individualized overall. If you are going to use a medication be sure to use the exact medication rather then bowel medications, you would use what was ordered for the patient and that would include the dose and frequency. You included a rationale for each intervention. HS
	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	1	Your evaluation should be a mirror of the abnormal assessment findings from the assessment and lab/diagnostic tests from the front of the care map. You included information such as the vital signs that were not necessary as well as the risk factors which are non-modifiable. You did not include a reassessment of the high fall risk or bruising. HS
	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: **Jessica, you did not include an in-text citation therefore this care map is a Needs improvement. You must include this and resubmit it.**
You have some good information in your care map for your patient however some information is also missing. The assessment findings box is an area that I feel needs more information to paint a clearer picture of the patient and her abnormal findings. You had some missing information here as stated above. The other area that could include more would be the nursing priorities, you listed just 3 problems for a patient that is 101 years old that has abnormal assessment findings.
You need to make sure you double check your work prior to submitting. You have a couple things that are mistypes that could

Total Points:39/45

Faculty/Teaching Assistant Initials: HS

have been identified just by reviewing it prior to submitting. **Nice job with the interventions and making them specific to the patient. When reflecting be sure to mirror the abnormal assessment and lab findings that were identified. HS** **2/10/26 The in-text citation has been added. Your care map is now satisfactory. HS**	

Student Name: J. Seciliot	**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	All requirements met.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	4. good list of nursing priorities, good range of body systems. 6. There are some assessment findings that could be highlighted and some that are not related to the priority problem you selected, so one point was lost here. 7/8. Good list of potential complications and signs/symptoms of each one.
	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**	2	
	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**	2	Good list of interventions, but no medications are listed? Was this intentional? There is not a single medication you would give someone to assist with their mobility? Not even something that you could give to help prevent a complication? (DVT Prophylaxis, pain medication to assist with participation in therapy, medication to assist with bowels/cirrhosis to promote more movement). I came up with an additional 4 interventions. This makes yours 71% complete so one point lost here. Interventions are not prioritized
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	1	
	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	

							(assessments should be first, medications second, education/promotion of activities third). After prioritizing them, only 3/10 are in correct order, so only 1 point was given here.

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. Did not re-evaluate all items, only 80% complete.
	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

Faculty/Teaching Assistant Initials: RH

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

Student name: Jessica Seciliot								
Skills Lab Competency Evaluation Performance Codes: **S**: Satisfactory **U**:Unsatisfactory	**Lab Skills**							
	Week 1	**Week 1**	**Week 1**	**Week 1**	**Week 1**	**Week 2**	**Week 2**	**Week 9**
	Insulin (2,3,5,7)*	**Assessment** (2,3,4,5,7)*	**IV Math Application** (3,7)*	**Lab Day** (1,2,3,4,5,6,7)*	**IV Skills** (2,3,5,7)*	**Trach** (1,2,3,4,5,6,7)*	**EBP** (3,7)*	**Lab Day** (1,2,3,4,5,6,7)*
	Date: 1/6/26	**Date: 1/6/26**	**Date: 1/7/26**	**Date: 1/7/26**	**Date: 1/9/26**	**Date: 1/14/26**	**Date: 1/14/26**	**Date: 3/9/26**
Evaluation:	**S**	**S**	**S**	**S**	**S**	**S**	**S**	
Faculty/Teaching Assistant Initials	DW	DW	DW	DW	DW	DW	DW	
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 demonstrated competence with tracheostomy care and tracheostomy suctioning, great job! You were able to maintain sterility throughout both procedures and were conscientious of your sterile field. During trach suctioning, you required two prompts: one related to hyper

oxygenating the patient prior to performing suctioning, and the other related to returning the oxygen to the previous setting after completing suctioning. During trach care, you required one prompt related to re-assessing the patient's respiratory status after completing trach care. Otherwise, well done. Keep up the hard work! 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: Jessica Seciliot					
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	82.5%		
Date: 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	**U**	**HS**	**2/9/2026/S/HS 94.9%**
		DCE Score	74.2%		
Date: 2/23/26	Shadow Health (Basic Patient Case: Pharmacology) (*1, 2, 3, 4, 5, 6)	Scenario	**S**	**SA**	**NA**
		DCE Score	85.7		
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