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

Student: Laurel Sieger

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.

* 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	S	NA	S	NA	S	NA	NA	
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**		NA	NA	NA	S	NA	S	NA	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	S	S	S	NA	S	NA	NA	
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**		S	S	S	S	NA	S	NA	NA	
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**		S	S	S	S	NA	S	NA	NA	
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**		NA	NA	NA	NA	NA	S	NA	NA	
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**					S			NA	NA	
Faculty Initials		RH	KA	RH	RH	CB	KA			
Clinical Location		Detox	Artisans	Hospice	1S	No Clinical	1S			

* End-of-Program Student Learning Outcomes

Comments:

Week 3 – 1a & 1d – Laurel, you did a great job discussing substance use disorder and how it relates to mental health and other physical and environmental aspects regarding the patient's health. You explained the importance of community services such as the Sandusky Artisans Center as well as other types of group therapy that would be beneficial for patients with substance use disorder. KA

Week 5: 1(a)- You did a great job discussing your patient's pathophysiology of their diagnosis this week in your CDG. RH

Week 7 – 1a – Laurel, you were able to discuss your patient's diagnosis and the reason for her admission for the patient you cared for this week. KA

Week 7 – 1f – Laurel, you did a nice job developing a nursing therapy group for the inpatient psychiatric unit. The dice game related to anger management coping skills was an excellent idea and well received by the patient on the unit. Nice job! KA

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

Comments:

Week 5: 2(a, b)- You were able to compile a thorough health history of your patient as well as collected their labs and diagnostic testing related to their admission at 1 south. Great job. RH

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

Comments:

Week 3 – 3f – Laurel, you responded to all CDG questions with thoughtfulness and discussed some excellent points about addiction and recovery. Your responses were thorough and well-written. You supported your CDG post information with an appropriate reference and in-text citation.
KA

* End-of-Program Student Learning Outcomes

Week 4: 3(a, f)- Great job with your reflection journal. It seems like hospice was not all what you expected, and you got to experience some new things. I am glad you were able to talk with the wife while doing post-mortem care on her husband. She probably appreciated the distraction and your willingness to talk with her. RH
Week 5: 3(a, f)-Laurel, you did great with your CDG this week and answered all questions thoroughly with in depth discussion. You also did great with communicating with the patients this week on the unit. Keep up the good work! RH

Week 7 – 3 a, c, d – Laurel, you discussed your patient's lack of group participation and how she would benefit from one-on-one therapy. You also discussed your use of the therapeutic techniques of exploring, giving recognition, and offering self to communicate with you patient. KA
Week 7 – 3f –Laurel, you responded to all CDG questions related to your 1 South clinical experience. Your responses were brief and not expanded on. Your word count was less than 250 words for your CDG post. You did however support your response with a reference and in-text citation. Please be thoughtful of your work count in the future to ensure you receive a satisfactory for your CDG posts. KA

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

Comments:

Week 4: 4(a)- great job passing medications with your hospice nurse. RH

Week 5: 4(a, b, c, e)- great job with medication administration this week. You were able to look up all medications and discuss them with me as well as the patient. You were very informative to your patient about each of the medications. RH

* End-of-Program Student Learning Outcomes

Objective

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

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
a. Identify the need for the community resources-detox unit available to patients with a mental illness. **(noticing, interpreting)**		S	S	NA	NA	NA	S	NA	NA	
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**		S	S	S	S	NA	S	NA	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)**		S	NA	NA	NA	NA	S	NA	NA	
d. Attend Narcotics/ Alcoholics Anonymous meeting. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**		NA	S	NA	NA	NA	S	NA	NA	
Faculty Initials		RH	KA	RH	RH	CB	KA			

Comments:

Week 2: 5(b, c)- You attended the detox unit for observation this week. You turned in all appropriate paperwork as well as posted your clinical discussion group. RH

Week 3 – 5a, 5b, & 5d – Laurel, you did a great job discussing the importance of community resources like the Sandusky Artisans and how they help individuals with addiction find support through recovery. KA

* End-of-Program Student Learning Outcomes

Objective

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

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

Comments:

Week 5: 6(a-c)- You used the EHR to find information on your patient as well as used the EMAR to administer medication to your patient with little to no assistance. Great job. RH

Week 7 – 6c – Laurel, thank you for sharing the hotline number to the Genesis House you researched this week. KA

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

Comments:

One strength would be communicating with clinical staff to figure out resources that are available for patients in different situations, for example pregnant patients and what facilities are available for them. How were you able to communicate these findings to the patients? RH I could communicate these findings to the patients verbally or with written information, even brochures if available. KA

Week 4: 7(c)- Great job with your reflection journal this week. The way you described your experiences and how it will impact your nursing care is awesome. Your change in view of all hospice does allows you to use hospice as a referral to your patients in your future practice as well. RH

Week 5: 7(c)- You were a very active participant in debriefing this week and you reflected on your experience on 1 south. You were also able to provide some improvements or changes you will incorporate for your next clinical. RH

Week 7 – 7e – Clinical evaluation tool submitted after due date and time. Please remember to submit all clinical evaluation tools by Saturday at 2200. Please make sure to write a goal on how you will prevent receiving a U in this competency in the future. KA In the future I will double check to make sure all work is turned in, I will make a

check list to be sure that it gets done. I'm sorry this happened I had completed it and had submitted other things to my drop box and this was supposed to get submitted along with those.

Week 8: I'm sorry that my tool was once again late, I believe there was a glitch in my internet. I will double check in the future that the tool was successfully submitted.

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Laurel Seiger				**Course Objective:**			
Date or Clinical Week: Week 7							
Criteria		**3**	**2**	**1**	**0**	**Points Earned**	**Comments**
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	**(lists at least 7*) *provides explanation if < 7**	**(lists 5-6)**	**(lists 5-7 but no specific patient data included)**	**(lists < 5 or gives no explanation)**	2	Laurel you did a nice job completing the noticing section and identifying assessment findings, lab findings, and risk factors for your assigned patient. I know the assessment section was difficult related to your patient having a medical assessment that was WNL. What are your thoughts about isolation or pacing? I know she spent a lot of time in her room as well as she would sometimes be walking around a lot. What type of affect do you think she had? Also, did she have an anxiety or depression score? The lab section was well done. Your risk factors section was good and my only suggestion would be to include her not maintaining her medication regimen. KA
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Laurel, you did a nice job identifying all the nursing priorities for your patient and selecting the priority with the highest importance. You were able to identify 3 complications for the nursing priority and associated signs and symptoms for each. When highlighting pertinent data what are your thoughts about highlighting delusions, hearing God, and life stressors? KA
	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	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	

	to monitor for each complication.						
Responding	8. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	Laurel, you did nice job writing nursing interventions for your nursing priority. The only interventions that need to be added are Assess patient's safety q15 minutes, assess patient mood and signs and symptoms of mania, and encourage patient to attend group therapy daily.
	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	Laurel, you did a nice job reevaluating the patient's assessment data and noting you would continue your plan of care. KA
	14. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

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.**

Faculty/Teaching Assistant Comments: **Laurel, you did a nice job satisfactorily completing your care map. Please see comments above for area you can improve on. KA**

Total Points: **39/42**

Faculty/Teaching Assistant Initials: KA

Geriatric Assessment Rubric
2023

Student Name: _Laurel Seiger_ Date: __6/26/2023____

Clinical Assessment Rubric

Mental/Physical Health Status Assessment

	Points Possible	Points Received
Physical Assessment – A few minor sections not fully answered.	4	3
Geriatric Depression Scale (short form) Assessment	4	4
Short Portable mental status questionnaire	4	4
Geriatric Health Questionnaire	2	2
Time and change test	4	4
Cognitive Assessment (Clock Drawing)	4	4
Falls Risk Assessment (Get Up and Go)	4	4
Brief Pain inventory (Short form)	2	2
Nutrition Assessment (Determine Your Nutritional Health) – Did not total score.	4	2
Instrumental ADL/ Index of Independence in ADL	4	4
Medication Assessment – Medications on the BEERS List not identified on medication list.	4	3
Points	40	36

Education Assessment

	Points Possible	Points Received
Learning Needs Identified and Prioritized (3)	10	10
Priorities pertinent to learning needs (3)	5	5
Nursing interventions related to learning needs (5)	10	10
Points	25	25

Education Plan

	Points Possible	Points Received

Education Prioritization and Barriers to Education	5	5
Teaching Content and Methods used for Education	10	10
Evaluation of Education Plan	10	10
Education Resources attached	10	10
Points	35	35

Total Points _96/100_____

Laurel, you satisfactorily completed your Geriatric Assessment. Overall you you did a nice job completing all areas of the assessment. See comments above on areas for improvement. Terrific job! KA

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

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	S	S	
Faculty Initials	RH	RH	RH	CB	CB	
Remediation: Date/Evaluation/Initials	N/A	N/A	N/A	NA	NA	

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

STUDENT NAME(S): N. Doughty (A), J. Peterman (A), L. Seiger (M)
GROUP #: 7
SCENARIO: Alcohol/Substance Abuse Scenario
OBSERVATION DATE/TIME(S): 7/6/2023 1040-1155

CLINICAL JUDGMENT	OBSERVATION NOTES
COMPONENTS NOTICING: (1, 2, 5)* • Focused Observation: E **A** D B • Recognizing Deviations from Expected Patterns: E **A** D B • Information Seeking: **E** A D B	Introduced self when entering the room. Remember to identify patient. Focused observation on vital signs. Sought information on normal BP range. Noticed elevated BP of 152/76. Notices bruising. Asks how patient is doing emotionally. Recognized the need for education. Seeks information through CAGE questioning and CIWA assessment. Introduced self/role and identifies patient upon entering the room. Focused observation on vital signs. Sought information about patient's normal B- 156/85. Notices patient itching. Patient verbalizes she sees spiders. Need for CIWA score determined. Patient asks for a beer. Patient is questioned about daily consumption. Patient attempts to get nurses to call the doctor to get her a beer.
INTERPRETING: (2, 4)* • Prioritizing Data: E **A** D B • Making Sense of Data: E **A** D B	BP interpreted to be elevated, all other VS all WNL. Patients mood interpreted to be depressed. Prioritizes need for CAGE questionnaire. Prioritized need for CIWA assessment, score of 1. CIWA score determined to be 25.
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	Explains the SBP is elevated, DBP normal. Inquires about how bruises feel. Discussion with patient about her mood (loss of friend). Performs CAGE questionnaire and questions patient about drinking routine/preferences. Performs CIWA scale assessment appropriately with a score of 1.

	Medications prepared, patient identified. Medications explained, patient denies depression. Med nurse questions patient about recent loss. Amitriptyline, vitamins, metoprolol. Medications administered. Patient educated on coping mechanisms. Resources from chart provided to patient. Nice job discussing THC, alcohol use. Great job with therapeutic communication. CIWA score assessed appropriately. Lorazepam prepared, patient identified, and medication administered. Asks patient about lost friend. Good job explaining symptoms of alcohol withdrawal and offering alternatives to patient. GI system assessed due to gastritis.
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)*** 3. **Determine appropriate medication administration steps utilizing the CIWA scale. (4)***	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: 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. Shows mastery of necessary nursing skills. Reflecting: Evaluates and analyzes personal clinical performance with minimal prompting primarily about major events or decisions; key decision points are identified, and alternatives are considered. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates

4. Provide patient with appropriate education on community support and resources. (5)* *** Course Objectives** **You are satisfactory for this scenario. Nice work! BS**	nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses

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: