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

Student: Mallory Jamison

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)
5/31/2025	1	Late Detox Center Survey	6/2/2025 (1H)

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	S	NA	S			
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	S	NA	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)**	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	S	NA	S			
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	~~NA~~ S	NA	S	NA	S	NA	S			
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	NA	NA	NA	NA	NA	NA	S			
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				S						
Faculty Initials	NS	RH	SA	RH	NS	NS				
Clinical Location	Detox Unit	N/A	Sandusky Artisans	Stein Hospice of the Western Reserve	1S	NA	1S			

Comments:

* End-of-Program Student Learning Outcomes

Week 1 1(d) – Nice job discussing methods identified in promoting independence and self-care in the detox facility. Good insight and examples provided. NS
Week 1 1(e) – Social determinants of health were discussed in the assigned CDG for the detox unit; therefore, this competency was changed to “S”. NS

Week 3(1a-e): Great job discussing risk factors for individuals fighting addiction and how therapies/meetings help with sobriety. SA

Week 4: 1(g)- See rubric for the Geriatric Assessment below. RH

Week 5 1(a) – Good job this week discussing your client’s history of physical and mental illness. You were able to identify his long-standing history of schizoaffective disorder with severe depression, including the use of ECT therapy in the past. You were able to discuss how the milieu/environment in the special care unit impacted his current admission and healing process. (1b) – You did well discussing the medications prescribed related to his mental health condition. Good work correlating medications aimed at treating his symptoms of schizoaffective disorder, as well as identifying medications prescribed related to potential side effects of and antipsychotics. NS

Week 5 1(e) – You provided great details related to SDOH that can impact your client’s mental health. His lack of social support and loss of loved ones has left him feeling isolated, making it difficult to manage his mental health disease process. NS

* End-of-Program Student Learning Outcomes

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)

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	NA	NA	S	NA	NA			
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. **(noticing, recognizing)**	NA	NA	NA	NA	S	NA	NA			
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. **(noticing, interpreting)**	S	NA	S	S	S	NA	S			
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. **(noticing, interpreting, responding, reflecting)***	NA	NA	NA	NA	NA	NA	S			
e. Apply the principles of asepsis and standard precautions. **(responding)**	~~NA~~ S	NA	S	S	S	NA	S			
f. Practice use of standardized EBP tools that support safety and quality. **(noticing, responding)**	~~NA~~ S	NA	S	S	S	NA	S			
Faculty Initials	NS	RH	SA	RH	NS	NS				

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

Comments:

Week 1 2(e) – You discussed having the opportunity to perform wound care/dressing change during your experience. In doing so, you used the principles of asepsis and standard precautions to help maintain wound integrity, promote healing, and reduce the risk of infection. NS

Week 1 2(f) – You discussed the use of the CIWA and COWS scales for assessment of substance withdrawal in your CDG response. These are evidence-based tools aimed at supporting the safety and well-being of patient's experiencing withdrawal or detox from a substance. NS

Week 3 (2c): You did a good job discussing how individuals with substance abuse problems cope and handle situations they may encounter. SA

* End-of-Program Student Learning Outcomes

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 schizoaffective disorder. You were able to note his visual and auditory hallucinations that led to suicidal ideations. NS

* End-of-Program Student Learning Outcomes

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

Comments:

Week 1 – Be sure to pay close attention when evaluating each competency for the given week. For example, you gave yourself an "NA" for posting your CDG appropriately. You completed the CDG assignment for the clinical assignment and posted appropriately. NS

* End-of-Program Student Learning Outcomes

Week 1 3(a,c,d) – You discussed the opportunity to interact and communicate with client's during your clinical experience, which differed from your expectations going in. Its great to hear that some of the client's were willing to allow you to participate in their care. In your discussion, you identified potential barriers to communication and benefitted from the opportunity to engage. NS

Week 1 3(f) – Good work with your CDG responses for the Detox unit question prompts. You provided great detail and supporting evidence. All criteria were met for a satisfactory evaluation. See my comments on your post for further details. NS

Week 3(3f): Great job on your cdg this week! Each question was answered thoroughly, meeting all requirements. SA

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 your client's hallucinations and distractions on the unit that impacted concentration. Good thoughts on identifying different methods that could assist in effective communication, such as removing the client from a stimulating environment. NS

Week 5 3(e) – Excellent 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

* End-of-Program Student Learning Outcomes

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

Comments:

Week 4: 4(a)- Did the nurse you were with not administer any medication this week? This competency also says “observe” so if you were able to observe them administering medication, this should be changed to “S” but if not, it can remain “N/A” RH

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)**	S	NA	~~NA~~ S	NA	NA	NA	S			
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	S	NA	S	S	NA	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) ****	S	NA	NA	NA	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	NA	S	NA	NA	NA	NA			
Faculty Initials	NS	RH	SA	RH	NS	NS				

****Alternative Assignment Comments:**

Week 3(5a,b,d): Great job attending the Sandusky Artisan's and participating in a meeting with individuals facing substance abuse challenges. SA

* 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	NA	NA	S			
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	NA	NA	NA	NA	S	NA	S			
Faculty Initials	NS	RH	SA	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. 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	NA	NA	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)**	S	NA	~~NA~~ S	S	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)**	~~NA~~ S	NA	S	S	S	NA	S			
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. **(responding)**	~~NA~~ U	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	NA	S	S	S	NA	S			
Faculty Initials	NS	RH	SA	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 1 7(d,f) – These competencies were all changed to "S" because they relate to the evaluations provided as satisfactory by the Detox center nurse. Each of these competencies relate to your participation and professionalism in all clinical experiences and interactions with client's and healthcare team members. NS

Week 1 7(e) – This competency was changed to a "U" due to late submission of the detox center survey as outlined in the syllabus. This was your first week in a new semester with outside clinical agencies and new requirements. You will get the hang of everything that is due each week. Be sure to utilize the syllabus to ensure all aspects are completed moving forward. If you have any questions just let me know. Be sure to address the "U" next week as outlined in the directions on the first page of the clinical tool. NS

* End-of-Program Student Learning Outcomes

Week 2 7(e): I received a U last week because I turned in my detox clinical survey in late. I was not paying good enough attention when we were going over the syllabus and clinical requirements in class, therefore leading to me having to pay the consequences of turning it in late. I now know to make sure I am listening and paying better attention in class so that I don't miss any important information or turn assignments in late.

Week 3(7c): Great job this week reflecting on your clinical experience and your thoughts/feelings related to substance abuse. SA

Week 4 7(c)- Great job with your reflection journal on your hospice experience. I would also be interested to hear how the patient who did not want to be embalmed was transferred quickly to meet that time frame. It sounds like you were able to learn a lot from this experience. RH

Week 5 7(a): A strength I felt like I had in delivering care to the patient with a mental illness this week was that I was outgoing and willing to sit at the tables with patients sitting with them at group and while they were coloring, and I talked to multiple different patients and got them to break the ice with me. One in particular opened up with me about how he recognizes he needs help with his mental health and that even though he doesn't want to be in 1S, he knows he needs to. I felt like it was a very therapeutic conversation. Awesome strength to note! That is one of the most important objectives of this course, initiating and developing therapeutic communication skills. While this unit can be intimidating at first, its great to hear that you were able to identify socialization and communication as a strength. I noticed on numerous occasions you sitting at various locations throughout the unit, offering yourself, and providing support. Well done! NS

Week 7 7(a): A strength I felt like I had in delivering care to the patient with a mental illness this week was in doing better thinking of ways to formulate my words in a therapeutic manner and being able to remember therapeutic communication techniques that we learned about from the book. This is because I could definitely notice a difference between this time and my first week at 1S, where my first week I found myself not knowing what to say to the patients sometimes, but this week I felt much more comfortable responding in discussions about difficult topics.

Care Map Evaluation Tool**
Psych
2025

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials

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

Comments:

* End-of-Program Student Learning Outcomes

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

Student Name:				**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:

Geriatric Assessment Rubric
2025

Student Name: _Mallory Jamison____ Date: __6/19/25_____

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	0
Instrumental ADL/ Index of Independence in ADL	4	4
Medication Assessment	4	4
You did a nice job assessing your client. You identified the patient is having a high fall risk with the remainder of the other assessments within normal limits. You did not turn in a completed nutrition assessment for your client. You also identified one of their medications being on the BEERS list. On the physical assessment portion, you could have put NA in a few of the areas noting they were not applicable instead of leaving them blank, but other than that you were thorough with filling it out. KA		
Points	40	36

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
You identified promoting nutrition, increasing		

exercise to improve strength and fall risk, and promoting socialization as your education priorities for your client. This matches the client assessment findings. You identified appropriate goals and outcomes for each learning need. KA		

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 Your education plan was well thought out and individualized to your client. KA	45	45

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

Total Points ___96/100_____

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. *

Mallory, you satisfactorily completed your Geriatric Assessment. Great job! KA

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

Student Name: Mallory Jamison **Date or Clinical Week:** 4			**Course Objective :**			
Criteria	**3**	**2**	**1**	**0**	**Points**	**Comments**

						Earned	
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 and risk factors for your client you completed the geriatric assessment on. You noted they did not know of any recent lab/diagnostic results to include. 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 client's nursing priorities and highlighting your client's highest nursing priority. You highlighted the relevant findings that supported the nursing priority. You 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**	2	You did a nice job including relevant nursing interventions. All of your interventions were prioritized, timed, individualized, realistic, and included rationales. You did not have any assessment interventions included for your patient. What about assessing the home for tripping hazards or other fall risks? What about assessing ROM of strength for the patient? You included great education interventions that addressed these areas but did not assess them. 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**	3	You reassessed all highlighted assessment findings and noted you would continue the client'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. You did a great job connecting all the dots with this client that you worked with. Terrific job! KA**

Total Points: **44/45**

Faculty/Teaching Assistant Initials: KA

Psychiatric Nursing
2025

Student Name: **Clinical Date:**

Criterion #1 **Process Recording is organized and neatly completed** **(5 points total)** • Typed process recording (2) • Correct grammar and spelling (3)	**Total Points:** **Comments:**
Criterion #2 **Assessment (7 points total)** • Identifies pertinent client background, current medical and psychiatric history (3) • Provides self-assessment of thoughts and feelings prior and during therapeutic communication interaction with client (2) • Identifies the milieu and effects on client (2)	**Total Points:** **Comments:**
Criterion #3 **Mental Health Nursing Diagnosis** **(8 points total)** • Identifies priority mental health problem (4) • Provides at least five relevant/related data findings (2) • Provides at least five potential complications with signs and symptoms (2)	**Total Points:** **Comments:**
Criterion #4 **Nursing Interventions** **(10 points total)** • Identifies at least 5 pertinent nursing interventions in priority order, including a rationale and timeframe (7) • Identifies a therapeutic communication goal (3)	**Total Points:** **Comments:**
Criterion #5 **Process Recording** **(15 points total)** • Provides direct quotes for all interchanges (3) • Verbal and nonverbal behavior is described for all interactions (6) • Students thoughts and feelings concerning each interaction is provided (6)	**Total Points:** **Comments:**
Criterion #6 **Process Recording** **(20 points total)** • Analysis of each interaction providing type of	**Total Points:** **Comments:**

communication (therapeutic/nontherapeutic) (6) • Provides technique for each interaction (exploring, probing, etc.) (6) • Provides explanation for interactions (8)	
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 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,	**Total Points:** **Comments:**

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	

Simulation Evaluations

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

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): Mallory Jamison (M) Cathryn Palagyi (A)

GROUP #: 5 Part 1

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/26/2025 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	Introduced self and role when entering the room to develop trust. Focused observation on vital signs and orientation to environment. Focused observation on patient's mental status. Noticed bruising and abrasions. Asked client about pain related to abrasions. Noticed recent loss and stressors. Noticed BP 150/88 related to anxiety. Noticed depression. Noticed anxiety level of 4. Sought further information from the client related to anxiety. Sought further information related to CAGE questionnaire responses. Sought information related to client's interest in attending group therapy. Sought information from the client prior to medication administration.
INTERPRETING: (2,4)* • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritized vital sign assessment. Made sense of elevated BP. Prioritized CAGE questionnaire based on patient denial of substance use. Made sense of positive CAGE questionnaire. Prioritized CIWA assessment. Made sense of CIWA score of 5 (moderate anxiety). Interpreted CIWA protocol appropriately, did not administer substitution therapy according to protocol. Prioritized education related to group therapy and mental health services. Made sense of thiamine and folic acid prescription related to alcohol use disorder.
RESPONDING: (1,2,3,5)*	CAGE questionnaire performed in full.

• 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	CIWA assessment performed. Provided education on the benefits of group therapy. Discussed use of outpatient services. Therapeutic communication provided with education related to mental health services. Educated client on medications to be administered. Encouraged client to attend group. Provided resources related to stress and coping. Offered self and utilized therapeutic communication techniques throughout.
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)*** • **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. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Focuses on the most relevant and important data useful for explaining the patient's condition. 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. Communicates effectively; explains interventions; calms and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. 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!

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: