

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

**Student:**

Ashley Huntley

**Final Grade: Satisfactory**

**Semester: Summer Session**

**Date of Completion: 7/24/23**

**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:**

K. Ammanniti MSN, RN, CHSE

**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
<b>Competencies:</b>		S	S	S	S	NA	S	NA	NA	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>		S	S	S	S	NA	S	NA	NA	S
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. <b>(interpreting)</b>		S	S	NA	S	NA	S	NA	NA	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>		S	S	S	S	NA	S	NA	NA	S
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care <b>(noticing)</b>		S	S	S	S	NA	S	NA	NA	S
e. Recognize social determinants of health and the relationship to mental health. <b>(reflecting)</b>		S	S	S	S	NA	S	NA	NA	S
f. Develop and implement an appropriate nursing therapy group activity. <b>(responding)</b>		NA	S	NA	NA	NA	NA	NA	NA	S
g. Develop a geriatric physical/mental health assessment and education plan. <b>(Geriatric Assessment) (responding)</b>					S NA			S	NA	
Faculty Initials		BS	RH	RH	NS	BS	NS	KA	KA	KA
Clinical Location		1 SOUTH	1 SOUTH	Sandusky Artisans Recovery Center	Hospice/ NPS	NA/Sim.	Detox Alternative Assignment	NA/ GA	NA	

\* 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 (f)- your nursing therapy group activity was well received and the patients enjoyed it. Good job keeping them all interesting and getting some patients to share their thoughts and feelings. RH

Week 4: 1(a)- You discussed a lot of environmental influences that could cause a patient to want to start using substances and how that impacted them or how they avoided those environments in your discussion post. RH

Week 7 - Satisfactorily completed all components of the alternate assignment for the Erie County Community Health Center Detox Facility clinical experience. The entire vSim module for Andrew Davis; the pre-test, scenario, post-test, documentation assignment, and guided reflection questions were all completed appropriately. Nice work! BS

Week 8 – 1g – You satisfactorily completed your geriatric assessment. Please see comments on the rubric for details. KA

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

### Comments:

Week 2- 2a,b- Good job discussing your patient's medical and psychiatric history. You also provided reasons and circumstances surrounding her current admission. BS

Week 3: 2(b, c, d)- You completed a care map this week that showed detailed thought process in identifying labs/diagnostic testing and relating it to your patient's diagnosis. You also looked at their coping mechanisms and had great interactions with your patient this week. RH

\* End-of-Program Student Learning Outcomes

<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>		S	S	S	S	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. <b>(responding)</b>		S	S	NA	S	NA	S	NA	NA	S
c. Identify barriers to effective communication. <b>(noticing, interpreting)</b>		S	S	S	S	NA	S	NA	NA	S
d. Construct effective therapeutic responses. <b>(responding)</b>		S	S	S	S	NA	S	NA	NA	S
e. Construct a satisfactory patient-nurse therapeutic communication. <b>(Nursing Process Study) (responding, reflecting)</b>					S			NA	NA	S
f. Posts respectfully and appropriately in clinical discussion groups. <b>(responding, reflecting)</b>		S	S	S NI	NA	NA	NA S	NA	NA	S
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. <b>(responding)</b>		S	S	S	S	NA	S	NA	NA	S
h. Teach patient/family based on readiness to learn and patient needs. <b>(responding, reflecting)</b>		S	S	NA	S	NA	S	NA	NA	S
Faculty Initials		BS	RH	RH	NS	BS	NS	KA	KA	KA

**Comments:**

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

Week 3: 3(d)- You did a great job having therapeutic interactions with your patient this week! RH

Week 4: 3(f)- Please refer to the guidelines of the CDG each week and ensure you are following all directions. Some of your answers were within the word count but some of them were significantly under the requirement. RH

\* End-of-Program Student Learning Outcomes

Week 5 3(e) – Excellent work with your nursing process recording assignment related to therapeutic communication. 90/100 points were received for a satisfactory evaluation. See comments provided throughout the document and on the attached grading rubric for more details. RH

Week 7 – 3f – Satisfactorily completed the reflection questions related to the Detox Alternative assignment based on the CDG rubric. NS

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

**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 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 3: 4(a, d, e)- Your medication administration was great this week. You were able to advocate for your patient requesting certain medications and then they were ordered. You observed the six rights of medication administration and documented appropriately. You were able to relate the medication to the disease process and educate the patient on what adverse reactions to watch for. RH

Week 5 4(a-e) – Nice job discussing the safety concerns related to medication administration in the hospice clinical rotation in your reflection assignment. 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. <b>(noticing, interpreting)</b>		S	S	S	NA	NA	S	NA	NA	S
b. Discuss recommendations for referrals to appropriate community resources and agencies. <b>(reflecting)</b>		S	S	S	S	NA	S	NA	NA	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	<del>NA</del> S	NA	NA	S
d. Attend Narcotics/Alcoholics Anonymous meeting. <b>(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation))</b>		NA	NA	S	NA	NA	NA	NA	NA	S
Faculty Initials		BS	RH	RH	NS	BS	NS	KA	KA	KA

### Comments:

Week 7- 5c- Satisfactorily completed all components of the alternate assignment for the Erie County Community Health Center Detox Facility clinical experience. The entire vSim module for Andrew Davis; the pre-test, scenario, post-test, documentation assignment, and guided reflection questions were all completed appropriately. Nice work! BS

\* End-of-Program Student Learning Outcomes

**Objective**

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

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

**Comments:**

Week 3: 6(a, b, c)-You did great documenting on your nursing therapy group activity this week. You also were able to look in the electronic chart as well as hard copy of the chart for information for your care map. 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. <b>(reflecting)</b>		S	S	S	S	NA	S	NA	NA	S
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>		S	S	S	S	NA	S	NA	NA	S
c. Illustrate active engagement in self-reflection and debriefing. <b>(reflecting)</b>		S	S	S	S	NA	S	NA	NA	S
d. Incorporate the core values of caring, diversity, excellence, integrity, and “ACE” – attitude, commitment, and enthusiasm during all clinical interactions. <b>(responding)</b>		S	S		S	NA	S	NA	NA	S
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. <b>(responding)</b>		S	S	S	S	NA	S	NA	NA	S
f. Comply with the standards outlined in the FRMCSN policy, “Student Conduct While Providing Nursing Care.” <b>(responding)</b>		S	S	S	S	NA	S	NA	NA	S
Faculty Initials		BS	RH	RH	NS	BS	NS	KA	KA	KA

**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 3: 7(c)- You did a great job comparing the environment in the unit on Thursday vs. Friday while in debriefing. You also pulled information from the text to relate to how many patient with a psychiatric diagnosis had childhood trauma of some sort. Way to start connecting the dots! 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

Final – Ashley, you have satisfactorily completed the clinical portion of the Psychiatric Nursing course. You have worked on developing your mental health assessment skills and therapeutic communication skills throughout the semester. You have had a multitude of experiences related to many different mental health populations this semester. Keep up the nice work as you continue on into next semester. KA



Firelands Regional Medical Center School of Nursing  
Nursing Care Map Rubric

Student Name: <b>Ashley H</b>		Course Objective:					
Date or Clinical Week: <b>1 South; day 3</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	
	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	Good use of direct quotes in your signs and symptoms to monitor for 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	
<b>Responding</b>	8. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	Very thorough interventions. What about safety checks on your patient?
	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. 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>  Satisfactory</p> <p>Faculty/Teaching Assistant Initials: RH</p>	

### Nursing Process Study

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

Criterion #6 Process Recording	20 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic) and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) and example from interactions.	15 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) and no example from interactions provided.	10 Point Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), no technique (exploring, focusing, reflecting, formulating a plan of action, etc.) and/or no example from interactions provided.	0 Points Analysis not provided for each interaction	20
Criterion #7 Process Recording	10 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 10 interchanges between patient and student.	6 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 7 interchanges between patient and student.	4 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 5 interchanges between patient and student.	0 Points There was less than 5 interchanges between patient and student provided.	0
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 style="text-align: right;"><b>Total Points:</b></p>					90
<p>Faculty comments: You did a good job with your nursing process. You lost points due to the conversation not having a logical flow and no real beginning or ending. It felt as if there were parts of the conversation missing and it did not make sense.</p> <p style="text-align: right;"><b>Faculty Initials:</b></p>					S
					RH

Geriatric Assessment Rubric  
2023

Student Name: Ashely Huntley

Date: 7/21/23

**Clinical Assessment Rubric**

**Mental/Physical Health Status Assessment**

	Points Possible	Points Received
Physical Assessment	4	4
Geriatric Depression Scale (short form) Assessment	4	4
Short Portable mental status questionnaire	4	3
Geriatric Health Questionnaire	2	2
Time and change test	4	4
Cognitive Assessment (Clock Drawing)	4	4
Falls Risk Assessment (Get Up and Go)	4	4
Brief Pain inventory (Short form)	2	2
Nutrition Assessment (Determine Your Nutritional Health)	4	4
Instrumental ADL/ Index of Independence in ADL	4	4
Medication Assessment	4	4
Points	40	39

**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 99/100

Great job! Points were lost due to not having a final score on the short mental questionnaire. RH

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

<b>vSim Evaluation</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	S
Faculty Initials	BS	RH	NS	BS	BS	KA
<b>Remediation:</b> Date/Evaluation/Initials	NA	N/A	NA	NA	NS	NA

\* Course Objectives

# Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S): Ashley Huntly (A), Jade Ward (M)

GROUP #: 1

SCENARIO: 2

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     <b>A</b>     D     B</li> <li>• Recognizing Deviations from   Expected Patterns:           E     <b>A</b>     D     B</li> <li>• Information Seeking:         E     <b>A</b>     D     B</li> </ul>	<p>Introduced self and role when entering the room. Focused observation on patient's mental status and orientation. Focused observation on vital signs.</p> <p>Noticed bruises and abrasions.</p> <p>Noticed tremors. Noticed increased anxiety. Noticed BP 154/78. Noticed diaphoresis. Noticed nervousness. Noticed itching. Noticed visual hallucinations. Noticed agitation.</p> <p>Explored further information related to refusal of available resources.</p> <p>Did not seek further information related to history of substance misuse.</p>
<p><b>INTERPRETING: (2, 4)*</b></p> <ul style="list-style-type: none"> <li>• Prioritizing Data:            <b>E</b>     A     D     B</li> <li>• Making Sense of Data:        <b>E</b>     A     D     B</li> </ul>	<p>Prioritized vital sign assessment. Made sense of elevated BP due to anxiety and potential withdrawal symptoms.</p> <p>Prioritized CIWA assessment.</p> <p>Made sense of CIWA assessment interpreting score of 22.</p> <p>Prioritized focused physical respiratory assessment prior to administering a CNS depressant medication.</p> <p>Interpreted rationale for Ativan administration. Appropriate dosage administered calculated based on protocol (4mg).</p>
<p><b>RESPONDING: (1, 2, 3, 5)*</b></p> <ul style="list-style-type: none"> <li>• Calm, Confident Manner:     E     <b>A</b>     D     B</li> <li>• Clear Communication:        E     <b>A</b>     D     B</li> <li>• Well-Planned Intervention/   Flexibility:                    E     <b>A</b>     D     B</li> <li>• Being Skillful:                E     <b>A</b>     D     B</li> </ul>	<p>CIWA assessment performed in full</p> <p>Neuro assessment performed to determine orientation.</p> <p>Focused assessments performed prior to medication administration.</p> <p>Discussed participation in group therapy activities.</p> <p>Teamwork and collaboration to determine appropriate CIWA score and Ativan dose per protocol (4mg).</p> <p>Educated on Ativan administration for anxiety.</p>

	<p>Provided education on support groups and encouraged patient to participate.</p> <p>Did not perform Brief mental health evaluation.</p>
<p><b>REFLECTING: (6)*</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis: E    <b>A</b>    D    B</li> <li>• Commitment to Improvement: E    <b>A</b>    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><b>1. Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)*</b></li> <li><b>2. Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)*</b></li> <li><b>3. Determine appropriate medication administration steps utilizing the CIWA scale. (4)*</b></li> <li><b>4. Provide patient with appropriate education on community support and resources. (5)*</b></li> </ol> <p><b>* Course Objectives</b></p> <p><b>You are satisfactory for this scenario. NS</b></p>	<p><b>Lasater Clinical Judgement Rubric Comments:</b></p> <p><b>Noticing:</b> Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads.</p> <p><b>Interpreting:</b> Focuses on the most relevant and important data useful for explaining the patient’s condition. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient’s data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success.</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 evaluating weaknesses.</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:

none

Student eSignature & Date:

A handwritten signature in black ink, appearing to read "Ashley Hunter". The signature is written in a cursive, flowing style with a large loop at the end.

7/25/23