

2 EVALUATION OF CLINICAL PERFORMANCE TOOL
Psychiatric Nursing- 2025
Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Seth Linder

Final Grade: Satisfactory/Unsatisfactory

Semester: Summer Session

Date of Completion:

Faculty: Brian Seitz MSN, RN, CNE, Nicholas Simonovich MSN, RN, Kelly Ammanniti MSN, RN, CHSE
Rachel Haynes MSN, RN
Teaching Assistant: Stacia Atkins BSN, RN

Faculty eSignature:

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. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

Clinical Patient Profile
Meditech Documentation
Evaluation of Clinical Performance Tool
Onsite Clinical Debriefing
Online Discussion Rubric
Nursing Process Recording Rubric
Geriatric Assessment Rubric
Lasater Clinical Judgment Rubric
Virtual Simulation scenarios
EBP Presentations
Hospice Reflection Journal
Observation of Clinical Performance
Clinical Nursing Therapy Group
Nursing Care Map Rubric

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
Initials	Faculty Name		
BS	Brian Seitz MSN, RN, CNE		
NS	Nicholas Simonovich, MSN, RN		
KA	Kelly Ammanniti MSN, RN, CHSE		
RH	Rachel Haynes MSN, RN		
SA	Stacia Atkins BSN, RN		

5/9/2025

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 needed 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, and 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.

Objective										
	1. Apply the principles of psychiatric theory in the care of adolescent to geriatric patients with a mental illness diagnosis. (1, 2, 3, 5, 6, 7, 8)*									
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies:	N/A	S	S	S						
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. (noticing)	N/A	S	S	S						
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. (interpreting)	N/A	S	S	S						
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. (responding)	N/A	S	S	S						
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care (noticing)	N/A	S	S	S						
e. Recognize social determinants of health and the relationship to mental health. (reflecting)	N/A	S	S	S						
f. Develop and implement an appropriate nursing therapy group activity. (responding)	N/A	N/A	S	N/A						
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment) (responding)	N/A	N/A	N/A	N/A						
Faculty Initials	KA	SA	RH							
Clinical Location	N/A	1South	1South	Hospice						

Comments:

5/9/2025

Week 2- (1a-e) Great job with both of your CDGs this week in which you described the relationship between your patient's mental health, physical health, and environment. You were able to correlate the patient's prescribed therapies to their current diagnosis, and you did a great job discussing social determinants of health that play a role in your patient's mental health. Remember to enter your clinical site. Nice job! SA

Week 3: 1(b, c, d, f)- This week you were able to discuss your client's interactions in therapy group and how this benefited the client. This included how the client was planning for their discharge plan and how they were going to implement new techniques at home to help their mental health. You were also able to describe three types of therapeutic communication you used with the clients on the unit this week. You were able to provide a therapy group this week by leading a chair yoga session. The clients liked this and said it was a great reset or way to relax. Good job! RH

Objective										
2. Synthesize concepts related to psychopathology, health assessment data, evidenced based practice and the nursing process using clinical judgment skills to plan and care for patients with mental illness. (1, 2, 3, 4, 5, 6, 7, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies:	N/A	S	S	S						
a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. (noticing)	N/A	S	S	S						
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. (noticing, recognizing)	N/A	S	S	S						
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. (noticing, interpreting)	N/A	S	S	S						
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting)*	N/A	N/A	S	N/A						
e. Apply the principles of asepsis and standard precautions. (responding)	N/A	S	S	S						
f. Practice use of standardized EBP tools that support safety and quality. (noticing, responding)	N/A	S	S	S						
Faculty Initials	KA	SA	RH							

*When completing the 1South Care Map CDG & Geriatric Assessment refer to the Care Map Rubric.

Comments:

5/9/2025

Week 2 (2a-c,e,f)- Great job discussing your patient's past medical and mental health history in your CDG, as well as describing factors that create a culture of safety in the psychiatric unit. SA

Week 3: 2(a-f)- You were able to complete competency a-d while completing your care map this week. You also were able to present your EBP article at the end of the clinical day Friday. RH

Objective										
3. Refine basic verbal and nonverbal therapeutic communication skills when interacting with patients, families, and members of the health care team. (1, 2, 3, 5, 7, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
a. Illustrate professionally appropriate and therapeutic communication skills in interactions with patients, and families. (responding)	N/A	S	S	S						
b. Demonstrate professional and appropriate communication with the treatment team by observing the SBAR format for handoff communication during transition of care. (responding)	N/A	S	S	S						
c. Identify barriers to effective communication. (noticing, interpreting)	N/A	S	S	S						
d. Develop effective therapeutic responses. (responding)	N/A	S	S	S						
e. Develop a satisfactory patient-nurse therapeutic communication. (Nursing Process Study) (responding, reflecting)				S						
f. Posts respectfully and appropriately in clinical discussion groups. (responding, reflecting)	N/A	S	S	S						
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. (responding)	N/A	S	S	S						
h. Teach patient/family based on readiness to learn and patient needs. (responding, reflecting)	N/A	S	S	S						
Faculty Initials	KA	SA	RH							

Comments:

Week 2 (3a-d,f-h)- Great job with the identification of barriers for your assigned patient that may hamper their communication skills. You did a great job with CDG post, following all expectations of CDG rubric. Great job with assessing your patient for the readiness to learn and comprehension of adaptive coping skills and behaviors. Nice job communicating with clients and staff as well! SA

5/9/2025

Week 3: 3(a, c, d)- You were able to use therapeutic communication with the clients on the unit this week. You further developed these skills while also discussing them in your CDG post this week. You identified three types of therapeutic communication you used while talking with clients this week. You were able to identify barriers to communication during discussion in debriefing at the end of both clinical days. RH

Objective										
4. Demonstrate knowledge of frequently prescribed medications utilized in treating mental illness. (1, 4, 5, 6, 7)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
a. Observe &/or administer medication while observing the six rights of medication administration. (responding)	N/A	S	S	S						
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. (responding, reflecting)	N/A	S	S	S						
c. Identify the major classification of psychotropic medications. (interpreting)	N/A	S	S	S						
d. Identify common barriers to maintaining medication compliance. (reflecting)	N/A	S	S	S						
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. (responding, reflecting)	N/A	S	S	S						
Faculty Initials	KA	SA	RH							

Comments:

Week 2 (4a-e)- Excellent job demonstrating knowledge of prescribed medications your client is taking to treat mental health on this week's CDG. You observed administered medications to your client with the staff nurse and asked appropriate questions in debriefing. Great discussion of common barriers to maintaining medication compliance in your CDG this week as well. SA

Week 3: 4(a-e) You were able to witness medication administration with the RN and your client this week while on the unit. You were able to identify the types of medications as well as what they were indicated for in regards to your client. You were able to identify why clients were not compliant with medications during discussion with the nurses and myself. RH.

Objective										
5. Develop an awareness of community Mental Health resources and services. (5, 6, 7, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
a. Identify the need for the community resources-detox unit available to patients with a mental illness. (noticing, interpreting)	N/A	S	S	N/A						
b. Discuss recommendations for referrals to appropriate community resources and agencies. (reflecting)	N/A	S	S	S						
c. Collaborate with the Erie County Health Department Detox Unit while observing the care of a patient with mental illness-substance abuse. (Community Agency Observation-Detox Unit) **	N/A	N/A	N/A	N/A						
d. Recognize and describe the need for substance abuse recovery resources. (Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation))	N/A	N/A	N/A	N/A						
Faculty Initials	KA	SA	RH							

****Alternative Assignment**

Comments:

Week 2 (5a,b)- Excellent job attending group therapy and participating in discussion on employment resources you were able to correlate them within your CDG and in debriefing for needs of the client. SA

Week 3: 5(b)- you were able to identify some community resources while on clinical this week as well as mentioning the Firelands "Hope" hotline in your CDG this week. RH

* End-of-Program Student Learning Outcomes

Objective										
6. Demonstrate satisfactory proficiency when using informatics and techniques in the assessment of patients with a mental illness diagnosis. (1, 2, 3, 4, 6, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies:	N/A	S	S	S						
a. Demonstrate competence in navigating the electronic health record. (responding)										
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes-utilizing the electronic health record. (responding)	N/A	S NA	S	N/A						
c. Demonstrate the use of technology to identify mental health resources. (responding)	N/A	S	S	S						
Faculty Initials	KA	SA	RH							

Comments:

Week 2 (6a,c)- Great job navigating the electronic health record to research information on your patient. I changed 6b to “NA” because the only time you will document in the chart is when you provide the group therapy activity on 1S. SA

Week 3: 6(a-c)- You were able to incorporate technology in your CDG this week by providing the Firelands “Hope” hotline as an additional resource for clients. You demonstrated competence in navigating the electronical health record and documentation when documenting on your therapy group you led this week. RH

Objective

7. Evaluate self-participation in patient care experiences with the focus on safety, ethical, legal, and professional responsibilities. (7)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
a. Identify your strengths for care delivery of the patient with mental illness. (reflecting)	N/A	S	S	N/A						
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care. (responding)	N/A	S	S	S						
c. Illustrate active engagement in self-reflection and debriefing. (reflecting)	N/A	S	S	S						
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE" – attitude, commitment, and enthusiasm during all clinical interactions. (responding)	N/A	S	S	S						
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (responding)	N/A	S	S	S						
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." (responding)	N/A	S	S	S						
Faculty Initials	KA	SA	RH							

Objective 7a: Provide a comment for the highlighted competency each week of your 1 South clinical. Put "NA" for the weeks not assigned to 1 South.

Comments:

Week 2 (7a)- I felt that I was able to talk to the patient with therapeutic communication. I spent a good amount of time talking to the patient, making them feel heard and that they matter. The patient was very open and honest with me, which allowed them to become more comfortable and calm. You did an excellent job communicating with all the patients this week on 1 south. Keep up all your hard work! SA

Week 3 (7a)- I felt that I was able to be nonjudgemental when talking with the patient. I respected his values and background without bias. He had very strong opinions about certain things but I did not give any of my own personal thoughts while communicating. Great job using active listening and encouraging the client to talk with you this week. Being nonjudgmental is a key part of therapeutic communication. RH

* End-of-Program Student Learning Outcomes

Care				Map
Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials	
6/16/25	Thought Process, Disturbed	S/RH	N/A	
Evaluation Tool**				
Psych				
2025				

***Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. ***

Comments:

* End-of-Program Student Learning Outcomes

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric-1 South

Student Name: S. Linder				Course Objective:			
Date or Clinical Week: 3							
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 criteria met. RH
	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	All criteria met. RH
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	9. for intervention #1- you can include safety in this as well. 11. For intervention 2, 9, 10, and 11 there is no frequency listed. This puts you at 63% complete.
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	2	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	All criteria met. RH
	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 no in-text citation or reference is 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: 44/45	
						Faculty/Teaching Assistant Initials: RH	

Geriatric Assessment Rubric
2025

Student Name: _____

Date: _____

Clinical Assessment Rubric

Mental/Physical Health Status Assessment

	Points Possible	Points Received
Physical Assessment	4	
Geriatric Depression Scale (short form) Assessment	4	
Short Portable mental status questionnaire	4	
Geriatric Health Questionnaire	2	
Time and change test	4	
Cognitive Assessment (Clock Drawing)	4	
Falls Risk Assessment (Get Up and Go)	4	
Brief Pain inventory (Short form)	2	
Nutrition Assessment (Determine Your Nutritional Health)	4	
Instrumental ADL/ Index of Independence in ADL	4	
Medication Assessment	4	
Points	40	

Education Assessment

	Points Possible	Points Received
Learning Needs (Purpose) Identified and Prioritized (3)	10	
Goals and Outcomes Identified (2)	5	
Points	15	

Education Plan

	Points Possible	Points Received
Teaching Content	10	
Methods of Instruction	10	
Education Resources attached	10	
Barriers to Education Plan	5	
Evaluation of Education Plan	10	
Points	45	

An in-text citation and reference are required.	---	---
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Total Points _____

You must receive a total of 77 out of 100 points to receive a “S” grade on the Evaluation of Clinical Performance tool. Due date can be located on the clinical schedule.

*Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric- Geriatric Assessment

Student Name:				Course Objective:			
Date or Clinical Week:							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)		
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	(lists at least 3*) *provides explanation if < 3		(lists 3 but no specific patient data included)	(lists < 3 or gives no explanation)		
	3. Identify all risk factors relevant to the patient.	(lists at least 5*) *provides explanation if < 5	(lists 4)	(lists 3)	(lists < 3 or gives no explanation)		
Interpreting	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	5. State the goal for the top nursing priority.	Complete			Not complete		
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)		
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)		
Responding	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete		
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete		
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete		

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete		
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete		
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete		

Reference

An in-text citation and reference are required.

The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.

The care map will be graded “unsatisfactory” if no in-text citation or reference is included.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

*****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *****

Faculty/Teaching Assistant Comments:

Total Points:

Faculty/Teaching Assistant Initials:

Nursing Process Grading Rubric
Firelands Regional Medical Center School of Nursing
Psychiatric Nursing
2025

Student Name:

Clinical Date:

Criterion #1 Process Recording is organized and neatly completed (5 points total) • Typed process recording (2) • Correct grammar and spelling (3)	Total Points: Comments:
Criterion #2 Assessment (7 points total) • Identifies pertinent client background, current medical and psychiatric history (3) • Provides self-assessment of thoughts and feelings prior and during therapeutic communication interaction with client (2) • Identifies the milieu and effects on client (2)	Total Points: Comments:
Criterion #3 Mental Health Nursing Diagnosis (8 points total) • Identifies priority mental health problem (4) • Provides at least five relevant/related data findings (2) • Provides at least five potential complications with signs and symptoms (2)	Total Points: Comments:
Criterion #4 Nursing Interventions (10 points total) • Identifies at least 5 pertinent nursing interventions in priority order, including a rationale and timeframe (7) • Identifies a therapeutic communication goal (3)	Total Points: Comments:
Criterion #5 Process Recording (15 points total) • Provides direct quotes for all interchanges (3) • Verbal and nonverbal behavior is described for all interactions (6) • Students thoughts and feelings concerning each interaction is provided (6)	Total Points: Comments:

Criterion #6 Process Recording (20 points total) • Analysis of each interaction providing type of communication (therapeutic/nontherapeutic) (6) • Provides technique for each interaction (exploring, probing, etc.) (6) • Provides explanation for interactions (8)	Total Points: Comments:
Criterion #7 Process Recording (10 points total) • Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion (6) • There are at least 10 interchanges between the client and student (4)	Total Points: Comments:
Criterion #8 Evaluation (15 points total) • Self-evaluation of communication with client (5) • Identify at least 3 strengths and 3 weaknesses of therapeutic communication (10)	Total Points: Comments:
Criterion #9 Evaluation (10 points total) • Identify at least 3 barriers to communication including interventions or communication that could have been done differently (5) • Identify all pertinent social determinants of health (5)	Total Points: Comments:
Criterion #10 Reference/Citation • An in-text citation and reference are required. • If not present, missing components will need to be added and the assignment re-submitted.	
Total possible points = 100 77-100 = Satisfactory ≤ 76= Unsatisfactory *Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. * Course Objective: 2. Synthesize concepts related to psychopathology, health assessment data, evidence-based practice, and the nursing process using clinical judgment skills to plan and care	Total Points: Comments:

for clients with mental illness. (1,2,3,4,5,6,7,8).* Course Objective: 3. Refine basic verbal and nonverbal therapeutic communication skills when interacting with patients, families, and members of the health care team. (1,2,3,5,7,8).* Clinical Competency: 2(d) Formulate a prioritized nursing plan of care utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting) Clinical Competency: 3(e) Develop a satisfactory patient-nurse therapeutic communication. (Nursing Process Study) (responding, reflecting) *End-of-Program Student Learning Outcomes	
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Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2025
Simulation Evaluations

Students Name:					
Performance Codes: S: Satisfactory U: Unsatisfactory			Evaluation	Faculty Initials	Remediation Date/Evaluation/Initials
Date: 6/6/2025	vSim (Linda Waterfall) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz	S	RH	N/A
Date: 6/13/2025	vSim (Sharon Cole) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz	S	RH	N/A
Date: 6/20/2025	vSim (Li Na Chen Part 1) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz			
Date: 6/20/2025	vSim (Li Na Chen Part 2) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz			
Date: 6/25-26/2025	Live Simulation (*1, 2, 3, 4, 5, 6,7)	Scenario			
		Reflection Journal			
		Survey			
Date: 6/27/2025	vSim (Sandra Littlefield) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz			
Date: 7/3/2025	vSim (George Palo)	Pre-Quiz, Scenario, SBAR,			

	(Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	and Post Quiz			
Date: 7/18/2025	vSim (Randy Adams) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz			

* Course Objectives

Comments:

EVALUATION OF CLINICAL PERFORMANCE TOOL

Psychiatric Nursing
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 & Date: