

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

Student:

Taylor Whitworth

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)
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

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

* End-of-Program Student Learning Outcomes

Comments:

Week 2- 1a,e- Nice job discussing the pathophysiology of your patients diagnosis and some of its potential contributing factors. Nice job also discussing potential risk factors for depressive disorders. BS

Week 3: 1(a, b)- Good job discussing and connecting the pathophysiology of your patient with their diagnosis this week. RH

Week 6(1a-d): Taylor, great job during your Erie County Health Department Detox Unit clinical experience this week. You did an excellent job with your CDG discussing the services that are provided, process for admission, barriers to culturally and spiritually competent care at the agency, the role of the nurse, and methods that are used to assist the patient to achieve self-care. Keep up all your great work! CB

Week 7-1(a,d) Excellent job attending and actively participating in your Sandusky Artisans clinical experience this week. You did a great job discussing the current trends in substance abuse, as well as the need for related mental health programs in your CDG. Keep up all your great work! BL

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

Comments:

* End-of-Program Student Learning Outcomes

Week 2- 2a,b- Good job discussing your patient's medical and psychiatric history. You also provided reasons and circumstances that contributed to her current admission. BS
Week 3: 2(a-d)- You completed a care map for your patient this week with related the labs, diagnostic testing, and health history to their care during this admission. You also were able to relate their coping mechanisms as well. RH

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	S	NA	NA S	NA	NA S			
b. Demonstrate professional and appropriate communication with the treatment team by using the SBAR format for handoff communication during transition of care. (responding)		S	S	NA	S	NA	NA			
c. Identify barriers to effective communication. (noticing, interpreting)		S	S	NA	NA S	NA	NA			
d. Construct effective therapeutic responses. (responding)		NI	S	NA	S	NA	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	S	NA	S NA	S	S			
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. (responding)		S	S	NA	S	S	S			
h. Teach patient/family based on readiness to learn and patient needs. (responding, reflecting)		S	S	NA	NA	NA	NA			
Faculty Initials		BS	RH	RH	NS	CB	BL			

Comments:

Week 2- 3c- Great job discussing important factors that create a culture of safety specific to the psychiatric setting. BS

Week 3: 3(a, c, d)-You did a great job communicating with the patients on the unit this week. You were able to identify and explain some therapeutic communication techniques in your discussion post as well as how your patient responded to them. RH

* End-of-Program Student Learning Outcomes

Week 5 3(e) – See the attached grading rubric below for more details. Taylor, you did an excellent job satisfactorily completing your NPS on your patient. You did a nice job putting everything in quotes and outlining the patient’s conversation with you, but your nonverbals were limited. I would have liked to see you explore the nonverbals that were occurring throughout the conversation. Sitting, standing, arms crossed, arms open, tense shoulders, relaxed positioning, etc. are all aspects of nonverbals. We general are portraying some nonverbals at all times. Nice work! KA

Week 6(3f): Excellent job with your CDG this week! Your responses were very detailed and reflected much knowledge. CB

Week 7-3(f) Satisfactory completion of your CDG this week. Great job! BL

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

Comments:

Week 2- 4a,b,e- Nice work this week administering medications while observing the six rights and of documenting administration. Great job also discussing the uses and implications of psychiatric medications. You also did a nice job discussing the side effects and assessments related to the use of psychotropic medications. Important lab values for your patient were provided, as were rationales for those values. Nice job! BS

Week 3: 4(a, b, c)-Great work with medication administration this week. You were able to observe the six rights with the patient as well as educate them on what medications they were getting as well as potential side effects. You were able to document appropriately in the EMAR. RH.

Week 5 4(a-e) – Haldol was discussed in the hospice reflection journal based on the hospice clinical experience. 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	S	NA			
b. Discuss recommendations for referrals to appropriate community resources and agencies. (reflecting)		NA	NA	NA	NA	S	NA S			
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	S	NA			
d. Attend Narcotics/Alcoholics Anonymous meeting. (Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center Observation)		NA	NA	NA	NA	NA	S			
Faculty Initials		BS	RH	RH	NS	CB	BL			

Comments:

Week 6(5a-c) Great job attending the Erie County Health Department Detox Unit and satisfactorily completing your CDG for the experience. CB

Week 7-5(b,d) You did a great job attending and actively participating in your Sandusky Artisans clinical experience this week. Your CDG was very well done and you did an excellent job discussing the current trends in substance abuse, as well as the need for related mental health programs. You accurately identified risk factors associated with substance abuse, and shared your thoughts and feelings about working with patients who are dealing with substance abuse. Keep up all your hard work! BL

* End-of-Program Student Learning Outcomes

* 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:		S	S	NA	NA	NA	NA			
a. Demonstrate competence in navigating the electronic health record. (responding)		S	S	NA	NA	NA	NA			
b. Demonstrate satisfactory documentation of physical and psychiatric assessments and nursing notes utilizing the electronic health record. (responding)		NA	S	NA	NA	NA	NA			
c. Demonstrate the use of technology to identify mental health resources. (responding)		NA	S	NA	NA	NA	NA			
Faculty Initials		BS	RH	RH	NS	CB	BL			

Comments:

Week 3: 6(a, b, c) You used the EHR appropriately to find information about your patient for your care map. You were also able to document on the therapy group you lead in groups. RH

* 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	S	NA	S	S	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	S	NA	S	S	S			
c. Illustrate active engagement in self-reflection and debriefing. (reflecting)		S	S	NA	S	S	S			
d. Incorporate the core values of caring, diversity, excellence, integrity, and “ACE” – attitude, commitment, and enthusiasm during all clinical interactions. (responding)		S	S	NA	S	S	S			
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (responding)		S	S	NA	S	S	S			
f. Comply with the standards outlined in the FRMCSN policy, “Student Conduct While Providing Nursing Care.” (responding)		S	S	NA	S	S	S			
Faculty Initials		BS	RH	RH	NS	CB	BL			

Comments:

Week 2- 7b- You did a nice job discussing the steps taken on the psychiatric unit that promote a culture of safety. BS

Week 3: 7(c)-You did a great job discussing the difference in your patient from Thursday to Friday. The differences in mood in your patient as well as on the unit was a great observation. RH

Week 5 7(c) – I appreciated the in-depth level of responses provided in your hospice reflection journal this week. You elaborated on your thoughts and provided good examples to support your discussion. Job well done. See my feedback provided to the reflection journal in the designated dropbox for more details. NS

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

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)	3	
	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	5. could a history of depression impact ineffective coping? What about history of anxiety? Just some thoughts to consider. 6/7. Good complications and signs to watch for in relation to the complications!
	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	3	
	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	
Responding	8. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	“determine readiness for change” is a GREAT intervention! This opens the door for education for the patient in regards to change in their life.
	9. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	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	

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. This could be “modify plan of care” to use this plan of care in a transitioning role from inpatient to outpatient services. It is also possible to terminate this plan of care and create a new one as well. Just something to think about
	14. Evaluation includes one of the following statements: <ul style="list-style-type: none"> • Continue plan of care • Modify plan of care • Terminate plan of care 	Complete			Not complete	3	
<p>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.</p> <p>Faculty/Teaching Assistant Comments:</p> <p style="color: red;">In regards to your social determinates of health: do you think his grieving process is going well or is there an ineffective grieving pattern here? Just a question as that could be another nursing diagnosis for your care map. RH</p>						Total Points: 42/42 Satisfactory	
						Faculty/Teaching Assistant Initials: RH	

Criteria	Ratings				Points Earned
Criterion #1 Process Recording is organized and neatly completed	<p align="center">5 Points</p> <p>Typed process recording with spelling and grammar correct.</p>	<p align="center">3 Points</p> <p>Typed process recording with 5 or less spelling and grammar mistakes.</p>	<p align="center">1 Points</p> <p>Typed process recording with 5 or more spelling and grammar mistakes.</p>	<p align="center">0 Points</p> <p>Process recording is not typed with 10 or more spelling and grammar mistakes.</p>	5
Criterion #2 Assessment	<p align="center">7 Points</p> <p>Identifies pertinent patient background, current medical and psychiatric history. Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.</p>	<p align="center">5 Points</p> <p>Identifies areas of assessment but incomplete data provided in 2 of the 4 areas. Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.</p>	<p align="center">3 Point</p> <p>Identifies areas of assessment but incomplete data provided in 3 of the 4 areas. Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.</p>	<p align="center">0 Points</p> <p>Missing data in all 4 areas of assessment.</p>	7
Criterion #3 Mental Health Nursing Diagnosis (priority problem)	<p align="center">8 Points</p> <p>Identifies priority mental health problem (not a medical diagnosis) providing at least 5 potential complications.</p>	<p align="center">5 Points</p> <p>Identifies Priority mental health problem provides at least 4 potential complications.</p>	<p align="center">3 Point</p> <p>Identifies priority mental health problem provides at least 3 potential complications.</p>	<p align="center">0 Points</p> <p>Does not provide priority mental health problem and/or less than 3 potential complications.</p>	8
Criterion #4 Nursing Interventions	<p align="center">10 Points</p> <p>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</p>	<p align="center">6 Points</p> <p>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.</p>	<p align="center">4 Point</p> <p>Identifies 4 or less nursing interventions but not prioritized and/or <u>no rationale</u> or time frame provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.</p>	<p align="center">0 Points</p> <p>Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.</p>	10
Criterion #5 Process Recording	<p align="center">15 Points</p> <p>Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.</p>	<p align="center">10 Points</p> <p>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.</p>	<p align="center">5 Point</p> <p>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.</p>	<p align="center">0 Points</p> <p>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.</p>	10

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
<p>Total Possible Points= 100 points 77-100 points= Satisfactory completion. 76-53 points= Needs Improvement < 53 points= Unsatisfactory</p> <p>Faculty comments: Taylor, you did an excellent job satisfactorily completing your NPS on your patient. You did a nice job putting everything in quotes and outlining the patient's conversation with you, but your nonverbals will limited. I would have liked to see you explore the nonverbals that were occurring throughout the conversation. Sitting, standing, arms crossed, arms open, tense shoulders, relaxed positioning, etc. are all aspects of nonverbals. We general are portraying some nonverbals at all times. Nic work! KA</p>					<p>Total Points: 95/100</p>

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

vSim Evaluation	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)
Performance Codes: S: Satisfactory U: Unsatisfactory						
Evaluation	S	S	S	S	S	
Faculty Initials	BS	RH	NS	CB	CB	
Remediation: Date/Evaluation/Initials	NA	N/A	NA	NA	NA	

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S): Kenneth Seibold (A), Taylor Whitworth (M)

GROUP #: 2

SCENARIO: 1

OBSERVATION DATE/TIME(S): 7/5/2023 0920-1035

CLINICAL JUDGMENT	OBSERVATION NOTES
<p>COMPONENTS NOTICING: (1, 2, 5)*</p> <ul style="list-style-type: none"> • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B 	<p>Introduced self and role when entering the room. Sought information on patient's admitting reason.</p> <p>Noticed bruising and abrasions from fall. Sought further information related to fall at home.</p> <p>Noticed ETOH use at home and denial of substance use.</p> <p>Noticed mild anxiety.</p> <p>Sought further information related to alcohol use. Didn't seek information related to more positive coping skills.</p> <p>Noticed recent loss and potential stressors.</p> <p>Noticed medication orders appropriately on eMAR.</p>
<p>INTERPRETING: (2, 4)*</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p>Prioritized vital sign assessment. Prioritized focused assessment on mental status and orientation related to events at home.</p> <p>Prioritized CIWA assessment. Made sense of anxiety being potentially related to substance withdrawal.</p> <p>Prioritized CAGE questionnaire.</p> <p>Made sense of CAGE questionnaire results and need for referral.</p> <p>Made sense of CIWA assessment with interpretation of score 3 (mild anxiety).</p> <p>Made sense of eMAR and no need to administer substitution therapy based on score.</p>
<p>RESPONDING: (1, 2, 3, 5)*</p> <ul style="list-style-type: none"> • 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 	<p>Performed CIWA assessment in full.</p> <p>Good therapeutic communication. Good encouragement related to alcohol use and non-judgmental approach to promote honesty. Discussed the importance of understanding information for treatment not judgement.</p> <p>Manual BP obtained.</p> <p>Partial brief mental health status evaluation.</p>

	<p>CAGE questionnaire performed in full.</p> <p>Focused neuro assessment completed.</p> <p>Consider educating on community resources such as NA/AA.</p> <p>Good education provided on medications to be administered. Rationale, side effects, and implications discussed. Dosage calculation performed accurately.</p> <p>Therapeutic communication provided related to recent loss. Consider asking about coping mechanisms other than drinking. See if you can get her to open up about substance use any more.</p> <p>Followed up after medication administration.</p>
<p>REFLECTING: (6)*</p> <ul style="list-style-type: none"> • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B 	<p>Each member of the group actively participated during debriefing. Appropriate questions were asked. Identified rationale behind decision making. Identified use of clinical judgment during the scenario. Each group member discussed strengths and weaknesses in their performance. Alternate choices were discussed for improvement in the future.</p>
<p>SUMMARY COMMENTS: * = Course Objectives</p> <p>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</p> <p>E= Exemplary</p> <p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p> <p>Objectives:</p> <ol style="list-style-type: none"> 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)* 3. Determine appropriate medication administration steps utilizing the CIWA scale. (4)* 4. Provide patient with appropriate education on community support and resources. (5)* <p>* Course Objectives</p>	<p>Lasater Clinical Judgement Rubric Comments:</p> <p>Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. 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.</p> <p>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.</p> <p>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.</p> <p>Reflecting: 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.</p> <p>Satisfactory completion of Mental Health simulation scenario.</p>

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:

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Student eSignature & Date: