EVALUATION OF CLINICAL PERFORMANCE TOOL
Psychiatric Nursing- 2023
Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student:

Megan Barber

Final Grade: Satisfactory/Unsatisfactory

Semester: Summer Session

Date of Completion:

Faculty: Brian Seitz MSN, RN, Fran Brennan MSN, RN, Chandra Barnes MSN, RN,
Nick Simonovich MSN, RN, Brittany Lombardi MSN, RN, Kelly Ammanniti MSN, RN
Teaching Assistants: Rachel Haynes 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 on the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, or U". 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, the following week it must be addressed with a comment as to why it is no longer a "U". If the student does not state why the "U" is corrected, then it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. If the final performance code is unsatisfactory in any one of the competencies, a grade of unsatisfactory is given. If a pattern of unsatisfactory performance occurs after performing the competency satisfactorily, this also constitutes a grade of unsatisfactory. An unsatisfactory as a final score in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. 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
Participation in adjunctive therapies (N.A./A.A.; Erie County Detox
Unit, Hospice inpatient care)
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)
7/8/2023	1	Simulation survey not completed by due date.	7/10/2023

Initials	Faculty Name
BS	Brian Seitz MSN, RN, CNE
FB	Frances Brennan, MSN, RN
KA	Kelly Ammanniti MSN, RN, CHSE
BL	Brittany Lombardi MSN, RN, CNE
NS	Nick Simonovich MSN, RN
CB	Chandra Barnes MSN, RN
RH	Rachel Haynes BSN, RN

* End-of-Program Student Learning Outcomes

<div align="center">

PERFORMANCE CODE

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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.

* End-of-Program Student Learning Outcomes

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	NA	~~S~~ NA				
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**		S	NA	S	NA	~~S~~ NA				
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**		S	NA	S	S	~~S~~ NA				
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**		S	NA	S	~~NA~~ S	~~S~~ NA				
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**		S	NA	S	S	~~S~~ NA				
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**		S	NA	~~S~~ NA	NA	NA				
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**					NA					
Faculty Initials	KA	KA	CB	NS	BS	BS				

		1S	NA	1S	Hospice, SARCC	Simulation				
Clinical Location										

Comments:

Week 2 – 1a – Megan, you were thoroughly able to discuss the pathophysiology behind your patient's admission diagnosis of major depressive disorder. Great job discussing potential causes even though it is difficult to identify the specific cause. KA

Week 2 – 1e – Megan, you did a nice job discussing specific social determinants of health and how they related to your patient. You identified housing as being the biggest concern related to SDOH and contributed to her most recent admission. KA

Week 2 – 1f – Megan, you did a great job developing and running a nursing therapy group this week. Your coping skills BINGO was fun and the patients all appreciated the prize of candy when they won! Wonderful job! KA

Week 4 1b – You were able to identify the benefit of group therapy for you selected patient. Although she did not attend on day one and joined half way through on day two, I think it was important to note how this type of therapy would help in her treatment. Additionally, you noticed how coloring was a form of therapy for her and you offered yourself and sat with her as she colored as a means of therapeutic intervention. NS

Week 5- 1a-d- (SARRCC) Nice job explaining the current trends in substance abuse, discussing the need for mental health programs for substance abuse, and discussing characteristics of individuals with substance abuse problems. You also identified risk factors associated with substance abuse and the prevalent family dynamics often present with substance abuse. Nice description of the roles family members often take when dealing with substance abuse and some of the health problems that often occur as a result. BS

(For the weeks you do not have clinical please mark all competencies with NA) BS

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

Comments:
Week 2 – 2a & 2b – Megan, you did a nice job discussing the patient you worked with this week and her reason for admission to the inpatient unit. KA
Week 2 – 2b – You did a great job identifying the abnormal labs your patient had and how they related to her medical history. What were all the labs they drew on your patient? Were there any labs that would pertinent for them to draw that they may not have drawn yet? KA
Week 2 – 2f – Megan great job identifying teamwork, patient involvement, transparency, and accountability as being major factors in creating a culture of safety on the psychiatric unit. KA

* End-of-Program Student Learning Outcomes

Week 4 2(a,b) – You were able to gather data on your patient through careful review of her chart. She was hesitant on extensive interaction; however, you utilized your time wisely to assemble a health history to better understand her condition. You provided assessment observations on your care map relevant to her admitting priority. Her positive UDS was identified as a potential risk factor for her mental health. The social isolation that you identified played a role in her increased safety risk to herself. NS

Week 4 2(d) – You submitted a satisfactory care map for the priority problem of risk for suicide based on your patient's admitting diagnosis of MDD with suicidal ideations and social isolation. See the completed care map grading rubric attached to this document for further comments. 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)**		S	NA	S	S	S̶ NA				
b. Demonstrate professional and appropriate communication with the treatment team by using the SBAR format for handoff communication during transition of care. **(responding)**		S	NA	S	NA	S̶ NA				
c. Identify barriers to effective communication. **(noticing, interpreting)**		S	NA	S	S	S̶ NA				
d. Construct effective therapeutic responses. **(responding)**		S	NA	S	S	S̶ NA				
e. Construct 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	S̶ U	S	NA				
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. **(responding)**		S	NA	S	S	S̶ NA				
h. Teach patient/family based on readiness to learn and patient needs. **(responding, reflecting)**		S	NA	S	S	S̶ NA				
Faculty Initials	KA	KA	CB	NS	BS	BS				

Comments:

* End-of-Program Student Learning Outcomes

Week 2 – 3f – Megan, you did a nice job responding to all the CDG questions on your 1 South clinical experience this past week. Your responses were well written and thorough. You included appropriate resources to support your information and included in-text citations. In the future include a coma between the author and year in your in-text citation. Keep up the terrific work! KA

Week 4 3(a) – You were able to use therapeutic communication techniques such as offering self, exploring, and seeking clarification in your interactions. When your patient did come out of her room she often sat alone coloring. Nice job getting out of your comfort zone and offering yourself to her in communication while she colored. Although she did not interact much, you provided her with the opportunity which can be therapeutic in understanding someone is there for you. NS

Week 4 3(f) – According to the CDG grading rubric, a "U" is given due to the second CDG prompt for the week pertaining to the care map not including an in-text citation and a reference. Since this was included as a CDG question, the CDG rubric must be followed in its entirety. A good place to reference and cite a resource on CDGs for care maps is the intervention section since most often a resource is utilized to gather that data. This will be expected in future course so I wanted to give you a heads up. If you have any questions don't hesitate to reach out for further clarification. Be sure to provide sufficient details in all your responses. With the in-text citation to the first CDG prompt, you were just barely over the word count limit. For example, the last question pertaining to the mental health resource located online you could elaborate more on how you located it and how it could be beneficial to your patient and her experiences. See my comments on your post for more detail. NS

For the future, I will remember to include an in text citation and reference for all CDG assignments, even care maps. I will include it in the reminder I have set on my phone. BS

Week 5- 3c,f,g- (SARRC) Nice job discussing your feelings and attitudes regarding working with individuals with substance abuse problems. Great job providing thorough responses on your CDG questions this week, nice work! Nice job also reflecting on your time at hospice and discussing what you did while there. BS

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

Comments:

Week 2 – 4a, 4b, & 4e – Megan, you did a great job discussing your patient's medications, their side effects, and nursing interventions related to each. You noted one of the medications having psychiatric side effects. Great job! You completed medication administration on the patient efficiently and accurately observing the rights of medication administration. The patient reported potentially not being administered a medication during the medication pass, but your accurate documentation and following of the rights of medication administration supported the fact you administered the medication as ordered. You thoroughly researched your medications and were well versed on each one before you administered them. Great job handling a difficult situation. KA

Week 4 4(b,c,e) – Nice job researching your patient's medications this week. You provide good details in your discussion of the medications. You understood the implications of each for your assigned patient. On day two you practiced the safety rights of medication administration when interacting with your patient. NS

* End-of-Program Student Learning Outcomes

Objective

5. Develop an awareness of community Mental Health resources and services. (5, 6, 7, 8)*			

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
a. Identify the need for the community resources- detox unit available to patients with a mental illness. **(noticing, interpreting)**		NA	NA	NA	NA	NA				
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**		NA	NA	~~NA~~ S	S	~~S~~ NA				
c. Attend Erie County Health Department Detox Unit observing the care of a patient with mental illness-substance abuse. **(Community Agency Observation-Detox Unit)**		NA	NA	NA	NA	NA				
d. Attend Narcotics/ Alcoholics Anonymous meeting. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**		NA	NA	NA	S	NA				
Faculty Initials	KA	KA	CB	NS	BS	BS				

Comments:
Week 5- 5b,d (SARCC)- You did a nice job describing the meeting platform at the Sandusky Artisans Recovery Community Center and discussing its effectiveness as a resource for individuals striving for sobriety. BS

* End-of-Program Student Learning Outcomes

Objective											
6. Demonstrate satisfactory proficiency when using informatics and techniques in the assessment of patients with a mental illness diagnosis. (1, 2, 3, 4, 6, 8)*											

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies: a. Demonstrate competence in navigating the electronic health record. **(responding)**		S	NA	S	NA	NA				
b. Demonstrate satisfactory documentation of physical and psychiatric assessments and nursing notes utilizing the electronic health record. **(responding)**		S	NA	S NA	NA	NA				
c. Demonstrate the use of technology to identify mental health resources. **(responding)**		S	NA	S	S	NA				
Faculty Initials	KA	KA	CB	NS	BS	BS				

Comments:

Week 5- 6c- Nice work utilizing two web-based resources in completion of your CDG this week. 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)**		S	NA	S	NA	~~S~~ 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	S	~~S~~ NA				
c. Illustrate active engagement in self-reflection and debriefing. **(reflecting)**		S	NA	S	NA	~~S~~ NA				
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE" – attitude, commitment, and enthusiasm during all clinical interactions. **(responding)**		S	NA	S	S	~~S~~ NA				
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. **(responding)**		S	NA	~~S~~ NI	S	~~S~~ NA				
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." **(responding)**		S	NA	S	S	~~S~~ NA				
Faculty Initials	KA	KA	CB	NS	BS	BS				

Comments:
Week 4 7(e) – I encourage you to be aware of body language at times during your clinical experiences. I recognize that these are early and long days on the clinical unit. Laying your head down on the table, even though you were still looking and paying attention, during debriefing when other students are presenting can give the appearance that you do not care or are uninterested. This also occurred during rec therapy and can be off-putting to staff and patients on the unit while we are there to learn. In reflecting, consider how you may feel if others did this while you were presenting and how it could be a distraction. Something to consider and work on moving forward. NS

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Megan Barber			Course Objective: 2*				
Date or Clinical Week: Week 4							

	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	Seven assessment findings/observations were provided based on review of the patient's chart and interaction with the patient on the unit. Consider including the specific plan for suicide if identified. Four abnormal diagnostic findings were identified. Five risk factors were provided. Consider including her history of substance use (THC) as a potential risk factor.
	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	Consider including her history of substance use as being relevant to the top priority of risk for suicide. As we discussed in the class, this is an important risk factor to note when considering potential for suicidal thoughts.
	5. 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**	2	
	6. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	7. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Respo	8. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	A list of 8 nursing interventions was provided for the priority problem of risk for suicide based on her admitting diagnosis. No assessment interventions
	9. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	

n d i n g	10. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3
	11. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3
	12. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3

were prioritized. It would be essential for the nurse to continually assess for risk factors and especially warning signs of suicide while under our care. Consider additional interventions such as creating a safety plan with the patient, encouraging

g **Reflecting**	13. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3
	14. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	0

All assessment findings were re-evaluated appropriately. A decision to continue, modify, or terminate the plan of care was not included.

Total Possible Points= 42 points 42-33 points = Satisfactory 32-21 points = Needs Improvement* < 21 points = Unsatisfactory* ***Total points adding up to less than or equal to 32 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**	**Total Points: 36/42 - Satisfactory**
	Faculty/Teaching Assistant Initials: NS

Nursing Process Study

Criteria	Ratings				Points Earned
Criterion #1 Process Recording is organized and neatly completed	5 Points Typed process recording with spelling and grammar correct.	3 Points Typed process recording with 5 or less spelling and grammar mistakes.	1 Points Typed process recording with 5 or more spelling and grammar mistakes.	0 Points Process recording is not typed with 10 or more spelling and grammar mistakes.	3
Criterion #2 Assessment	7 Points Identifies pertinent patient background, current medical and psychiatric history. Provides a self-assessment of thoughts and	5 Points Identifies areas of assessment but incomplete data provided in 2 of the 4 areas.	3 Point Identifies areas of assessment but incomplete data provided in 3 of the 4 areas.	0 Points Missing data in all 4 areas of assessment.	5

	feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.	Provides a **self-assessment of thoughts and feelings** prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.	Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.		
Criterion #3 Mental Health Nursing Diagnosis (priority problem)	8 Points Identifies priority mental health problem (not a medical diagnosis) providing at least 5 potential complications.	5 Points Identifies Priority mental health problem provides at least 4 potential complications.	3 Point Identifies priority mental health problem provides at least 3 potential complications.	0 Points Does not provide priority mental health problem and/or less than 3 potential complications.	8
Criterion #4 Nursing Interventions	10 Points Identifies all pertinent nursing interventions (at least 5) in priority order including a rationale and timeframe. Interventions must be individualized and realistic. Identifies a therapeutic communication goal	6 Points Identifies 4 or less nursing interventions in priority order including a rationale and time frame. Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.	6
Criterion #5 Process Recording	15 Points Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.	10 Points Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 7 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	5 Point Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 5 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	0 Points Direct quotes are not provided. Nonverbal and Verbal behavior is not described for less than half of the interactions. Student thoughts and feelings for less than half of the interactions provided.	15

Criterion #6 Process Recording	20 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic) and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) and example from interactions.	15 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) and no example from interactions provided.	10 Point Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), no technique (exploring, focusing, reflecting, formulating a plan of action, etc.) and/or no example from interactions provided.	0 Points Analysis not provided for each interaction	20
Criterion #7 Process Recording	10 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 10 interchanges between patient and student.	6 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 7 interchanges between patient and student.	4 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 5 interchanges between patient and student.	0 Points There was less than 5 interchanges between patient and student provided.	10
Criterion #8 Evaluation	15 Points Self-evaluation of communication with patient. Identify at least 3 strengths and 3 weaknesses of therapeutic communication.	10 Points Self-evaluation of communication with patient. Identified 2 strengths and 2 weaknesses of therapeutic communication.	5 Point Self-evaluation of communication with patient. Identified 1 strength and 1 weakness of therapeutic communication.	0 Points No self-evaluation was provided.	15
Criterion #9 Evaluation	10 Points Identify at least 3 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	6 Points Identify at least 2 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	4 Point Identify at least 2 barriers to communication did not include interventions or communication that could have been done differently. Did not identify any pertinent social determinants of health.	0 Points Identify at least 1 barrier to communication did not include interventions or communication that could have been done differently. Did not identify any pertinent social determinants of health.	10
Total Possible Points= 100 points **77-100 points= Satisfactory completion.** 76-53 points= Needs Improvement				**Total Points:**	92/100

< 53 points= Unsatisfactory

Faculty comments: Nice job on your Nursing Process Study, Megan. I would have liked to have more detail in your self-assessment, but otherwise very good.

Megan Barber

Faculty Initials: BS

Lasater Clinical Judgment Rubric Scoring Sheet

STUDENT NAME(S): M. Barber (M), M. Sweat (A)
GROUP #: 5-1
SCENARIO: Alcohol/Substance Abuse Scenario
OBSERVATION DATE/TIME(S): 7/6/2023   0800-0915

CLINICAL JUDGMENT					OBSERVATION NOTES
COMPONENTS NOTICING: (1, 2, 5)*					Introduced self and identifies patient when entering the room. Focused observation on vital signs. Notices bruising on patient. Sought information on normal BP range. Noticed elevated BP of 148/92 due to anxiety.
• Focused Observation:	E	**A**	D	B	
• Recognizing Deviations from					
Expected Patterns:	E	A	D	B	Did not inquire about recent loss of friend.
• Information Seeking:	E	A	D	B	
INTERPRETING: (2, 4)*					Prioritized vital sign assessment.
• Prioritizing Data:	E	**A**	D	B	Prioritized CAGE questionnaire based on patient discussion, interpreted to be positive.
• Making Sense of Data:	E	**A**	D	B	Prioritized CIWA scale assessment. Made sense of CIWA assessment score result of 1.
					Prioritized need to perform brief mental status evaluation.
					Implemented CIWA protocol noting no need for medication due to score of 1.

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	Questions origin of bruises. Vital signs obtained. Educated on medication compliance. Questioned patient to establish orientation. CAGE questionnaire performed. Medications prepared and administered. Educated patient about amitriptyline. CIWA assessment performed. Brief mental statue evaluation performed. Assessed readiness to learn and participate based on mental status. Educated on services such as detox facilities, helpline, and AA (Artisans). Therapeutic communication provided.
REFLECTING: (6)* • 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** **Objectives:** 1. **Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)*** 2. **Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)***	Lasater Clinical Judgement Rubric Comments: Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: **You are satisfactory for this scenario. Nice work! BS**. 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.

3. **Determine appropriate medication administration steps utilizing the CIWA scale. (4)***

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

* Course Objectives

You are satisfactory for this scenario. Nice work! BS.

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Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2023
Simulation Evaluations

vSim Evaluation Performance Codes: **S**: Satisfactory **U**: Unsatisfactory	Linda Waterfall (Anxiety/Cultural Scenario) (*1,2,3,4,5)	Sharon Cole (Bipolar Scenario) (*1,2,3,4,5)	Sandra Littlefield (Borderline Personality Disorder Scenario) (*1,2,3,4,5)	Live Adult Mental Health Simulation (Alcohol Withdrawal) (*1,2,3,4,5)	George Palo (Alzheimer's Disorder) (*1,2,3,4,5)	Randy Adams (PTSD Scenario) (*1,2,3,4,5)

	Date: 6/9/2023	Date: 6/23/2023	Date: 6/30/2023	Date: 7/5-6/2023	Date: 7/7/2023	Date: 7/21/2023
Evaluation	S	S	S	U	S	
Faculty Initials	KA	NS	BS	BS	BS	
Remediation: Date/Evaluation/Initials	NA	NA	NA	S	NA	

* Course Objectives

Week 4 – All requirements were met for satisfactory completion of the Sharon Cole vSim assignment. NS
Week 6- Simulation survey not completed by due date and time. Survey is now completed. 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: