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

Student: Cora Meyer

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

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: a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. **(noticing)**	NA	S	S	S	S	NA	S			
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	NA	S	S	S	S	NA	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)**	NA	NA	S	S	S	NA	S			
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	NA	S	S	S	S	NA	S			
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	NA	S	S	S	S	NA	S			
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	NA	NA	NA	NA	S	NA	NA			
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				S						
Faculty Initials	KA	RH	BS	RH	NS	NS				
Clinical Location	NO clinical	Sandusky Artisans	Hospice	Erie County Health Dept. Detox	1South	No Clincal	1 South			

Comments:

5/9/2025

Week 2: 1 (a, d)- You were able to identify risk factors for substance abuse in your CDG post this week. You were also able to link substance abuse to mental illness in your discussion post as well. You were also able to discuss the need for mental health programs and how these assist patients in the area. I like that you identified that we are treating the “whole person, not just the symptoms of addiction” in your post. Great reflection! RH

Week 4: 1(c, d)- You did a good job discussing barriers to cultural and spiritually competent care at the detox center. You were able to identify each role of the employees and how they assisted with care of the clients. You also identified methods of self-care that take place at the detox center such as promoting group meetings (like AA) and counseling. RH

Week 5 1(a,b) - Good job this week discussing your client’s history of mental illness. You were able to identify his history of bipolar disorder, major depressive disorder, and substance abuse. Recent life stressors and his history of mental illness led to an abrupt suicide attempt that he later regretted. (1b) – You did well discussing the medications prescribed related to his mental health condition. Good work correlating medications aimed at treating his symptoms of depression, as well as identifying medications prescribed related to potential side effects. NS

Week 5 1(e) – You provided great details related to SDOH that can impact your client’s mental health. His economic instability from recent job loss and home environment instability with his girlfriend were contributing factors to his feelings of hopelessness and suicide attempt. This certainly negatively impacts his mental health and can impact his ability to manage his mental health conditions moving forward. NS

Week 5 1(f) – Great work with your nursing therapy group activity this week! You were able to encourage active participation by the client’s in the milieu and helped them explore their feelings through the use of a beach ball game. This also helped them to be active on the unit. It seemed that they enjoyed your activity, well done! NS

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

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

Comments:

Week 2: 2 (c)- The group you described in your CDG sound as if it was quite diverse. I like that there were some older people who were trying to help the younger people in the group. I also love that there is an app for locating meetings. This is a great way to assist patients in their recovery and give them a resource or place to learn about coping mechanisms to assist them in their journey. RH

Week 5 2(a,b) – You provided descriptive details related to your client's past medical/mental health history, including specific assessment findings related to his major depressive disorder with suicide attempt. NS

Week 5 2(f) – Good job with your EBP presentation during debriefing on the topic of screen time and the impact on adolescent mental health. This was a relevant topic in today's society and initiated a good conversation during our debriefing time. Well done! NS

5/9/2025

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

Comments:

Week 2: 3 (a, c, d)- Week 2: 3 (a, c, d)- Use of professionalism and therapeutic communication is key when caring for patients. Identifying barriers to effective communication allows you to be able to know when to have therapeutic communication or when to exit a conversation. RH

Week 3 – 3f – You did a nice job reflectively responding to all the CDG questions related to your experience at hospice. Thank you for sharing your personal thoughts prior to attending, and then reflecting on those following your experience. You were thorough and thoughtful with your responses. Keep up the great work! BS

Week 5 3(a,c) – I appreciate your efforts in providing therapeutic communication to various clients on the unit this week. You actively participated in groups therapy, initiated 1:1 conversation, and offered yourself frequently. On day 2, you were able to spend time communicating with client's in the special care unit, which highlighted some unique communication techniques. (C) – Good work identifying potential barriers to communication, including the potential monopolizing of conversations during group therapy. This was witnessed and discussed on day 2. NS

Week 5 3(e) – Good work with your CDG requirements this week. You provided in-depth responses to the question prompts and supported your discussion with the use of reputable resources. All criteria were met for a satisfactory evaluation. See my comments for further details. NS

5/9/2025

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

Comments:

Week 5 4(a) – You were able to spend time with the assigned RN witnessing medication administration in the mental health unit. (b,c,e) good work discussing the prescribed medications for your assigned client. You did well to identify the specific use, classification, side effects, and nursing interventions for mental health related medications in your CDG response. You elaborated on potential barriers to medication compliance, such as unpleasant side effects and lack of financial security to afford the medications prescribed. Well done! NS

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

****Alternative Assignment**

Comments:

Week 2: 5 (b, d)- you were able to identify appropriate community resources for clients in your CDG this week as well as discuss the need/importance of having a substance abuse recovery resource in the area for clients. RH

Week 4: 5(a, b, c)- You did a great job discussing your experience at the detox center in your CDG this week. You were able to talk about the services they provide to clients and how clients are referred to this service. 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: a. Demonstrate competence in navigating the electronic health record. **(responding)**	NA	NA	NA	NA	S	NA	S			
b. Demonstrate satisfactory documentation ~~of psychiatric assessments and nursing notes~~ utilizing the electronic health record. **(responding)**	NA	NA	NA	NA	S	NA	NA			
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	NA	NA	S	S	S	NA	S			
Faculty Initials	KA	RH	BS	RH	NS	NS				

Comments:

Week 5 6(a) – Good work utilizing the EHR to gather data related to your client's admission. You were able to utilize the information obtained to gain a better understanding of your client and enhanced your clinical judgment as demonstrated by your CDG responses. You were also able to gain experience documenting in the EHR related to the nursing therapy group activity that you presented. NS

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

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: 7 (c)- You had a great reflection on your experience in your CDG this week. You were able to discuss how the clinical experience was able to allow you to see how much effort and time goes into assisting the clients. You also were able to be aware that you may be closed-minded and how this opened a new perspective for you. Great job! RH

Week 3 7a: My strengths for care delivery with hospice patients included being gentle and patient with the clients, as well as their families, listening to families stories and expressing and understanding of the hardships they're facing while losing their loved one. Yes, this is a huge part of hospice nursing and it sounds like you did a great job! BS

Week 3 – 7c –Cora, you did a wonderful job reflecting on your clinical experience at Hospice. BS

* End-of-Program Student Learning Outcomes

Week 4 7a: My strength for care delivery this week was listening to those in the detox unit tell their stories. Being there and listening to what they have on their minds without judgement, recommendations, or tips. In the stage of recovery, the patients were in they did not need someone such as myself telling them what to do. They will not be receptive to it. Great observation and use of silence/active listening with the clients. RH
Week 4: 7(c)- you were able to reflect on your feelings after your clinical experience and how you felt they were able to assist with the clients addiction as well as their mental health. RH

Week 5 7a- My strength for care delivery this week was trying to empathize with the patients on 1S. Listening to more manic patients and trying to steer the conversations toward self-care such as not needing sleep or eating more than a few bites of meals. As well as steering clear from using certain terms. Such as a patient utilizing the words like crazy or weird to describe other patients in the unit. Educating that everyone is there for a reason and that it's ok, everyone needs help. Very good, Cora! It is unfortunate to hear that a client was describing others in this way. Good job providing education as to how this can negatively impact their healing. I appreciate your desire and willingness to interact with client's in the special care unit. As you learned, this was a much different approach in communication and can be mentally taxing to the nurse. However, I think this was a good learning experience. Great job last week, keep up the hard work! NS

Week 7 7a- My strength for care delivery this week was understanding more about therapeutic communication. Every patient on 1S is going through their own individual experiences and each require slightly different forms of communication. Offering self is used often for patients who are not interested in communicating or are handling active hallucinations. Others require restating, making observations, accepting, voicing doubt, etc. to show understanding of, accepting of, and even expressing uncertainty for some. I felt that with this better understanding I was trying to make each conversation more individualized. So, for manic patients voicing doubt is acceptable. Offering self is appropriate for a specific patient on the unit who was having active auditory hallucinations because she did not want to talk. However, another student and I were available when she was ready to talk.

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

Comments:

* End-of-Program Student Learning Outcomes

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

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:

Student Name: _Cora Meyer___ Date:_6/19/2025_____

Clinical Assessment Rubric

Mental/Physical Health Status Assessment

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

Education Assessment

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

Education Plan

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

An in-text citation and reference are required.	---	---

Total Points 100/100 Satisfactory BS
Nice work, Cora!

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. *

Student Name: Cora Meyer	Course Objective: Synthesize concepts related to psycho-pathology, health assessment data, evidence based practice, and the nursing process using clinical judgment skills to plan and care for patients with mental illness.
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)**	3	Nice job identifying abnormal assessment findings and risk factors supporting your priority problem of risk for falls.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	1	Only one priority identified. Goal is stated and appropriate assessment findings highlighted. Potential complications identified. Signs and symptoms not identified but that's appropriate considering the complications.
	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	Interventions are prioritized, individualized, and realistic. Rationales provided.
	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**	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 highlighted assessment findings re-evaluated. Statement not made to continue, modify, or terminate 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**	0	

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: Cora, Nice work on your care map focusing on fall prevention for your patient. BS

Total Points: 40/45 Satisfactory. BS

Faculty/Teaching Assistant Initials: BS

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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	**Total Points:** **Comments:**

interaction is provided (6)	
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 psycho-pathology, health assessment data, evidence-based practice, and	**Total Points:** **Comments:**

the nursing process using clinical judgment skills to plan and care 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	

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	BS	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: 6/26/2025	Live Simulation (*1, 2, 3, 4, 5, 6,7)	Scenario	S	NS	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	NS	NA
Date:	vSim (George	Pre-Quiz,	S	NS	NA

7/3/2025	Palo) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Scenario, SBAR, 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:

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Cora Meyer (M), Brittany Rodisel (A)

GROUP #: 8 Part 2

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/26/2025 1230-1330

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
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	Introduced self and role when entering the room to initiate trusting relationship Explored patients' thoughts and feelings related to admission to mental health unit. Noticed BP 148/86 related to withdrawal symptoms. Noticed tremors, noticed anxiety, noticed tactile disturbances (itching), noticed visual hallucinations (spiders), noticed agitation, noticed restlessness Noticed bruises and abrasions Noticed recent loss of a friend, grieving Sought further information related to symptoms being experienced.
INTERPRETING: (2,4)* • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritized vital sign assessment when entering the room Prioritized CIWA assessment Interpreted CIWA score as 26-28 Interpreted symptoms of alcohol withdrawal Made sense of lorazepam as substitution therapy and symptom management

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	Attempted to explore client's thoughts, asked if she wanted to talk. Offered self. Maintained composure related to client's agitation and associated symptoms. Confronted visual hallucinations with reality CIWA assessment performed. Good teamwork and collaboration. Correct dosage calculation for lorazepam based on CIWA scale protocol. Administered 4mg PO as ordered. Lorazepam administered for substitution therapy Educated on lorazepam to be administered for symptoms experienced Provided resources for AA and outpatient mental health.
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.
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)***	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 subtlest 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: Generally, displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. 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: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates a desire to improve nursing performance; reflects on and evaluates experiences; identifies strengths and weaknesses; could be more systematic in evaluating weaknesses. Satisfactory completion of the simulation scenario. Great job!

• **Provide patient with appropriate education on community support and resources. (5)***	

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: