EVALUATION OF CLINICAL PERFORMANCE TOOL
Medical Surgical Nursing – 2026

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Taleigh Cook

Final Grade: **Satisfactory/Unsatisfactory**

Semester: **Spring**

Date of Completion:

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

Faculty eSignature:

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

DIRECTIONS FOR USE:

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

METHODS OF EVALUATION:

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

ABSENCE (Refer to Attendance Policy)

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

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

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

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

OTHER

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

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

Week	Care Map Top Nursing Priority	Evaluation & Instructor Initials	Remediation & Instructor Initials	Remediation & Instructor Initials
Week 5	Ineffective Cerebral Tissue Perfusion	S/NS	NA	NA
Week 6	Fluid Volume Excess	S/SA	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)			S	S	S	S	S	NA									
b. Correlate patient's symptoms with the patient's disease process. (Interpreting)			S	S	S	S	S	NA									
c. Correlate diagnostic tests with the patient's disease process. (Interpreting)			S	S	S	S	S	NA									
d. Correlate pharmacotherapy in relation to the patient's disease process. (Interpreting)			S	S	S	S	S	NA									
e. Correlate medical treatment in relation to the patient's disease process. (Interpreting)			S	S	S	S	S	NA									
f. Correlate the nutritional needs in relation to patient's disease process. (Interpreting)			S	S	S	S	S	NA									
g. Assess developmental stages of assigned patients. (Interpreting)			S	S	S	S	S	NA									
h. Demonstrate evidence of research in being prepared for clinical. (Noticing)	S		S	S	S	S	S	NA									
Indicate your clinical site as well as your patient's age and primary medical diagnosis in this box weekly.	Meditech, FSBS, IV Pump Sessions		5Tower Rehab, 72 y/o, THA	3T, 86 y/o, Back pain and Fall	4N, 89 y/o syncope, Acute ischemic stroke/ 89y/o fall, R patella	3T, 54 y/o, Syncope,	5T Rehab, 82 y/o, Subdural Hematoma,	NA									
Instructors Initials	**RH**		**MD**	**KA**	**NS**	**SA**	**RH**										

****Evaluate these competencies for the offsite clinicals:** **DH: 1h** **IC: 1h.** **ECSC: 1g, h** **OR: All**

Comments:

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

Week 1 (1h)- During week 1, the Meditech, FSBS and IV pump sessions were all considered clinical hours. You came prepared to each of them and demonstrated competency accordingly. For this reason, you have earned an S for this competency. NS/SA/DW/HS

Week 3 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 hip replacement! You did a great job with discussing how these all related together to provide the patient with appropriate nursing care! Great job! MD

Week 4 – 1a-h – You did a nice job discussing on clinical and in debriefing your patient's pathophysiology, signs and symptoms, diagnostic studies, medications, medical treatments, and their current diet/nutritional needs and how it correlated to their admitting diagnosis. You were able to discuss your medications on clinical and researched their purpose, side effects, and related nursing interventions before administering medication to your patient. You came to clinical on time and prepared to care for your patient diagnosed with back past after a fall. KA

Week 5 1(a-h) – This week you had the opportunity to care for two different patients. On day one, you cared for a patient admitted with frequent falls and an acute ischemic stroke. You were able to discuss the pathophysiology involved, including her risk factors of hypercholesterolemia, hypertension, former smoker, heart disease, and afib. You identified the lack of oxygenation blood flow to her brain as the primary cause of the stroke while discussing how her risk factors impair tissue perfusion. You were able to identify her signs and symptoms of drowsiness, altered pupillary reaction, frequent falls, and unsteady gait correlated with her diagnosis of stroke. Diagnostic tests were thoroughly reviewed, identifying subacute ischemia on the MRI, calcification of the carotid arteries on the Neck CTA, d-dimer elevation, and EKG results of afib. Great job digging through the chart to make correlations between her results and the nursing care required. You discussed the pharmacotherapy prescribed, specifically the duel antiplatelet therapy to reduce the risk of reoccurrence. I thought you did a great job conducting research to better understand your patient's condition and you performed detailed assessments, noticing numerous specific abnormalities related to the neurological system. On day 2, you cared for a patient admitted with a fall and patella tendon rupture in the post-operative period. You participated in the discussed of the pathophysiology involved, including the surgical management. NS

Week 6: (1a-h) Nice job making connections with your patient's diagnosis and their disease process. You were able to also discuss how each of their medications related to their diagnosis and how it would assist with their plan of care. Your care map was appropriate to your client's medical history and supported guidance to aide them with their care plan. SA

Week 7 (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 CDG of this patient as well. RH

Objective

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

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies: a. Perform inspection, palpation, percussion, and auscultation in the physical assessment of assigned patient. (Noticing)			S	S	S	S	S	NA									
b. Conduct a fall assessment and implement appropriate precautions. (Noticing)			S	S	S	S	S	NA									
c. Conduct a skin assessment and implement appropriate precautions and care. (Noticing)			S	S	S	S	S	NA									
d. Communicate physical assessment. (Responding)			~~S~~ U	S	S	S	S	NA									
e. Analyze appropriate assessment skills for the patient's disease process. (Interpreting)			S	S	S	S	S	NA									
f. Demonstrate skill in accessing electronic information and documenting patient care. (Responding)	S		S	S	S	S	S	NA									
	RH		**MD**	**KA**	**NS**	**SA**	**RH**										

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

Comments:

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

Week 3 Rehab Objective 2 E: This week your patient had a hip replacement surgery. During your assessment, you noticed that the patient's respiratory rate was 11 bpm and that the patient had delayed capillary refill in the affected leg. When completing documentation review, these findings were identified and when questioned if discussed with the primary nurse or faculty immediately following identification, it was determined communication was not completed. It is very important to remember to have communication with the primary nurse and the faculty/teaching assistant on abnormal assessment findings. We were able to have much communication on this in the clinical setting at the end of the day and discussed that this will be something to work on for the next clinical. I have full confidence that you will push yourself to improve your communication of your abnormal physical assessments! You are receiving an unsatisfactory rating for this competency this week. Please respond with how you will prevent this from occurring in the future. MD

I will prevent this in the future by communicating in a timely manner any pertinent objective or subjective data. With either the charge nurse or the primary nurse. You did a great job this week working on your communication with the nurse and provided updates on change in patient status promptly to your nurse and your instructor. Great job taking Monica's feedback and improving your patient care. KA
Week 4 – 2 a-f – You did a nice job completing your physical assessment. You recognized abnormal assessment findings and documented them appropriately. You made sure your patient was on high risk fall precautions and ensured they were utilized throughout your day as you cared for them. Your patient had a purewick and monitored the urine for color and clarity throughout the day. You provided peri care as needed and changed the purewick when required. You utilized the EMR to research your patient and ensured your assessment findings were documented appropriately. You did a nice job documenting and made changes when needed promptly. Your charting was thorough and you were able to complete it independently and timely. KA

Week 5 2(a,e) – You were thorough in your assessments this week, noticing numerous deviations from normal. You used sound clinical judgement in interpreting your findings as they related to her current and past medical history. On day one, you noticed that your patient had a delayed pupillary response when assessing PERLLA, which you questioned if she had a history of eye disorders. Digging through the chart and correlating medications prescribed, you were able to discover that she has a history of glaucoma and is being treated with pharmaceutical intervention. You also noticed bradycardia, vision impairment, unsteady gait, irregular heart rate, and lethargy, among other findings. On day 2, you noticed neck soreness, visual limitations with the use of glasses, hearing difficulty, poor oral hygiene, moist productive cough, non-pitting edema in the lower extremity, with the left being worse than the right, numbness and tingling to the fingers which you correlated with her diabetes, and knee incision with the use of a prevena wound vac. Excellent detail in your documentation and noticing skills. You did well analyzing and discussing pertinent priority assessments to be performed, including neurological, integumentary, and circulation assessments. Well done! NS

Week 6: (2a-f) You performed a full head to toe assessment on your client as well as a fall, IV, safety, and wound assessments. You focused on the client's skin, changed the dressing, and provided thorough education. You were able to communicate any abnormalities in your assessment to myself and the primary nurse as well. You charted all your findings in the EHR appropriately. SA

Week 7 (2a-f): You were able to perform all assessments on your patient this week and chart them appropriately in meditech. You also were able to identify a priority problem with your patient and perform a detailed focused reassessment on your patient related to that problem. You communicated changes in your assessment to the proper healthcare team member. RH

Objective

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

Weeks of the Course	1	2	3	4	5	6	7	8	Midterm	9	10	11	12	13	Make Up	Make Up	Final
Competencies: a. Perform standard precautions. (Responding)	S		S	S	S	S	S	NA									
b. Demonstrate nursing measures skillfully and safely. (Responding)	S		S	S	S	S	S	NA									
c. Demonstrate promptness and ability to organize nursing care effectively. (Responding)			S	S	S	S	S	NA									
d. Appropriately prioritizes nursing care. (Responding)			S	S	S	S	S	NA									
e. Recognize the need for assistance. (Reflecting)			S	S	S	S	S	NA									
f. Apply the principles of asepsis where indicated. (Responding)	S		S	S	S	S	S	NA									
g. Demonstrate appropriate skill with Foley catheter insertion, maintenance, & removal (Responding)			NA	NA	NA	NA	~~NA~~ S	NA									
h. Implement DVT prophylaxis (early ambulation, SCDs, ted hose, administer enoxaparin or heparin) based on assessment and physicians' orders (Responding)			S	S	S	S	S	NA									
i. Identify the role of evidence in determining best nursing practice. (Interpreting)	S		S	S	S	S	S	NA									
j. Identify recommendations for change through team collaboration. (Reflecting)			S	S	S	S	S	NA									
	RH		**MD**	**KA**	**NS**	**SA**	**RH**										

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

Comments:

Week 3 Rehab Objective 3 A, B, H: This week you were able to administer enoxaparin! You did an awesome job with appropriate standard precautions, demonstrating skillful and safe administration by discussing subcutaneous medication administration and completing the skill proficiently. You were also able to identify how the medication related to DVT prophylaxis! Great job! MD

Week 4 – 3 a-f – You did a nice job ensuring standard precautions were utilized throughout your day when caring for your patient. You worked well with your classmates to assist one another when needed. Your patient had an external urinary catheter that you provided care for, but you did not have the opportunity to care for a patient with and indwelling urinary catheter this week. You did a great job setting a goal for your patient related to coughing and deep breathing and utilizing the incentive spirometer. You assisted your patient with this goal by educating her and encouraging use of the IS when you were in the room to help her get closer to discharge. KA

Week 4 3(c,d) – I thought this was a great week for you related to time management and prioritization. You were timely with your assessments, nursing care, and documentation. This allowed your ample time to research your medications, which you did in great detail. You were independent in your interventions, and did not require prompts or reminders throughout the week. NS

Week 6: (3a-f, h-j) You used standard care precautions and recognized need for assistance by asking for help when needed and helping other nurses with other patients as well. You did great prioritizing assessments and tasks with your client this week. SA

Week 7 (3a-j): You performed hand hygiene appropriately throughout both clinical days. You were able to organize your day and perform all nursing tasks/assessments in a timely manner while working around the therapy schedule. You asked for help when needed. You were able to care for your patient's chronic foley during this clinical so 3g was changed to S. You had a busy clinical on both days due to your patient having an appointment outside the hospital and due to the therapy schedule both days. You did great even though you did mention feeling rushed. Good job being flexible and accommodating to the patient. RH

Objective

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

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

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

Comments:

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

Week 1 (3r)- You satisfactorily performed a Quality Control check of the glucometer as well as demonstrate skills and knowledge required for proper fingerstick blood glucose measurement with the ACCU-CHEK Inform II glucometer. SA/DW

Week 3 Rehab Objective 3 K, L, M: While administering medications, you were able to identify the rights of medication administration for patient, dosage, time, route, documentation, and medication. 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 did an awesome job providing step by step instruction on how to administer the subcutaneous medication and performing the administration! Awesome job! Keep up the great work! MD

Week 4 – 3 k-m – You did a nice job administering medications this week. You looked all medications up before administering and ensured the rights of medication administration were followed. You had the opportunity to administer PO medications this week. You checked the patient's labs and vital signs to ensure no medication needed to be held before administration. You made sure all medications were properly documented in the eMAR and updated your nurse when the process was complete. KA
Week 4 – 3q – You did a nice job monitoring your patient's saline lock for complications and documenting your IV site assessment in the patient EMR correctly. KA

For objective 3N I'm not 100% sure if that's what I did I know I primed the line for the antibiotic, but I'm assuming I also administered it.
Week 5 3(k,l,m,o,q) – Good work with your medication administration this week. You were prepared to discuss each medication, including the classification, indications, side effects, and nursing implications for each. Your research on medications was very thorough this week! You were able to administer numerous PO medications, eye drops, and also primed an IV line for an antibiotic. You also had the opportunity to regulate the IV flow rate of the antibiotic by programming it in the pump accurately. With each medication, you observed the rights of administration and performed three safety checks. You effectively utilized the BMV scanning system for each medication to promote safety. You confirmed that the correct dose was removed and administered. A FSBS was obtained on your patient on day and was communicated promptly to the RN. Great job! NS

Week 6: (3k-m) This week you performed medication administration. You identified all medications and were able to provide an analysis of all medications administered including type of medication, side effects, and nursing care performed after administration. You also performed all checks prior to administration to ensure you were giving the correct dosages of each medication to the correct patient. You were able to scan all medications in the MAR and chart them appropriately. You administered PO medications and assessing them during the administration. SA

Week 7 (3k-m): You were able to perform medication administration this week. You were well prepared with all medication information to review with me prior to pulling medications. You had thoroughly looked up medications to be prepared. You administered PO 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. RH

Objective

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

Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
Competencies: a. Integrate professionally appropriate and therapeutic communication skills in interactions with patients, families, and significant others. (Responding)			S	S	S	S	S	NA									
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	NA									
c. Report promptly and accurately any change in the status of the patient. (Responding)			U	S	S	S	S	NA									
d. Maintain confidentiality of patient health and medical information. (Responding)			S	S	S	S	S	NA									
e. Consistently and appropriately post comments in clinical discussion groups. (Reflecting)			S	S	NA	~~S~~ NA	S	NA									
f. Obtain report, from previous care giver, at the beginning of the clinical day. (Noticing)			S	S	S	S	S	NA									
			MD	**KA**	**NS**	**SA**	**RH**										

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

CDG	Week Completed	Initials
EBP Article: Discussing Evidence in Nursing Research	Week 7	RH
Patient Education: Identifying and Intervening on Knowledge Deficit	1/28-29/2026	KA
Safety: Restorative Care and Managing Potential Complications	1/21-22/2026	MD

Comments:

Week 3 Rehab Objective 4 C: I agree with your self-rating of unsatisfactory in this competency. As stated in 2E, you did not communicate the respiratory rate and the delayed capillary refill to your primary nurse or the faculty. We had much communication and you were able to set goals (as commented on in 7B by your reflection). I am positive you will make the goal you have set for yourself! Keep working hard! MD

Week 3 Rehab Objective 4 E: This week for your CDG you selected the topic of Restorative Care for your patient with a hip replacement. You successfully discussed a potential complication of a thrombosis that could lead to a DVT, PE, stroke, or heart attack. You were able to provide priority assessments and interventions including administering enoxaparin, encouraging ambulation with breaks while encouraging her to watch for and report signs of dizziness, or lightheadedness. You were able to correlate the possible complications with ambulation with her antihypertensives and the need for adequate fluid intake. You identified that her functional ability prior to her surgery was an independent with no assistive devices and that after surgery she was a minimum assist for short distances and used a walker/wheelchair for farther distances. You assisted with range of motion exercises to increase her functional abilities as well. You provided a satisfactory CDG with a reference, in-text citation, and adequate word count. Awesome job, Taleigh! MD
I will note any changes that are abnormal or not within the patients' baseline and try to communicate more promptly with the nurses and staff on duty. Great job addressing this during clinical this week! KA

Week 4 – 4 a-d, f – You worked well with classmates, assigned RN, and staff members to provide care for your assigned patient. You received report for your patient and asked questions as needed. You provided prompt updates to your nurse with status changes. You utilized the EMR to research information on your patient and ensured confidentiality was maintained. You provided an SBAR to your nurse when reporting off and made sure all pertinent information was passed on before leaving. KA
Week 4 – 4e – You did a great job responding to all CDG questions related to the knowledge deficit your patient had. You were thoughtful with your responses and explanation of the education you provided to your patient. You included an in-text citation and reference to support your responses. Keep up the wonderful work! KA

Week 5 4(c) – I can tell you took the feedback from previous weeks to heart and implemented a plan to communicate promptly. On multiple occasions this week, you promptly reported any abnormal vital signs and FSBS results to the assigned RN or faculty. Great job improving from earlier in the semester! NS

Week 6: (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 reported the patient You did a care map this week so I changed (4e) to NA. SA

Week 7 (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. You were able to find an EBP article related to your patient this week and posted about it in your CDG post.RH

Than

Objective

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

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

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

Comments: The teaching that I provided for my patient was to always keep the walker in front of her and close to her I used the analogy of it being like a best friend that you never want to leave you. I had mentioned this to her when she was working with physical therapy and beginning to walk up to the sink, my method of delivery was in a kind, silly manner. I had realized this need for teaching because I observed that when she was transferring short distances and or turning she wouldn't normally bring her walker with her. The method I used to have her validate her learning was to demonstrate how to properly use the walker. Great education! I am going to use this for my patients as well! What resources did you use to help you with this teaching? Did you use Lexicomp, UpToDate, or Skyscape? Please be sure to include a resource for 5B! MD

I think a teaching need for my patient would be to increase her fluid intake because she would barely drink any fluids. I positioned them closer to her, and her cup was refilled but that still wasn't a turning point. I encouraged these fluids along with deep breathing and coughing and educated her that I wanted to see if she felt like she was having shortness of breath, needed to cough up something, and overall that these teaching methods help prevent pneumonia. She stated that her cough was dry, and she felt like she needed to cough something up but couldn't get it out. I educated her on the use of the incentive spirometer and how it helps to clear the airway, increase oxygenation, and to use it 10x every hour or as often as she can remember. The resource that I used with these teachings was skyscape. Great job educating your patient this week as well as completing your CDG related to patient education. KA Thank you!

A teaching need for my second patient would be mobility after surgery and pain management. She mentioned, she was very independent at home when I asked her what devices she used to walk before surgery she said, "her legs" and that she didn't use anything but does keep a cane and a walker available if needed. It was important to educate her on the importance of moving and sitting in the chair to prevent blood clots, pneumonia, muscle weakness, constipation, and skin breakdown and to promote overall recovery. Even though she wasn't looking forward to sitting in the chair OT and I got her up after her meds, gave her a time frame she would be in the chair, and I offered her an ice pack since she stated the moving increased her pain. The resource I used was skyscape. Good discussion, Taleigh! You provided excellent detail in your response and highlighted high priority education to your patient to prevent complications. I am not sure if this was related to your day 1 or day 2 experience; however, it

was relevant for both. I think it is great that you included your rationale for why you are encouraging movement. Sometimes we tell patients they need to get up and move, but don't explain why. Giving rationale helps them to understand the plan of care and also motivates them to prevent the complications from occurring. Although your patient on day 2 was in quite a bit of pain with movement, it sounds like she understood the importance of mobility post-op and was willing to work with you. Also, giving her a time frame of how long she would be in the chair also gives her a goal to strive for. Great job incorporating her in the plan of care with education. NS

Week 6: With my patient being a previous smoker, having a history of a pulmonary embolism in both lungs and a lung collapse, I encouraged him to deep breath, cough, and encouraged movement so we could keep his lungs as clear as possible, and keep his fluid moving. I explained to him that I know it sounded weird but that it was to assess his ability to cough up any needed mucous or fluids and to see if he was congested and or struggling to breathe. Especially since he has had fluid volume excess that fluctuate. I used skyscape to assist me with this education. This is a great topic to educate and will also assist to prevent pneumonia. SA

Week 7: The first thing that I educated my patient on was the reasoning for a yellow fall risk bracelet. And that it was for safety measures used to alert all healthcare staff that he is an increased fall risk based off his age, medical history, current weakness, and falls in the past 6 months. I clipped the bottom of the bracelet to make it more comfortable for him too. I made sure he knew that this is a preventative measure. I educated on the importance of daily comprehensive reassessments even if I assessed that area the day before. Because he stated "you already did it yesterday you don't need to do it again today" I explained that we must address cognition as well as, skin integrity, and circulation every day in addition to medication side effects because a change can occur quickly and informed him that I wasn't going to force him to do anything. I used skyscape to assist me with my education. Great job! That is quite a few educational topics, that's fantastic. RH

Objective																	
6. Implement patient-centered plans of care utilizing the nursing process, clinical judgment, and consideration for cultural, ethnic, and social diversity. (2,3,4,5)*																	
Weeks of the Course	1	2	3	4	5	6	7	8	**Midterm**	9	10	11	12	13	**Make Up**	**Make Up**	**Final**
a. Develop and implement a priority care map utilizing the nursing process and clinical judgment. (Noticing, Interpreting, Responding, Reflecting)			NA	NA	S	S	~~S~~ N/A	NA									
b. **Identify factors associated with Social Determinants of Health (SDOH) &/or cultural elements that have the potential to influence patient care.**** (Noticing, Interpreting, Responding, Reflecting)			S	S	S	S	S	NA									
			MD	**KA**	**NS**	**SA**	**RH**										

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

See Care Map Grading Rubrics below.

Comments: A factor that I identified as a social determinant of health was the fact that my patient lives alone. Areas of concern with this could be social isolation and loneliness that could contribute to her mental health and anxiety. Her ability to get help during emergencies could be a worry along with being able to perform her ADL's adequately at home. Additionally, her limited mobility could make it difficult to run errands and limit her access to resources she needs. Aboslutely! What kinds of resources could we provide her to assist with these concerns? MD

I would say that my patients support system could be a SDOH because her husband was also older and he's her main caretaker so whatever he's able to do for her is basically what she gets. Her lack of mobility makes it harder as well because she is on the first floor and her husband is on the second, so this limits her access to him. She also expressed that one of her daughters that lives close by is not welcomed in her home and her other daughter lives hours away. Some resources that could be provided for these things are skilled nursing facilities, home health aides, home safety evaluations, adding grab bars a shower chair, and even telehealth visits. I agree this was a big concern for her since she was unable to get immediate assistance after her fall due to her support system at home. You did a nice job identifying resources that could help address this concern. KA

For my first patient I would conclude that a SDOH for her would be family and community support as well as transportation problems. When I asked who her support system was, she stated "my doggies" I had her repeat it a couple times to make sure I heard her correctly and that's she was being serious, she did mention she had a couple kids as well and then went back to sleep so I'm not sure how much help they are. To be fair she was very drowsy and lethargic, but no other examples of a support system were mentioned. I worry about her ability to get to appointments, meet her daily needs, and remain safe, especially due to her past medical history of MI's, stroke, and HTN. Some resources that could be provided to her would be a community senior transport van that really focuses on helping the disabled and elderly, caregiver support services to help her with her ADL's since she moves slower because of her brain damage and eyesight. Medication delivery considering that she had quite a few meds and

lastly meal on wheels/food delivery programs that would improve health stability. Good reflection, Taleigh! You did a great job communicating with your patient to identify potential SDOH that could impact her health outcomes. This was a tricky situation, as she was adamant about going back home after discharge, but her family who was not actively involved in her care, wanted her to go to a nursing home. These types of dilemmas are tricky in healthcare and we can collaborate with case management to determine the best course of action. I completely agree that her returning home by herself with limited support could lead to negative outcomes. She was already admitted with frequent falls and has a new diagnosis of a stroke. This puts her safety at great risk in the home setting. You identified some wonderful resources that could be of benefit to her if this were to be the case. The social and community context section of SDOH is an important one, because people's relationships with family, friends, etc. has a major impact on health and well-being. NS

Week 5 6(a) – Satisfactory completion of a nursing care map on the priority problem of ineffective cerebral tissue perfusion. See the attached grading rubric below for more details. NS.

Week 6: My patient this week had been having symptoms of dizziness with lightheadedness upon standing and felt unsteady their feet. I think that a SDOH would be potential financial strain considering that he is on medical leave from work and has been for a while as well as being readmitted. He had a history of cancer and endocrine disorders can be expensive, long-term care, medications, frequent appointments. Furthermore, paying for medical care, food, housing, and heating is a key factor for chronic illness patients. His disabilities with his chronic and acute conditions especially with syncope can cause transportation problems, which is very relevant because he frequently has appointments whether it's for GI, his liver, oncology, or a paracentesis. Great job recognizing that financials can impact a person's recovery. What are some resources we can provide to aid once they are discharged? SA

Week 7: For my patient this week it was hard trying to find a SDOH, but from what I've gathered I would say that his SDOH would be healthcare literacy when his wife is not around, she tended to correct him, tell him what to do and micromanage. I noticed he got irritated multiple times and instead of speaking up for what he wanted he just let it go and stopped talking because I'm assuming he thought her answer was good enough based off her nursing history. It appeared that he was very dependent on her even when it made him uncomfortable. I even tried to emphasize that he had the right to refuse when I noticed he was very reluctant to do certain things and made sure to use his name and make eye contact with him and she corrected stating "I should never tell patients that, it looks bad". I think that directing my questions and statements to him was very important and making sure I got an answer from him and not from his wife speaking over him. Great job advocating for your patient to speak for himself. Sometimes this can be difficult if you have a spouse who is micromanaging, but you did the right thing by speaking to him and saying he has the right to refuse. That is the right of any patient. RH

Week 7 (6a): this was changed to NA because you did not complete a care map this week, you did a Clinical Discussion Group post. RH

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

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

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

Comments:

Week 1: An area of strength from this week would be my participation level as well as my active listening skills. An area that I could work on doing more Nclex-style practice questions, before quizzes. This is a great goal, but please refer to the example above when creating a goal. You must have what you are going to do to practice, how many times you will do so, and by what date/time you will have done that. RH

Week 1: You are receiving a "U" for 7f due to submission of your tool past the due date/time. Please address this "U" and what you will do to prevent getting another in the future. This will remain a "U" until it is addressed. RH What I will do to prevent from getting another U in the future is to make sure I am double checking the document that I'm trying to submit before turning it in. I will do this every time we have a clinical tool or any assignment due. And I do this starting this weekend with my clinical tool and CDG.

Week 3: An area of strength I had was being able to perform a pretty accurate head-to-toe assessment in about 15 minutes on the patient without missing multiple things. Keep working hard and practicing to ensure it stays very accurate! MD Something I need to improve on is adequate and timely communication that is part of the reason why I rated myself a U for the 4C box, I need to communicate abnormal vital signs and assessment findings as soon as possible with either my clinical instructors or the nurse themselves and if I cannot find either clinical instructor or the patients nurse, I could report to charge. I think a way I could practice this is through communicating with our virtual patient on shadow health and focusing on answering the questions that revolve around giving report, and alerting any medical professional when changes occur. I will have this done by 1-22-26 and do it twice through my shadow health patient. This is an amazing goal! I love that you are going to use Shadow Health to assist you with this! Keep making strides with every clinical! I look forward to seeing your progress moving forward! MD

Week 3 Rehab Objective 7 C-H: Taleigh, this week has been a great experience witnessing your first week in the 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 4: An area of strength this week was that I was able to correlate some of the meds to the indication for my patient without doing extensive research. Something I need to work on is having my patient demonstrate the teach back method. I can do this when I'm showing my patient something new and immediately have them repeat it. I will have started this by 2/4/26. I agree the teach back method is an excellent way to help ensure your education is being received correctly and gives you the opportunity to address any further knowledge deficit that may still exist. KA

Week 5: An area of strength that I had this week I would say was making sure the patients knew they had a choice in pretty much everything I was doing, for example my first patient was not thrilled that I had to check every part of her body she stated she was cold, so I turned up the heat, she also asked if I was almost done and then I reassured her that there was only a couple more things I had to do and I would let her know that she could refuse at any time. With my second patient when asking her to tell me the months backwards I let her know that she could refuse especially since she already did it once. My first patient ended up apologizing for being pushy, but I think it helps people to know that we aren't forcing them to do things. This is a really good strength to note, Taleigh! A great example of patient-centered care by keeping the patient actively involved in the care provided. Patients have autonomy and the right to refuse, but might not always be aware of that. It can be hard as a student, as you are performing in-depth assessments that maybe the patient isn't used to. This can lead to frustration or lack of understanding as to why you are taking more time to be thorough. It sounds like you were able to build a rapport with both of your patients through communication, transparency, and including them in decision-making. Well done! NS

An area that I can work on is remembering what the medications for my patient do, once I get into the room I tend to forget once they are out of their package and I don't have my database sheet in front of me. I will improve this skill by grouping more medications by classification, focusing on specific indications, as well as looking up more medications on skyscape. I have already started doing this in my spare time after studying by using ATI and AI to clarify information. Great plan for improvement! Memorizing medications takes repetition and practice. Remember, you can always have your sheet in front of you that you filled out when researching the medications. This is a great reference to look back on if the patient has any questions. As you progress in your career and see these medications more often, you will start to remember them better. Keep up the hard work! NS

Week 6: An area of strength for me for me this week was noticing temperature change in the extremities of my patient and adapting my assessment around that. It is definitely nice to have the same patient two days in a row so that you can recognizes changes in status, so good job! SA
Something I need to work on is my organization when it comes to patient information the unexpected things that could pop up. I will start doing this next week during the first day of clinical by trying to organize my patient's data in a more specific manner that works for me even if my hand-off-report isn't very informative. Something I can do to help me with this is becoming more familiar with the SBAR sheets and where things are located and continuing to keep a timely routine with charting so I'm able to gather as much information as possible. It can be frustrating to not get a good hand off report. Do not be afraid to ask the primary nurse for more information and the more you get comfortable reviewing their charts you can find even more details that might get missed during report as well. Good job! SA

Week 7: An area of strength was for me this week was showing up, prepared and on time, even when feeling discouraged. An area of improvement for me would be filling out my SBAR sheet more at the beginning of the day and in the correct spots so that hand-off report is easier. I can do this by ensuring that I gather all the information from report even if I need to write it on the side of my sheet at first and then reorganize it. Also, by taking my data from my patient care packet and putting it on my SBAR sheet throughout the day and using my assessment information to help me include the most recent pertinent information. I can practice with the report sheet for my sim next week. I will implement this after spring break on March 11th. This is a great goal! If you need to bring more than one sheet to clinical feel free to print a few so you can rewrite it on a new paper if that works better for you. RH

Student Name: Taleigh Cook				**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	Nine abnormal assessment findings are listed, including both subjective and objective data. There were several assessment findings that you identified in your charting that were not included on this list. Some examples are missing teeth, use of dentures, weak pulses with delayed cap refill, lower extremity edema, syncope, possible delirium, apprehensiveness. Be sure to include all your abnormal findings in this section. Numerous abnormal labs/diagnostics were provided with specific details from the MRI and CT scan included. Well done! A thorough list of risk factors are identified and listed based on the patient's current and past medical history.
	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	Three priority nursing problems are identified and listed, with ineffective cerebral tissue perfusion being identified as the top priority problem. There are several additional priorities to consider adding to this list, such as: risk for falls (frequent falls at home), risk for bleeding (on multiple antiplatelet/anticoagulant medications), self-care deficit (lives at home alone), impaired memory, etc. Just some to consider! An appropriate goal statement is provided, directly related to the top nursing priority. Pertinent potential complications are identified and listed as they pertain to the top priority problem. For each potential complication, specific signs and symptoms to monitor for are provided.
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Res	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Several relevant nursing interventions related to the top priority are provided. Listed interventions are prioritized

ponding	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	appropriately. Each listed intervention includes a specific frequency to be performed. One point is deducted for "individualized" related to the medications listed in the intervention section. When including medications in the interventions, be sure to include specific prescriptions for the patient so that they are individualized for your specific patient. Instead of stating "Administer prescribed medications to support cerebral perfusion-antihypertensives, antiplatelets, etc", list the specific orders for your patient that you implemented. For example, "Administer Aspirin 81mg PO daily…" then provide the rationale.
	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**	3	Each listed intervention includes an appropriate rationale.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	Assessment findings are re-listed with most up to date findings. This was very detailed, great job. Based on the findings, it was appropriately determined to continue the plan of care.
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

Reference

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

Total Possible Points= 45 points 45-35 points = Satisfactory 34-23 points = Needs Improvement*	**Total Points: 42/45 – Satisfactory**

< 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: Taleigh, Great job with your care map submission for the priority problem of ineffective cerebral tissue perfusion. You were able to apply what you learned in the clinical setting and identified important aspects of a nursing plan of care to consider. You have received 42/45 points for a satisfactory evaluation. Your 1 required care map submission prior to midterm is now complete. Remember, you will submit one more satisfactory care map before the end of the semester. Don't hesitate to reach out with any questions/concerns. Keep up the hard work! NS**	**Faculty/Teaching Assistant Initials:** NS

Student Name: Taleigh Cook				**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	You provided a list highlighting the abnormal assessment findings. Be careful to not duplicate findings ("cold feet/L foot cool to touch"). 9 listed abnormal lab/diagnostic findings. You provided a thorough list of risk factors for the patient
	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	You provided a list of 6 nursing priorities highlighting the top priority. An appropriate goal for the priority problem is stated. You selected and highlighted the relevant information. Potential complications are listed appropriately and included signs and symptoms for each.
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	You provided a thorough list of interventions related to the top priority and provided a frequency and rationale for each. There are a few missing important interventions such as vital signs (which would help monitor the heart failure and pulmonary edema complication), respiratory assessment to monitor for crackles or SOB (all signs of fluid overload), and assess for acute cognitive changes. Be sure to include education as an intervention as well such as diet changes etc. Interventions are not prioritized. If your main priority is fluid volume excess, our first priority intervention would not be to
	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	

							"protect skin integrity".

	Criteria	3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	All highlighted assessment findings are reassessed and evaluated. Evaluation statement to "Continue plan of care" is completed.
	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:
In-text citation and reference are complete. Please be mindful to use correct APA formatting on the reference. Refer to the resources in Edvance or review the Purdue Owl website for proper use. Nice job.SA

Total Points:
42/45
Satisfactory

Faculty/Teaching Assistant Initials:
SA

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

Student name:								
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 or 3/10/26**
Evaluation:	**S**	**S**	**S**	**S**	**S**	**S**	**S**	
Faculty/Teaching Assistant Initials	RH	RH	RH	RH	RH	RH	RH	
Remediation: Date/Evaluation/Initials	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

*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 admiNstration (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. RH

Week 2
(Trach Care & Suctioning) - During this lab, you satisfactorily demonstrate competence with tracheostomy care and tracheostomy suctioning. RH/DW/NS/HS Great job with suctioning and explaining each step to the patient. One prompt needed. Maintained sterility with trach care. One prompt needed. RH.

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

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

Student Name:					
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**	**MD**	**NA**
		DCE Score	92.6%		
Date: 2/9/26	Shadow Health (Endocrine Hourly Rounds: Medical-Surgical) (*1, 2, 3, 4, 5, 6)	Scenario	**S**	**MD**	**NA**
		DCE Score	100%		
Date: 2/23/26	Shadow Health (Basic Patient Case: Pharmacology) (*1, 2, 3, 4, 5, 6)	Scenario	**S**	**RH**	**N/A**
		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