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

Student: **Isabella Riedy**

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)**	S	NA	S	S	NA	NA	S			
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	S	NA	S	~~NA~~ S	NA	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)**	S	NA	S	S	S	NA	S			
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	S	NA	S	S	NA	NA	S			
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	S	NA	S	S	NA	NA	S			
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	NA	NA	S	NA	NA	NA	NA			
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				NA						
Faculty Initials	BS	RH	KA	RH	BS	RH				

Clinical Location	1 South	NA	1 South	Sandusky Artisans Recovery Center	Hospice	NA	Detox Center			

Comments:

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 great job discussing the nursing therapy group and how your patient participated in the activity. Even though she was quiet, I am glad she interacted with you when you initiated conversations. 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 – Izzy, you did a nice job developing a nursing therapy group for the inpatient psychiatric unit. The emotions activity with clouds and balloons was an excellent idea and well received by the patient on the unit. You did a nice job creating this from a template. Terrific job! KA

Week 4: 1(a, b, c)- In your CDG this week you discuss various risk factors that put someone at risk for developing substance abuse including personal triggers, trauma, stress, or history of mental illness. You further elaborated on how this relates to a client's coping mechanisms. You also talked about some resources/treatment options for those with substance abuse including support groups or group therapy and how this benefits their recovery. 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: 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	NA			
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. **(noticing, recognizing)**	S	NA	S	NA	NA	NA	NA			
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. **(noticing, interpreting)**	S	NA	S	S	NA	NA	NA			
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. **(noticing, interpreting, responding, reflecting)***	NA	NA	S	NA	NA	NA	NA			
e. Apply the principles of asepsis and standard precautions. **(responding)**	S	NA	S	NA	S	NA	S			
f. Practice use of standardized EBP tools that support safety and quality. **(noticing, responding)**	S	NA	S	NA	NA	NA	NA			
Faculty Initials	BS	RH	KA	RH	BS	RH				

*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 4: 2(c)- you were able to discuss some coping mechanisms clients can use in your CDG this week. RH

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)**	S	NA	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)**	S	NA	S	NA	S	NA	S			
c. Identify barriers to effective communication. **(noticing, interpreting)**	S	NA	S	S	S	NA	S			
d. Develop effective therapeutic responses. **(responding)**	S	NA	S	S	S	NA	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)**	S	NA	S	S	S	NA	S			
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. **(responding)**	S	NA	S	S	S	NA	S			
h. Teach patient/family based on readiness to learn and patient needs. **(responding, reflecting)**	S	NA	S	NA	NA	NA	NA			
Faculty Initials	BS	RH	KA	RH	BS	RH				

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 – I am glad you had the opportunity to have conversations with patients this week on 1-South and practice you therapeutic communication techniques. You discussed how you utilized restating, giving recognition, and offering self when communicating with patients this week. KA

5/9/2025

Week 2 – 3f – Izzy, you responded to all CDG questions for your 1 South clinical thoroughly and 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. Keep up the terrific work! KA

Week 4: 3(e, f) You did a great job with your CDG this week, all the questions were answered thoroughly! Your Nursing Process Rubric is included below. RH

Week 5 – 3f – You did a nice job reflectively responding to all of 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

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	NA	NA	S	NA	S			
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. **(responding, reflecting)**	~~NI~~ S	NA	S	NA	NA	NA	NA			
c. Identify the major classification of psychotropic medications. **(interpreting)**	~~NI~~ S	NA	S	NA	NA	NA	NA			
d. Identify common barriers to maintaining medication compliance. **(reflecting)**	S	NA	S	NA	NA	NA	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	NA			
Faculty Initials	BS	RH	KA	RH	BS	RH				

Comments:

Week 1- 4 b,c,d,e- I changed these NIs to S based on your CDG for Day 2. 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)**	NA	NA	NA	NA	NA	NA	S			
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	NA	NA	NA	S	NA	NA	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	NA	NA	S			
d. Recognize and describe the need for substance abuse recovery resources. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**	NA	NA	NA	S	NA	NA	NA			
Faculty Initials	BS	RH	KA	RH	BS	RH				

****Alternative Assignment Comments:**

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

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 did a nice job discussing the Sandusky Artisans Recovery Community Center (SARCC) and all the programs they have to offer. There are so many other programs outside of their NA/AA groups that can help patients with mental health concerns outside of addiction. Nice job! 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	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	S	NA	S			
c. Illustrate active engagement in self-reflection and debriefing. (**reflecting)**	S	NA	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)**	S	NA	S	S	S	NA	S			
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. **(responding)**	S	NA	S	S	S	NA	S			
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." **(responding)**	S	NA	S	S	S	NA	S			
Faculty Initials	BS	RH	KA	RH	BS	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 1 (7a): My strength when providing care to my patient with a mental health illness was being able to meet their communication needs. My patient on clinical day one was hyperverbal and they wanted someone or something to talk to 24/7. I was able to recognize that when my patient did not have someone to talk to or that was interacting with them, they became extremely agitated and would start causing problems with the other patients. Once I recognized this, I made sure to spend as much time with them as possible and met their communication needs by listening, providing support, and establishing a therapeutic relationship. My goal is to continue being able to meet my patients communication needs and establish a therapeutic relationship. I plan to do this by paying attention to my patients body language and reactions, approaching them calmy and slowly, recognizing patterns, and asking them if there's anything I can do to meet their needs. Great discussion, Isabella. Each patient is unique and has their own specific needs regarding care. Recognizing this allows us to adapt our approach to best meet those needs. BS

* End-of-Program Student Learning Outcomes

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

Week 3 (7a): My strength during this clinical when providing care to the patients was stepping out of my comfort zone. During this clinical I found it difficult to approach the patients and interact with them. Most of the patients at first did not seem interested in having any conversations or interactions. Noticing this at the beginning made me hesitant when having to approach them to interact. While the patient's body language and facial expressions did not seem inviting, I did not want to assume and needed to introduce myself, so I approached them anyway. Once I sat down with everyone they interacted, played games, had conversations, and interacted with group activities. They were all very grateful to have the students there and have their needs met. My goal is to continue stepping out of my comfort zone when in difficult situations. I plan to do this by assessing my feelings before approaching the situation, setting goals, and starting small. An example of a goal for this situation would be to have 3 different conversations before the first group. An example of starting small for this situation would be just approaching the group and actively listening. I am glad you recognized this was something uncomfortable and still made the effort to talk to the patients. You definitely have a growth mindset which will serve you well as you continue on in your career in nursing. KA

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 4: 7(c)- Great job reflecting on your feelings related to this clinical experience. You did a good job describing your feelings throughout the experience and how you became more comfortable. RH

Week 5 – 7c –Izzy, you did a wonderful job reflecting on your clinical experience at Hospice and sharing your thoughts prior to and following the clinical. BS

* End-of-Program Student Learning Outcomes

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
6/12/25	Ineffective Coping	S KA	NA

Comments:

* End-of-Program Student Learning Outcomes

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

Student Name: Isabella Reidy				**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 all abnormal findings, labs/diagnostics, and risk factors for your patient this week. 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 most of the relevant findings that supported the nursing priority. Smoking could also be highlighted in the risk factors related in ineffective coping. You also listed appropriate complications and signs and symptoms the nurse would assess for your chosen nursing priority. For the risk of substance use complication, I think lack of support is a risk factor for it versus a sign and symptom a nurse would assess. Maybe erratic behavior, pupillary changes, or track marks may be better options for S&S. 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)**	2	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	You did a nice job including all relevant nursing interventions. All of your interventions were prioritized, timed, individualized, realistic, and included rationales. 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**	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**	2	You reassessed all highlighted assessment findings except your highlighted labs. Remember these need to be reassessed as well. If you have no new values or there is no change in them just state that in this section. You 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 for areas to address in the future when creating care maps. KA

Total Points: 43/45

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.	---	---

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. *

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:

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

Student Name: Isabella Reidy **Clinical Date:** 6/10/2025

Criterion #1 **Process Recording is organized and neatly completed** **(5 points total)** • Typed process recording (2) • Correct grammar and spelling (3)	**Total Points:** 5 **Comments:** Appropriately typed with correct grammar and spelling.
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:** 7 **Comments:** Identified client appropriately including the background medical and psychiatric histories. Thank you for sharing your pre- and post- self-assessments. Identified the milieu thoroughly.
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:** Correctly identified priority problems highlighting the top priority. Appropriately listed all data and complications related to the clients listed priority problems.
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:** Interventions are listed appropriately with realistic frequency and rationales. Correctly lists a therapeutic communication appropriate to their client.
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:** 15 **Comments:** Thoroughly lists all communication interactions. Provides verbal and non-verbal cues, also recognized correct therapeutic and non-therapeutic techniques. Provides own thoughts with each interaction.
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:** 20 **Comments:** Correctly analyzes each interaction. Recognizes each interaction as therapeutic or non-therapeutic appropriately. Correctly identifies each technique. Explains all interactions.

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: Communication was relevant and appropriate, flowed with a beginning and ending. Correctly lists enough interchanges between client and student.**
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: Provides a thorough self-evaluation. Thoroughly lists strengths and weaknesses.**
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: Appropriately lists three barriers of communication with rationalization of each. Thoroughly identifies SDOH. Rationalizes an appropriate evaluation for needs of improvement with communication and interventions experienced with the client.**
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.	**In- text citation and reference provided.**
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 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)**	**Total Points: 100/100 Satisfactory** **Comments: Izzy, overall you did an excellent job on your nursing process recording. All documentation was appropriately recorded. Evaluations were thorough. Recognized areas for improvement post interaction and clinical experience. Keep up the great work! SA**

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)	Pre-Quiz, Scenario, SBAR,	S	RH	N/A

	(Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	and Post Quiz			
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	RH	N/A
Date: 7/3/2025	vSim (George Palo) (Nursing-Mental Health) (*1, 2, 3, 4, 5, 6,7)	Pre-Quiz, 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): Jessica Bower M/A, Abigail McNulty (M), Isabella Riedy (A)

GROUP #: 1

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/25/2025 0800-0900

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	Notices the client's blood pressure is elevated. Notices the client appears tired. Seeks out information related to client's substance use history. Recognizes the client does not need Lorazepam based on the CIWA Scale score. Notices the client is complaining of visual hallucinations. Notices the client is complaining of itching. Seeks out information related to the client's support system and substance use. Recognizes the client needs Lorazepam based on the CIWA Scale score.
INTERPRETING: (2,4)*	
• Prioritizing Data: E **A** D B • Making Sense of Data: E **A** D B	Prioritizes performing the CAGE Questionnaire and CIWA Scale. Interprets the CAGE Questionnaire as suggesting potential alcohol abuse. Interprets the CIWA Scale score as 2. Interprets the CIWA Scale score as 21. 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 client. Asks about sleep. Obtains vital signs BP-150/82. Asks the client questions related to orientation and reason for admission. Performs brief mental status evaluation. Questions client about alcohol use. Questions client about mood, nutrition. Performs the CAGE Questionnaire. Performs the CIWA Scale. Inquires about bruising and asks about the client's recent fall Utilizes therapeutic communication with the client. Medication nurse educates the client on medications to be administered. Medication nurse identifies and scans client leaves room to look-up medication client, educates client. Medication nurse administers ordered daily medications. Further questions about the fall and alcohol use. Discusses some community resources related to alcohol use. Introduces self and identifies client. Obtains vital signs. BP 148/88. Asks about nausea/vomiting. Performs CIWA Scale. Medication nurse verifies client and scans. Administers Lorazepam 4 mg PO (per protocol). Attempts to utilize therapeutic communication with the client. No education provided related to community resources or support groups.
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 client admitted for an acute mental health crisis. (1, 2, 3)*** • **Utilize the CIWA scale to assess a client with a history of substance abuse. (1, 2)*** • **Determine appropriate medication administration steps utilizing the CIWA scale. (4)*** • **Provide client 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 client's situation from the client 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 client'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 clients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant client 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 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: