

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

**Student:**

Sela Berry

**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		
<b>BS</b>	<b>Brian Seitz MSN, RN, CNE</b>		
<b>FB</b>	<b>Frances Brennan, MSN, RN</b>		
<b>KA</b>	<b>Kelly Ammanniti MSN, RN, CHSE</b>		
<b>BL</b>	<b>Brittany Lombardi MSN, RN, CNE</b>		
<b>NS</b>	<b>Nick Simonovich MSN, RN</b>		
<b>CB</b>	<b>Chandra Barnes MSN, RN</b>		
<b>RH</b>	<b>Rachel Haynes BSN, RN</b>		

\* 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
<b>Competencies:</b>		NA	S	S	NA S	S	S			
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. <b>(noticing)</b>		NA	S	S	NA S	S	S			
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. <b>(interpreting)</b>		NA	S	S	NA S	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. <b>(responding)</b>		NA	S	S	NA S	S	S			
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care <b>(noticing)</b>		NA	S	S	NA S	S	S			
e. Recognize social determinants of health and the relationship to mental health. <b>(reflecting)</b>		NA	S	S	NA	S	S			
f. Develop and implement an appropriate nursing therapy group activity. <b>(responding)</b>		NA	NA	S	NA	NA	NA			
g. Develop a geriatric physical/mental health assessment and education plan. <b>(Geriatric Assessment) (responding)</b>					S					
Faculty Initials		RH	BS	BS	BS	BS	BL			
Clinical Location		NA	1 South	1 South	Artisans	Hospice	Detox			

\* End-of-Program Student Learning Outcomes

**Comments:**

Week 3- 1a,e- Real 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 4- 1e,f- Nice job including social determinants of health on your nursing care map and identifying a community resource that your patient could benefit from. Nice job also developing and implementing an appropriate nursing therapy group activity. BS

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.

Week 6- 1c- Great job sharing your observations on the hospice care you were able to observe and participate in. BS

Week 7-1(a-d) Sela, 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! BL

<b>Objective</b>										
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
<b>Competencies:</b>										
a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. <b>(noticing)</b>		NA	S	S	NA	S	NA			
b. Identify patient’s subjective and objective findings including labs, diagnostic tests, and risk factors. <b>(noticing, recognizing)</b>		NA	S	S	NA	S	NA			
c. Demonstrate ability to identify the patient’s use of coping/defense mechanisms. <b>(noticing, interpreting)</b>		NA	S	S	NA	NA	S			
d. Formulate a prioritized nursing care map utilizing clinical judgment skills. <b>(noticing, interpreting, responding, reflecting)</b>		NA	NA	S	NA	NA	NA			
e. Apply the principles of asepsis and standard precautions. <b>(responding)</b>		NA	S	S	NA	S	S			

\* End-of-Program Student Learning Outcomes

f. Practice use of standardized EBP tools that support safety and quality. ( <b>noticing, responding</b> )		NA	S	S	NA	S	S			
Faculty Initials		RH	BS	BS	BS	BS	BL			

**Comments:**

Week 3- 2a,b- Good job discussing your patient’s medical and psychiatric history. You also provided reasons and circumstances surrounding his current admission. BS  
 Week 4- 2a,b,c,d- Great job correlating your assessment data with your patient’s medical and psychiatric history and identifying the priority problem and potential complications. Nursing interventions were provided and prioritized with rationales included. You also did a nice job evaluating the plan of care and identified social determinants of health that affect the patient. Nice work! BS

<b>Objective</b>										
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. <b>(responding)</b>		NA	S	S	NA	S	S			
b. Demonstrate professional and appropriate communication with the treatment team by using the SBAR format for handoff communication during transition of care. <b>(responding)</b>		NA	S	S	NA	NA	NA			
c. Identify barriers to effective communication. <b>(noticing, interpreting)</b>		NA	S	S	NA S	S	S			
d. Construct effective therapeutic responses. <b>(responding)</b>		NA	S	S	NA	S	S			
e. Construct a satisfactory patient-nurse therapeutic communication. <b>(Nursing Process Study) (responding, reflecting)</b>					NA					
f. Posts respectfully and appropriately in clinical discussion groups. <b>(responding, reflecting)</b>		NA	S	S	S	S	S			
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. <b>(responding)</b>		NA	S	S	S	S	S			
h. Teach patient/family based on readiness to learn and patient needs. <b>(responding, reflecting)</b>		NA	S	S	NA	S	NA			
Faculty Initials		RH	BS	BS	BS	BS	BL			

**Comments:**

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

Week 4- 3a,b,c,d- Nice job discussing your patient's group participation and the group dynamics. Nice job also describing the ways in which participation in the groups is intended to benefit the patients. You also did a nice job discussing the therapeutic communication techniques you use when interacting with your patient. BS

\* End-of-Program Student Learning Outcomes

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! BS

Week 6- 3f- Nice job sharing your thoughts and observations regarding the time you were able to spend at Stein Hospice/Hospice of the Western Reserve. As you discussed, family dynamics come into play with end-of-life decisions. Things are fine when everyone is on the same page, but can get ugly when there are differences. BS

Week 7-3(f) Satisfactory completion of your CDG for the Erie County Health Department Detox Unit. 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. <b>(responding)</b>		NA	S	S	NA	S	NA			
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. <b>(responding, reflecting)</b>		NA	S	S	NA	S	NA			
c. Identify the major classification of psychotropic medications. <b>(interpreting)</b>		NA	S	S	NA	S	NA			
d. Identify common barriers to maintaining medication compliance. <b>(reflecting)</b>		NA	S	S	NA	S	NA			
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. <b>(responding, reflecting)</b>		NA	S	S	NA	S	NA			
Faculty Initials		RH	BS	BS	BS	BS	BL			

**Comments:**

Week 3- 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 effects, adverse effects, nursing interventions and safety issues, 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 4- 4a,b,c,e- Nice job administering medications this week in the psychiatric department. Medication classifications were determined, uses and implications were discussed, as were side-effects, appropriate nursing interventions, and important safety implications related to the use of psychotropic medications. 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. <b>(noticing, interpreting)</b>		NA	NA	NA	NA	NA	S			
b. Discuss recommendations for referrals to appropriate community resources and agencies. <b>(reflecting)</b>		NA	NA	NA	NA S	NA S	S			
c. Attend Erie County Health Department Detox Unit observing the care of a patient with mental illness-substance abuse. <b>(Community Agency Observation-Detox Unit)</b>		NA	NA	NA	NA	NA	S			
d. Attend Narcotics/Alcoholics Anonymous meeting. <b>(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation))</b>		NA	NA	NA	S	NA	NA			
Faculty Initials		RH	BS	BS	BS	BS	BL			

### Comments:

Week 4- 5b- You identified a mental health resource in your CDG this week, The National Alliance on Mental Illness. BS

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

Week 6- 5b- It certainly sounds as if you were able to gain a better understanding/perspective of the services offered at hospice. BS

Week 7-5(a-c) Great job attending the Erie County Health Department Detox Unit and satisfactorily completing your CDG for the experience. BL

\* End-of-Program Student Learning Outcomes

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

**Comments:**

Week 4- 5b- You identified a mental health resource in your CDG this week, The National Alliance on Mental Illness, that could benefit your patient. BS

\* End-of-Program Student Learning Outcomes

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

### Comments:

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

Week 4- 7d- Professional behavior observed at all times while on the clinical floor. BS

Firelands Regional Medical Center School of Nursing  
Nursing Care Map Rubric

Student Name: <b>Sela Berry</b>		Course Objective: <b>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.</b>					
Date or Clinical Week: <b>Week 4</b>							
Criteria		3	2	1	0	Points Earned	Comments
<b>Noticing</b>	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	Nice work identifying all subjective and objective abnormal assessment findings, lab values and diagnostics, and relevant 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	
<b>Interpreting</b>	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Nice job identifying nursing priorities and correlating it to assessment data. Nice job also of identifying potential complications and their associated symptoms.
	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	
<b>Responding</b>	8. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Nice job with interventions. I would suggest adding an education intervention or two.
	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	Good, complete evaluation.
	14. Evaluation includes one of the following statements: <ul style="list-style-type: none"> <li>Continue plan of care</li> <li>Modify plan of care</li> <li>Terminate plan of care</li> </ul>	Complete			Not complete	3	
<p>Total Possible Points= 42 points  42-33 points = Satisfactory  32-21 points = Needs Improvement*  &lt; 21 points = Unsatisfactory*  <b>*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.</b></p> <p>Faculty/Teaching Assistant Comments:</p>						<p><b>Total Points: 42/42</b>  <b>Satisfactory. BS</b></p> <p>Faculty/Teaching Assistant Initials:  <b>Great work Sela! BS</b></p>	

### Nursing Process Study

Criteria	Ratings				Points Earned
Criterion #1 Process Recording is organized and neatly completed	<b>5 Points</b> 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.	<b>5</b>
Criterion #2 Assessment	<b>7 Points</b> 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	5 Points 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	3 Point 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	0 Points Missing data in all 4 areas of assessment.	<b>7</b>

	on patient.	communication interaction with patient. Identifies the milieu and effects on patient.	communication interaction with patient. Identifies the milieu and effects on patient.		
Criterion #3 Mental Health Nursing Diagnosis (priority problem)	<b>8 Points</b> Identifies priority mental health problem (not a medical diagnosis) providing at least 5 potential complications.	<b>5 Points</b> Identifies Priority mental health problem provides at least 4 potential complications.	<b>3 Point</b> Identifies priority mental health problem provides at least 3 potential complications.	<b>0 Points</b> Does not provide priority mental health problem and/or less than 3 potential complications.	<b>8</b>
Criterion #4 Nursing Interventions	<b>10 Points</b> 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	<b>6 Points</b> 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.	<b>4 Point</b> 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.	<b>0 Points</b> Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.	<b>10</b>
Criterion #5 Process Recording	<b>15 Points</b> Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.	<b>10 Points</b> 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.	<b>5 Point</b> 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.	<b>0 Points</b> 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.	<b>15</b>
Criterion #6 Process Recording	<b>20 Points</b> 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.	<b>15 Points</b> 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.	<b>10 Point</b> 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.	<b>0 Points</b> Analysis not provided for each interaction	<b>20</b>
Criterion #7	<b>10 Points</b>	<b>6 Points</b>	<b>4 Points</b>	<b>0 Points</b>	<b>10</b>

Process Recording	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.	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.	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.	There was less than 5 interchanges between patient and student provided.	
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  &lt; 53 points= Unsatisfactory</p> <p>Faculty comments: Great work on your Nursing Process Study, Sela! Your responses were well thought out and thorough. Again, nice job!</p> <p><b>Sela Ward</b></p>				<p><b>Total Points:</b></p>	<p><b>100/100</b></p> <p><b>Faculty Initials: BS</b></p>

# Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S): Sela Berry (M), Keyara Schneider (A)

GROUP #: 1

SCENARIO: 1

OBSERVATION DATE/TIME(S): 7/5/2023 0800-0915

CLINICAL JUDGMENT	OBSERVATION NOTES
<p><b>COMPONENTS NOTICING: (1, 2, 5)*</b></p> <ul style="list-style-type: none"> <li>• Focused Observation:           E     A     D     B</li> <li>• Recognizing Deviations from   Expected Patterns:           E     A     D     B</li> <li>• Information Seeking:         E     A     D     B</li> </ul>	<p>Introduced self and role when entering the room. Focused observation on vital signs. Sought information on normal BP range. Noticed elevated BP of 150/74 due to anxiety.</p> <p>Focused observation on patient's mental status.</p> <p>Sought information related to signs of withdrawal. Noticed patient's refusal of alcohol use. Sought information related to last alcoholic drink.</p> <p>Noticed bruising and abrasions. Noticed mismatching socks.</p> <p>Sought information on home environment. Asked about brother's drinking in the home. Sought further information related to fall at home.</p> <p>Noticed recent loss and stressors. Noticed mild anxiety. Consider exploring alternative coping mechanisms when dealing with stress/loss,</p>
<p><b>INTERPRETING: (2, 4)*</b></p> <ul style="list-style-type: none"> <li>• Prioritizing Data:           E     A     D     B</li> <li>• Making Sense of Data:       E     A     D     B</li> </ul>	<p>Prioritized vital sign assessment. Prioritized CIWA scale assessment. Made sense of CIWA assessment score result of 3.</p> <p>Made sense of eMAR and CIWA protocol noting no need for medication assisted treatment (Ativan).</p> <p>Prioritized therapeutic communication based on substance use denial.</p> <p>Prioritized CAGE questionnaire based on patient discussion. Made sense of positive CAGE questionnaire.</p>

<p><b>RESPONDING: (1, 2, 3, 5)*</b></p> <ul style="list-style-type: none"> <li>• Calm, Confident Manner: E A D B</li> <li>• Clear Communication: E A D B</li> <li>• Well-Planned Intervention/ Flexibility: E A D B</li> <li>• Being Skillful: E A D B</li> </ul>	<p>Full set of vital signs obtained.</p> <p>CIWA assessment performed in full with teamwork and collaboration.</p> <p>Therapeutic communication provided related to recent loss. Discussed history of mental health and coping mechanisms. Assessed readiness to learn and participate based on mental status.</p> <p>CAGE questionnaire performed in full.</p> <p>Educated on services such as AA/NA. Therapeutic communication provided.</p> <p>Did not perform Brief Mental Status Evaluation in full. Asked orientation questions only.</p> <p>Only administered vitamin medications initially. Did not administer amitriptyline or metoprolol. Be sure to review the eMAR closely. Went back to obtain the remaining medications. Appropriate dosage calculation performed for metoprolol. (Discussed misunderstanding of MAR used and how to best interpret scheduled times during debriefing.)</p>
<p><b>REFLECTING: (6)*</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis: E A D B</li> <li>• Commitment to Improvement: E A D B</li> </ul>	<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><b>SUMMARY COMMENTS: * = Course Objectives</b></p> <p><b>Satisfactory completion of the simulation scenario is a score of “Developing” or higher in all areas of the rubric.</b></p> <p><b>E= Exemplary</b></p> <p><b>A= Accomplished</b></p> <p><b>D= Developing</b></p> <p><b>B= Beginning</b></p> <p><b>Objectives:</b></p> <ol style="list-style-type: none"> <li>1. <b>Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)*</b></li> <li>2. <b>Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)*</b></li> <li>3. <b>Determine appropriate medication administration steps utilizing the CIWA scale. (4)*</b></li> <li>4. <b>Provide patient with appropriate education on community support and resources. (5)*</b></li> </ol>	<p><b>Lasater Clinical Judgement Rubric Comments:</b></p> <p><b>Noticing:</b> 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><b>Interpreting:</b> Focuses on the most relevant and important data useful for explaining the patient’s condition. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse.</p> <p><b>Responding:</b> 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.</p> <p><b>Reflecting:</b> 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</p>

**\* Course Objectives**

evaluating weaknesses.

**Satisfactory completion of Mental Health simulation scenario. NS**

## Simulation Evaluations

<b><u>vSim Evaluation</u></b>  Performance Codes:  <b>S:</b> Satisfactory  <b>U:</b> 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)
	<b>Date:</b> 6/9/2023	<b>Date:</b> 6/23/2023	<b>Date:</b> 6/30/2023	<b>Date:</b> 7/5-6/2023	<b>Date:</b> 7/7/2023	<b>Date:</b> 7/21/2023
Evaluation	S	S	S	S	S	
Faculty Initials	RH	BS	BS	BS	BS	
Remediation: Date/Evaluation/Initials	N/A	NA	NA	NA	NA	

\* Course Objectives

**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: