

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

Student: Nevaeh Walton

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)
6/6/25	1	Missing vSim Posttest	6/12/25 1 hour KA
6/10/25	8	Called off 1 South clinical	6/13/25 8 hours KA
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:	S	NA	S	NA	S	NA				
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. (noticing)										
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. (interpreting)	S	NA	S	NA	NA	NA				
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)	S	NA	S	NA	NA S	NA				
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care (noticing)	S	NA	S	NA	NA S	NA				
e. Recognize social determinants of health and the relationship to mental health. (reflecting)	S	NA	S	NA	S	NA				
f. Develop and implement an appropriate nursing therapy group activity. (responding)	S	NA	S	NA	NA	NA				
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment) (responding)				S						
Faculty Initials	BS	RH	KA	RH	BS					
Clinical Location	1S	NA	1S	NA	Detox	NA				

Comments:

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Week 1- 1a- You did a nice job explaining the pathophysiology of your client's diagnosis. 1c- You also did a great job of describing the milieu and how it can assist clients to regain their independence as they strive for self-care and discussed the social determinants of health and how they can affect a person's mental health. BS

Week 3 – 1b, c, d – You did a nice job discussing nursing group therapy and your patient's involve in group. I am glad they actively participated in all therapy groups including chair yoga and music therapy. KA

Week 3 – 1e – You were able to discuss how some of your patient's SDOHs were affecting their ability to manage their mental health while on clinical. KA

Week 3 – 1f – Nevaeh, you did a nice job developing a nursing therapy group for the inpatient psychiatric unit. The "I am" emotions and reflections worksheet was an excellent idea and well received by the patient on the unit. Terrific job! KA

Week 5- 1c- You did a nice job identifying barriers to culturally and spiritually competent care at the Erie County Health Department Detox unit. You explained the roles of the healthcare professionals at the detox unit and also explained their responsibilities. 1d- You also did a great job discussing various methods that can help clients to achieve self-care. BS

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:	S	NA	S	NA	NA	NA				
a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. (noticing)	S	NA	S	NA	NA	NA				
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. (noticing, recognizing)	S	NA	S	NA	NA	NA				
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. (noticing, interpreting)	S	NA	S	NA	NA S	NA				
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting)*	NA	NA	S	NA	NA	NA				
e. Apply the principles of asepsis and standard precautions. (responding)	S	NA	S	NA	S	NA				
f. Practice use of standardized EBP tools that support safety and quality. (noticing, responding)	S	NA	S	NA	NA	NA				
Faculty Initials	BS	RH	KA	RH	BS					

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

Comments:

Week 1- 2a,b,f- You did a nice job summarizing your client's psychiatric and medical history and the reason for their current admission. You also did a great job identifying factors that create a culture of safety in the psychiatric setting. BS

Week 2 – 2a & 2b – You thoroughly researched your patient and was able to connect your patient's medical and psychiatric history to their recent admission through your care map and discussion while on clinical. KA

Week 3 – 2d – You satisfactorily completed your care map this week on your chosen patient. See the rubric for further details. KA

Week 5- 2c- You did a nice job discussing the importance of patients receiving treatment at the detox center and using their time there to develop new coping mechanisms during their path to achieve sobriety. BS

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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)	S	NA	S	NA	S	NA				
b. Demonstrate professional and appropriate communication with the treatment team by observing the SBAR format for handoff communication during transition of care. (responding)	S	NA	S	NA	NA	NA				
c. Identify barriers to effective communication. (noticing, interpreting)	S	NA	S	NA	S	NA				
d. Develop effective therapeutic responses. (responding)	S	NA	S	NA	S	NA				
e. Develop a satisfactory patient-nurse therapeutic communication. (Nursing Process Study) (responding, reflecting)				S U						
f. Posts respectfully and appropriately in clinical discussion groups. (responding, reflecting)	S	NA	S	NA	S	NA				
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. (responding)	S	NA	S	NA	S	NA				
h. Teach patient/family based on readiness to learn and patient needs. (responding, reflecting)	S	NA	S	NA	NA	NA				
Faculty Initials	BS	RH	KA	RH	BS					

Comments:

Week 1- 3c- You were able to identify several barriers to effective communication and discuss ways to develop a successful nurse-client relationship. BS

Week 3 – 3a, c, d – You were able to discuss different therapeutic communication techniques you utilized while you were on clinical and how it impacted your patient. You were able to utilize silence, offering general leads, and reflecting when communicating with your patient. KA

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Week 2 – 3f – Nevaeh, you responded to all CDG questions for your 1 South clinical thoughtfully. You were able to discuss some excellent points on related to the nursing therapy groups and therapeutic communication. You discussed an appropriate mental health resource that could benefit the patients of 1-South. You included an appropriate resource and an in-text citation in your post. You barely met the required word count. Please be mindful of this in the future. KA

Week 4: 3(e)- Please see rubric below for feedback on NPS. RH

Week 5- 3f- Great job on your CDG this week. Your responses were thorough and well thought-out. It sounds like you learned a lot about the Erie County Health Center Detox unit and the services they provide for those struggling with various addictions. BS

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)	S	NA	S	NA	S	NA				
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. (responding, reflecting)	S	NA	S	NA	NA	NA				
c. Identify the major classification of psychotropic medications. (interpreting)	S	NA	S	NA	NA	NA				
d. Identify common barriers to maintaining medication compliance. (reflecting)	S	NA	S	NA	S	NA				
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. (responding, reflecting)	S	NA	S	NA	NA	NA				
Faculty Initials	BS	RH	KA	RH	BS					

Comments:

Week 1- 4 b,c,d,e- You did a great job providing a list of all medications prescribed for your client and discussed implications for their use, major classifications, common side effects, and significant nursing interventions/assessments associated with each medication. BS

* End-of-Program Student Learning Outcomes

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)	S	NA	S	NA	S	NA				
b. Discuss recommendations for referrals to appropriate community resources and agencies. (reflecting)	NA	NA	NA	NA	S	NA				
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) **	NA	NA	NA	NA	S	NA				
d. Recognize and describe the need for substance abuse recovery resources. (Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation))	NA	NA	NA	NA	NA	NA				
Faculty Initials	BS	RH	KA	RH	BS					

****Alternative Assignment**

Comments:

Week 3 – 5a – You discussed a detox center in Kentucky that can assist the patients experiencing substance use disorder in your CDG this week. KA

Week 5- 5a,c- You did a great job describing the Erie County Health Center Detox unit and discussing the services they provide to their clients as they attempt to beat their addiction. You also discussed how clients are referred to then center. 5b- You discussed that you would recommend this agency to a client struggling with addiction issues so that they can go through the withdrawal process in a safe manner. BS

* 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:	S	NA	S	NA	NA	NA				
a. Demonstrate competence in navigating the electronic health record. (responding)										
b. Demonstrate satisfactory documentation utilizing the electronic health record. (responding)	NA	NA	S	NA	NA	NA				
c. Demonstrate the use of technology to identify mental health resources. (responding)	S	NA	S	NA	NA	NA				
Faculty Initials	BS	RH	KA	RH	BS					

Comments:

Week 1- 6a- You were able to utilize the electronic health record to research your client's history, their medications, and treatments. BS

Week 3 – 6c – You discussed the Robert Alexander Center for Recovery in Kentucky website. They offer multiple options of care for those who are suffering from substance use disorder. KA

* End-of-Program Student Learning Outcomes

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)	S	NA	S	NA	NA	NA				
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care. (responding)	S	NA	S	NA	NA	NA				
c. Illustrate active engagement in self-reflection and debriefing. (reflecting)	S	NA	S	NA	NA	NA				
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE" – attitude, commitment, and enthusiasm during all clinical interactions. (responding)	S	NA	S	NA	S	NA				
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (responding)	S	NA	NA S	NA	S	NA				
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." (responding)	S	NA	S	NA	S	NA				
Faculty Initials	BS	RH	KA	RH	BS					

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.

Week 1 (7,a)- I feel like I used nonjudgmental language when communicating with the patient, and encouraged them to express their feelings. In the coming weeks, you will need to elaborate more when responding to this competency. BS

Week 3 (7a): I feel like I used therapeutic communication skills such as active listening, silence, and by offering general leads. For example, when one of the patients was telling me one of the reasons why she voluntary entered 1-South and I used a couple of general leads but mostly used silence to give her time to process her thoughts and what she felt comfortable sharing with me. Great job! I am glad you felt comfortable talking to the patients and practicing your therapeutic communication techniques. KA

Week 3 (7e): I was unable to make it to one of my scheduled clinical days, showing a lack of professional behavior. You called off appropriately and made sure everyone was aware you were missing clinical. You also contacted the course coordinator to promptly schedule your makeup clinical day. KA

Comments:

Week 1- 7b- You did a nice job noticing factors on the psychiatric floor that helped to create an overall culture of safety on the unit. 7d- Professional behavior was observed at all times while on 1-South. BS

* End-of-Program Student Learning Outcomes

Week 3 – 7b – You were able to discuss the positive impact of group therapy and how it helps promote a safe environment for all patients. KA

Week 5- 7c- You did a great job evaluating your feelings, attitudes, and responses to clients related to the services offered at the Erie County Health Center Detox Unit. BS

Care Map Evaluation Tool**
Psych
2025

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

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/13/25	Risk for injury	S KA	NA

Comments:

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

Student Name: Nevaeh Walton				Course Objective: 2d			
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	You identified abnormal findings, labs/diagnostics, and risk factors for your patient this week. You would want to consider adding your patient’s anxiety and depression scores unless they were 0. KA
	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 did a nice job listing all your patient’s nursing priorities and highlighting your patient’s highest nursing priority. You highlighted all relevant findings that supported the nursing priority. Instead of “risk for injury” it would be better worded as “risk for self-harm”. You also listed appropriate complications and signs and symptoms the nurse would assess for your chosen nursing priority. KA
	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	1	You did a nice job including relevant nursing interventions. All of your interventions were prioritized, timed, realistic, and included rationales. You are missing several interventions appropriate for this nursing priority. You should assess appetite and skin for signs of self-harm, provide resources related to patient concerns, and list appropriate medications to make the care map interventions more individualized. KA
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	1	

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	You reassessed all highlighted assessment findings and noted you would continue the patient's plan of care. KA
	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: You satisfactorily completed your care map. See comments above on areas to improve on in the future. Please me mindful of the interventions section. KA						Total Points: 41/45	
						Faculty/Teaching Assistant Initials: KA	

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		
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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: **Nevaeh Walton**

Clinical Date: **5/29/25**

Criterion #1 Process Recording is organized and neatly completed (5 points total) • Typed process recording (2) • Correct grammar and spelling (3)	Total Points: 2 Comments: There were several missing punctuations and spelling errors (correctly spelled words but not the correct usage ex. “were” instead of “we’re”). KA
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: 4 Comments: You did a nice job identifying the reason for the patient’s admission as well as pertinent background information that affected his current status. You did a great job reflecting on your feelings related to during the interaction, but only wrote one sentence about your feelings before your interaction. You did not describe the milieu. You reflected on what was going on with your patient and their mental health, but did not describe the current state of the milieu. KA
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: 8 Comments: You identified as your patient’s priority problem as ineffective coping and included supporting data and complications associated with the priority. I question if it should be risk for suicide since you identified that your patient has suicidal ideations. KA
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: 10 Comments: You identified 5 pertinent nursing interventions for your priority. All interventions were prioritized and included a timeframe and rationale. Your goal for the communication was reflective of your planning and with consideration of the patient you were working with. KA
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: 12 Comments: All but 2 of your interchanges was in quotes at the beginning and at the end. Your conversation was mainly verbal with only at the opening did you mention nonverbals. Try to be more thoughtful of the nonverbals that are occurring during each interchange. How was eye contact and body positioning during the conversation? You were very reflective on your thoughts throughout. KA

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: 16 Comments: You did a nice job analyzing each interchange. Each one had the technique and whether it was nontherapeutic or therapeutic. Some did not explain why it was chosen, but over half did. KA
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: 10 Comments: The conversation had a natural beginning and ending. . You had 26 verbal interchanges documented and analyzed. KA
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: 15 Comments: You did a nice job reflecting on your conversation and identifying both the strengths and areas to improve on in relation to the conversation. Reflecting on therapeutic conversations is the best way to improve our therapeutic communication in the future. KA
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: 10 Comments: You patient had multiple barriers affecting the ability of the therapeutic communication being effective. Nice job recognizing them and trying to help overcome these barriers. KA
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.	You did not include an in-text citation and reference in your nursing process recording. You are required to add an in-text citation and reference and resubmit this to your Dropbox by Saturday at 2200. KA
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 for clients with mental illness. (1,2,3,4,5,6,7,8).*	Total Points: 87/100 Comments: Nice job Nevaeh! You did a good job reflecting on and analyzing the conversation you had with your patient. The conversation had a beginning and ending. You need to add an in-text citation and reference before your nursing process recording can be satisfactory. You are receiving an unsatisfactory related to missing citation. Please correct and resubmit by Saturday at 2200. KA 87/100

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

Nevaeh, thank you for adding an in-text citation and reference to your nursing process recording. Comments above still apply since that is the only update you made to your submission. You have now satisfactorily completed your nursing process recording. KA

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	U	RH	S/KA
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	KA	NA
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	S	RH	N/A
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	S	RH	N/A
Date: 6/25-26/2025	Live Simulation (*1, 2, 3, 4, 5, 6,7)	Scenario	S	BS	NA
		Reflection Journal	S	BS	NA
		Survey	S	BS	NA
Date: 6/27/2025	vSim (Sandra Littlefield) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, Scenario, SBAR, and Post Quiz	S	BS	NA
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:

6/6/25 – vSim Linda Waterfall – You did not complete the posttest for the simulation by the due date and time. You completed the vSim posttest on 6/12/25. KA

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse

STUDENT NAME(S) AND ROLE(S): Jameson Lee (A), Seth Linder (A), Naveah Walton (M), Stevi Ward (M)

GROUP #: 2

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/25/2025 0920-1020

CLINICAL JUDGMENT COMPONENTS	<u>OBSERVATION NOTES</u>
NOTICING: (1,2,5)* - Focused Observation: E A D B - Recognizing Deviations from Expected Patterns: E A D B - Information Seeking: E A D B	Notices the patient's blood pressure is elevated. Notices the patient appears anxious. Seeks out information related to patient's substance use history. Recognizes the patient does not need Lorazepam based on the CIWA Scale score. Observes visual hallucinations. Seeks out information related to the patient's support system and substance use. Recognizes the patient needs Lorazepam based on the CIWA Scale score.
INTERPRETING: (2,4)* Prioritizing Data: E A D B	Prioritizes performing the CAGE Questionnaire and CIWA Scale. Interprets the CAGE Questionnaire as suggestive of alcohol

• Making Sense of Data: E A D B	abuse. Interprets the CIWA Scale score as 5. Interprets the CIWA Scale score as 19. Interprets CIWA protocol accurately for Lorazepam dose (4 mg PO).
RESPONDING: (1,2,3,5)* • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Introduces self and identifies patient. Establishes orientation. Obtains vital signs. BP-150/88. Asks the patient questions related to reason for admission, history of drinking. Performs the CAGE Questionnaire. Performs the CIWA Scale. Utilizes therapeutic communication with the patient. Inquires about bruises on arm and face. Provides information on available community resources for alcohol/substance abuse. Medication nurse educates the patient on medications to be administered. Medication nurse identifies patient and scans wristband. Discusses recent loss with patient and suggests talking to someone about it. Medication nurse administers ordered daily medications. Introduces self and identifies patient. Establishes orientation. Obtains vital signs. BP- 148/86. Performs CIWA Scale. Medication nurse verifies patient and scans wristband. Administers Lorazepam 4 mg PO (per protocol). Attempts to utilize therapeutic communication with the patient. Provides education related to withdrawal symptoms and substitution therapy. Community resources discussed and

	offered.
REFLECTING: (1,2,5)* - Evaluation/Self-Analysis: E A D B - Commitment to Improvement: E A D B	Group members actively participated during debriefing. Appropriate questions were asked. Each group member discussed what they felt were strengths and weaknesses in their performance. Alternate choices were discussed for improvement in the future. Each member verbalized something they would do differently if they were to do the scenario again. Each member also stated a take-away point from the scenario.
SUMMARY COMMENTS: * = Course Objectives Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric. E= Exemplary A= Accomplished D= Developing B= Beginning Scenario Objectives: Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)* Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)* Determine appropriate medication administration steps utilizing the CIWA scale. (4)* Provide patient with appropriate education on community support and resources. (5)*	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Assumes responsibility; delegates team assignments; assesses patients and reassures them and their families. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. Satisfactory completion of the simulation scenario. Great job! BS

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: