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

Student: Abigail Foote **Final Grade: Satisfactory**

Semester: Summer Session **Date of Completion: 7/15/2025**

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: Stacia Atkins BSN, RN

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)**	N/A	S	~~N/A~~ S	S	N/A	S	N/A	N/A	N/A	S
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	N/A	N/A	~~N/A~~ S	S	N/A	S	N/A	N/A	N/A	S
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**	N/A	S	S	S	N/A	S	N/A	N/A	N/A	S
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	N/A	S	S	S	N/A	S	N/A	N/A	N/A	S
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	N/A	N/A	N/A	S	N/A	S	N/A	N/A	N/A	S
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	N/A	N/A	N/A	S	N/A	N/A	N/A	N/A	N/A	S
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				S				N/A		S
Faculty Initials	NS	RH	SA	KA	KA	BS	BS	SA	SA	SA
Clinical Location	N/A	Hospice & Sandusky Artisans center	Detox Center	1-South	Sim Lab	1-South	N/A	No Clinical	No Clinical	

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 focused on family history as well as other habits such as smoking and drinking. You also discussed mental illness and how this can alter a person's thinking. You were also able to discuss the need for a good support system and program for those who are experiencing substance abuse in your CDG this week. Great job! RH

Week 3 (1a-d) This week you were able to observe competent care and identify appropriate methods that will assist the patient to regain independence in your CDG post for the detox center. Great job! SA

Week 4 – 1 a – You did a nice job discussing your patient's admitting diagnosis of depression and the pathophysiology of the disease process. KA
Week 4 – 1c – You did a nice job describing the current state of the milieu and how it impacted your patient's behaviors and participation on the unit. KA
Week 4 – 1e – You did a nice job discussing social determinates of health in relation to your patient. You identified chronic illness and past trauma as being SDOH factors that are negatively impacting your patient's ability to manage their mental health. KA
Week 4 – 1f – Abbi, you did a nice job developing a nursing therapy group for the inpatient psychiatric unit. The sharing of your fears and feelings activity was an excellent idea and well received by the patient on the unit. I know you slightly altered it based on what was currently occurring in the milieu, but you did a nice job adjusting on the fly. Terrific job! KA
Week 4 – 1g – You satisfactorily completed your geriatric assessment. Please see comments in the rubric at the end of your tool for details. KA
Week 6- 1b,c,d- You did a nice job discussing group dynamics and group participation from your client. You also explained how participation in the group was intended to benefit those who participate. Although your client did not participate, you explained how an activity like painting could be beneficial for them. BS

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

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

Comments:

Week 2: 2 (c)- You were able to identify how clients are using substances as coping mechanisms and how this relates to current trends we are seeing. RH

Week 4 – 2 a & b – You did a nice job discussing your patient's medical and psychiatric history. You discussed how it related to the patient's current admission and signs and symptoms. You also discussed the importance of monitoring the patient's labs including performing a toxicology screen related to the patient having been admitted for an overdose. KA
Week 4 – 2f – You did a nice job discussing the EBP tools utilized on 1 South to promote safety. You specifically discussed the use of the 15-minute check sheet in promoting safety. KA
BS

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

Comments:

Week 2: 3 (b)- I changed this to "S" because you should have seen/participated in SBAR handoff while on hospice clinical. RH
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) Great job on your CDG this week! Each question was answered thoroughly meeting all requirements. SA

Week 4 – 3 c & e – You identified your patient as having a short attention span and being drowsy which were barriers that effect therapeutic communication. KA
Week 4 – 3f – Abbi, you did a nice job responding to all the CDG questions for days 1 and 2 of your 1 South clinical experience. You were thorough and thoughtful with your responses. You included an in-text citation and reference for both postings. Keep up the terrific work! KA
Week 6- 3a,c,d- You did a great job discussing the therapeutic communication techniques you used when communicating with your client and provided rationales as to why it was therapeutic. As you pointed out, this type of communication is especially important when talking with clients experiencing high levels of anxiety. BS

Week 8- Satisfactory completion of Nursing Process Recording, 84/100. Please see attached rubric below. SA

Objective

4. Demonstrate knowledge of frequently prescribed medications utilized in treating mental illness. (1, 4, 5, 6, 7)*

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

Comments:

Week 2: 4(a)- Did you observe any medication pass during your hospice clinical? If so, this should be changed to an “S”, but if not this can remain “N/A” RH

Week 4 – 4b, c, & e – You discussed the multiple medications your patient was taken along with their implications for use, common side effects, and important nursing assessment and interventions for each. KA
Week 4 – 4d – You were able to identify barriers a patient may have in maintaining compliance with taking their medications. You included not feeling the therapeutic effect of the medication right away as well as forgetting to take the medication regularly as being barriers. KA
Week 6- 4a,b,c- You were able to observe your nurse administer several psychotropic medications to patients. 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)**	N/A	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	N/A	S	S	N/A	N/A	N/A	N/A	N/A	N/A	S
c. Collaborate with the Erie County Health Department Detox Unit while observing the care of a patient with mental illness-substance abuse. **(Community Agency Observation-Detox Unit) ****	N/A	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
d. Recognize and describe the need for substance abuse recovery resources. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	N/A	S
Faculty Initials	NS	RH	SA	KA	KA	BS	BS	SA	SA	SA

****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 3 (5a-c) Great job this week discussing your observations at the Detox center. 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)**	N/A	N/A	N/A	S	N/A	S	N/A	N/A	N/A	S
b. Demonstrate satisfactory documentation ~~of psychiatric assessments and nursing notes~~ utilizing the electronic health record. **(responding)**	N/A	N/A	N/A	S	N/A	N/A	N/A	N/A	N/A	S
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	N/A	N/A	N/A	S	N/A	S	N/A	N/A	N/A	S
Faculty Initials	NS	RH	SA	KA	KA	BS	BS	SA	SA	SA

Comments:

Week 4 – 6a & b – You researched your patient using the electronic health record. You gathered all the necessary data to help put the pieces together related to your patient's admission and medical history. You did a nice job accurately documenting attendance of the patients to your nursing activity group in the electronic health record. Great job! KA

Week 6- 6c- You were able to utilize technology to identify an important mental health resource for clients in need and gave a good explanation of the resource and the services provided at Firelands Counseling and Recovery Services. BS

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

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 did a great job reflecting on your experience with Artisan's as well as with Hospice this week. Your hospice reflection journal was very thoughtful. You were able to express what you were expecting prior to the experience as well as how the experience compared to your expectations. You were able to identify how this is a different type of nursing compared to a traditional nursing unit in a hospital. I am glad you saw the experience as rewarding and it brought to light some things that you were not anticipating to be brought into the nursing field. RH

Week 3 (7c-f) In your discussion post, you provided great information on a reflection of your time at the Detox center. Great job! SA

Week 4- My strengths for care delivery were getting my patient to participate in some of the therapy groups even if she just wanted to go to her room, also getting her to talk a little bit of how she was feeling throughout the day even if she didn't want to open up all the way. My patient had very low energy so to get her up out of her room and talking was a big accomplishment. Great job! KA

* End-of-Program Student Learning Outcomes

Week 4 – 7b – You did a nice job discussing factors that promote a culture of safety on the psychiatric unit and worked with your classmates to promote safety while on clinical. KA

Week 6- My strengths this week were being able to therapeutically communicate with multiple clients on the floor and keep a lasting conversation going. It seemed that I provided a more trusting relationship with the clients, so they opened up more this time to talk. Another strength was being able to observe patients body language to be able to notice when they feel uncomfortable or ready to end the conversation which is important to keep them from getting agitated. Nice job, Abby. It is important to be able to read verbal and non-verbal cues to help maintain a therapeutic relationship. BS

Week 7- 7b- You did a great job discussing group participation and group dynamics and their potential benefits for those participating. Nice work! BS

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
7/1-7/2/2025	Risk for suicide.	Satisfactory BS	NA BS

Care Map Evaluation Tool**
Psych
2025

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

Comments:

* End-of-Program Student Learning Outcomes

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

Student Name: A. Foote **Date or Clinical Week:** Week 6				**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.		
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	Great job with identification of all subjective and objective assessment findings and pertinent risk factors.
	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	Nice job distinguishing the appropriate abnormal findings as they relate to the priority problem. Priority problems provided were relevant to your assigned patient. I would suggest that all of the assessment findings you listed should be highlighted. Complications provided with signs and symptoms of each complication included.
	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	Nice job providing a list of prioritized nursing interventions. Interventions all included a frequency and were realistic and individualized. A few were missing rationales.
	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**	2	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	Evaluation completed. Original assessment findings reassessed. Since the patient was discharged I would 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**	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: Nice work on your care map, Abby! BS

Total Points: 44/45 Satisfactory. BS

Faculty/Teaching Assistant Initials: BS

Geriatric Assessment Rubric
2025

Student Name: Abbi Foote 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_

Abbi, you received a satisfactory evaluation of the Geriatric Assessment. Great job! . Overall you did a very nice job. Keep up the hard work! SA

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

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

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

Student Name: Abigail Foote				**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)**	3	Great job with identification of all subjective and objective assessment findings and risk factors.
	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	Nice job distinguishing the appropriate abnormal findings as they relate to the priority problem. Priority problems provided were relevant to your assigned patient. Risk factors that would be related patient's diagnosis of bipolar and depression. Complications provided and signs and symptoms of each complication were very thorough.
	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	
Respo	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Nursing interventions were prioritized, frequencies provided, individualized, and realistic for the patient.
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	

n d i	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**	1	Missing rationales with most of the interventions.
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	Evaluation of your priority problem identified was done appropriately, great job!
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

Reference

An in-text citation and reference are required.
The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.
The care map will be graded “unsatisfactory” if no in-text citation or reference is included.

Total Possible Points= 45 points
45-35 points = Satisfactory
34-23 points = Needs Improvement*
< 23 points = Unsatisfactory*
***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

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

Faculty/Teaching Assistant Comments:

Total Points: 43/45 **Satisfactory**

Faculty/Teaching Assistant Initials: SA

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

Student Name: **Abigail Foote** **Clinical Date:** **6/20/2025**

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:** **8** **Comments:** **Interventions are listed appropriately and thoroughly with realistic frequency. Just a couple missed points for a couple of interventions were missing rationales. Correctly lists a therapeutic communication appropriate to their client.**
Criterion #5 **Process Recording** **(15 points total)**	**Total Points:** **15** **Comments:** **Thoroughly lists all communication interactions. Provides verbal and non-verbal cues,**

• 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)	**also recognized correct therapeutic and non-therapeutic techniques. Provides own thoughts with each interaction. Great job!**
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: 6** **Comments: Points missed for not interpreting each encounter as therapeutic or non-therapeutic appropriately. Correctly identifies each technique. Points missed for not providing an explanation with each interaction.**
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 nicely 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. *	**Total Points: 84/100 Satisfactory** **Comments: Abbi, nice job on your nursing process recording! You provided a thorough and appropriate interaction with your client. The evaluation of each step was appropriately**

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)** **Clinical Competency: 3(e**) Develop a satisfactory patient-nurse therapeutic communication. (**Nursing Process Study) (responding, reflecting)** *End-of-Program Student Learning Outcomes	**documented. Your client's history was documented thoroughly and descriptive. You also provided descriptive self-evaluations on your interactions, however, did not interpret each interaction as therapeutic, or non, and did not provide an explanation on each. Interventions were listed appropriately but just missed a couple rationales. Overall you are satisfactory for this assignment. Keep up the great work! SA**

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

	(*1, 2, 3, 4, 5, 6,7)				
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	BS	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	S	SA	NA

* Course Objectives

Comments:

Live Simulation- Please review the comments placed on the simulation scoring sheet below. In addition, review the individual faculty feedback placed within the simulation reflection journal dropbox. KA

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Abigail Foote (M), Sydney Fox (A), Marilyn Miller (A), Saige Ruffing (M)

GROUP #: 4

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/25/2025 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	Notices the patient's blood pressure is elevated. Notices the patient appears anxious. Seeks out information related to patient's substance use history. Recognizes the patient does not need Lorazepam based on the CIWA Scale score. Notices the patient is complaining of visual hallucinations. Notices the patient is complaining of itching. Seeks out information related to the patient's support system and substance use. Recognizes the patient needs Lorazepam based on the CIWA Scale score.
INTERPRETING: (2,4)* • Prioritizing Data: E A **D** B • Making Sense of Data: E **A** D B	Prioritizes performing the CAGE Questionnaire and CIWA Scale. Interprets the CAGE Questionnaire as suggestive of alcohol abuse. Does not prioritize CIWA Scale score. When prompted, interprets the CIWA Scale score as 2. Interprets the CIWA Scale score as 25. Interprets CIWA protocol accurately for Lorazepam dose (4 mg PO).
RESPONDING: (1,2,3,5)* • Calm, Confident Manner: E **A** D B • Clear Communication: E **A** D B • Well-Planned Intervention/ Flexibility: E **A** D B • Being Skillful: E **A** D B	Introduces self and identifies patient. Asks questions to establish orientation. Obtains vital signs. BP-150/88, RR-13. Asks the patient questions related to fall at home, reason for admission. Performs the CAGE Questionnaire. Education provided related to coping strategies, relaxation. Performs the CIWA Scale. Utilizes therapeutic communication with the patient.

	Medications nurse identifies and scans patient. Medication nurse educates the patient on medications to be administered. Medication nurse administers ordered daily medications. Introduces self and identifies patient. Obtains vital signs. BP- 148/82. Establishes orientation. Performs CIWA Scale. Medication nurse verifies patient and scans. Administers Lorazepam 4 mg PO (per protocol). Attempts to utilize therapeutic communication with the patient. Provides education related to withdrawal symptoms and substitution therapy. 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 patient admitted for an acute mental health crisis. (1, 2, 3)*** • **Utilize the CIWA scale to assess a patient**	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Makes an effort to prioritize data and focus on the most important, but also attends to less relevant or useful 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.

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)***	**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:

I reviewed my final clinical evaluation.

Student eSignature & Date: Abigail Foote 7/15/25