

EVALUATION OF CLINICAL PERFORMANCE TOOL
Psychiatric Nursing- 2024
Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student:

Dylan Wilson

Final Grade: Satisfactory/Unsatisfactory

Semester: Summer Session

Date of Completion:

Faculty: Chandra Barnes MSN, RN, Fran Brennan MSN, RN, Monica Dunbar, DNP, RN
 Brittany Lombardi MSN, RN, CNE, Heather Schwerer, MSN, 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 in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, U, or NA". 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, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. 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
- 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)
6/4/2024	2	EBP article assignment	6/5/2024 1400
6/15/2024	1	1 south clinical survey	
Initials	Faculty Name		
CB	Chandra Barnes, MSN, RN		
FB	Frances Brennan, MSN, RN		
MD	Monica Dunbar, DNP, RN		
BL	Brittany Lombardi MSN, RN, CNE		
HS	Heather Schwerer, MSN, RN		

* End-of-Program Student Learning Outcomes

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

Satisfactory (S): Safe, accurate each time, efficient, coordinated, confident, focuses on the patient, some expenditure of excess energy, within a reasonable time period, appropriate affective behavior, occasional supporting cues, minimal faculty feedback needed related to written clinical work.

UNSATISFACTORY CLINICAL PERFORMANCE

Needs Improvement (NI): Safe, accurate each time, skillful in parts of behavior, focuses more on the skill and self rather than the patient, inefficient, uncoordinated, anxious, worried, and flustered at times, expends excess energy within a delayed time period, frequent verbal and occasional physical directive cues in addition to supportive cues, faculty feedback required in several areas of clinical written work.

Unsatisfactory (U): Failure to achieve the course competency, safe but needs faculty reminders constantly, not always accurate, unskilled, inefficient, considerable expenditure of excess energy, anxious, disruptive or omitting behaviors, focus on skills and/or self, continuous verbal and frequent physical cues, unsafe, performs at risk to patient/clients/others, unable to function, incomplete, erroneous, faulty, illegible clinical written work, no feedback sought from faculty or response to feedback not evident in submitted written work. If the student does not self-rate a competency the competency is graded "U." A "U" in a competency must be addressed in writing by the student in the Evaluation of Clinical Performance tool. The student response must include how the competency has been or will be met at a satisfactory level. If the student does not address the "U," the faculty member (s) will continue to rate the competency unsatisfactory.

OTHER

Not Available (NA): The clinical experience which would meet the competency was not available.

Objective										
1. Apply the principles of psychiatric theory in the care of adolescent to geriatric patients with a mental illness diagnosis. (1, 2, 3, 5, 6, 7, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies:	NA	S	S	NA						
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. (noticing)	NA	S	S	NA						
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. (interpreting)	NA	S	S	NA						
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. (responding)	NA	S	S	NA						
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care (noticing)	NA	S	S	NA						
e. Recognize social determinants of health and the relationship to mental health. (reflecting)	NA	S	S	NA						
f. Develop and implement an appropriate nursing therapy group activity. (responding)	NA	S	S NA	NA						
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment) (responding)				S						
Faculty Initials	HS	CB	HS							
Clinical Location	No clinical	1 South	1 South	NA						

Comments:

* End-of-Program Student Learning Outcomes

Week 2(1a,b,e,f): Dylan, you did a great job this week in clinical, caring for patients diagnosed with a mental health disorder. Great explanation of social determinants of health related to your patient this week. You did an excellent job, planning an preparing an appropriate nursing therapy group activity for the patients of the milieu. CB

Week 3 (1a,b,c,d,e) You did a nice job this week identifying how mental health can be impacted by an individual's physical health, and also the environment in which they are a part of. You were also able to see how the spiritual component played a role in some of the patient's well-being. Nice job discussing the social determinants of health that impacted many of the patients this week. HS

(1f) I changed this competency to NA because you did not conduct a nursing therapy group this week. HS

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:	NA	S	S	NA						
a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. (noticing)	NA	S	S	NA						
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. (noticing, recognizing)	NA	S	S	NA						
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. (noticing, interpreting)	NA	S	S	NA						
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting)*	NA	NA S	S NI	NA						
e. Apply the principles of asepsis and standard precautions. (responding)	NA	S	S	NA						
f. Practice use of standardized EBP tools that support safety and quality. (noticing, responding)	NA	S	S	NA						
Faculty Initials	HS	CB	HS							

*When completing the 1South Care Map CDG refer to the Care Map Rubric

Comments:

Week 2(2a,b,f): Great job this week in the clinical, researching and discussing your patient's mental health and medical history. You were able to research and talk about an EBP article titled "Treatment patterns and sequences of pharmacotherapy for patients diagnosed with depression in the United States." related to mental health during clinical debriefing. I changed competency 2d to "S", although you did not create care map, you are always formulating a plan of care on your patients. CB

Week 3 (2a,b,c)-You were able to obtain a health history along with the mental health issues impacting your patient. You were also able to use both subjective and objective findings to assist in developing a plan of care for the patient. HS
(2d)- I changed this to a NI because you did not include an intext citation, and received an overall evaluation of needs improvement based on the total rubric score for the nursing care map. Please refer to the comments within the nursing care map rubric for suggestions on how to correct the missing information prior to resubmitting the nursing care map with the necessary revisions. HS

* End-of-Program Student Learning Outcomes

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

Comments:

Week 2(3a,c,d,f): Dylan, you did a great job with therapeutic communication this week. You completed day 1 and 2 cdgs Satisfactorily, meeting all requirements. CB

Week 3 (3a,c,d,f)- You did a nice job using therapeutic communication skills when interacting with the patients. You did not meet the requirements for the day 3 CDG resulting in a needs improvement evaluation. The day 4 CDG you met the requirements for the posting however, your in-text citation and the reference is not in APA format,

* End-of-Program Student Learning Outcomes

please refer to Purdue Owl for tips and or in Edvance under clinical resources, APA formatting. You can also reach out to faculty or seek assistance from Libby Kyle in the library. HS

Week 3- I will spend more time using Purdue owl to practice for future in text citations, or reach out to staff members to help.

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. Observe &/or administer medication while observing the six rights of medication administration. (responding)	NA	S	S	NA						
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. (responding, reflecting)	NA	S	S	NA						
c. Identify the major classification of psychotropic medications. (interpreting)	NA	S	S	NA						
d. Identify common barriers to maintaining medication compliance. (reflecting)	NA	S	S	NA						
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. (responding, reflecting)	NA	S	S	NA						
Faculty Initials	HS	CB	HS							

Comments:

Week 2(4a-e): Great job this week administering medications following the six rights of medication administration. You were able to research the prescribed medications for your patient, and discuss implications for use, side effects, classification, related interventions and safety issues. CB

Week 3 (4a-e)- You did a nice job this week administering medications. You followed the six rights of medication administration. You were able to discuss each prescribed medication for your patient, the indication for use, side effects, classification, related interventions and safety issues to monitor for. HS

* End-of-Program Student Learning Outcomes

Objective

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

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

****Alternative Assignment**

Comments:

Week 2(5b): You were able to discuss and observe discussion related to resources in the community to help patients with mental health disorders, therefore competency 5b was changed to a "S". CB

Week 3 (5a,b)- You were able to discuss the community resources that are available to those individuals in need within the community. HS

* End-of-Program Student Learning Outcomes

* End-of-Program Student Learning Outcomes

* End-of-Program Student Learning Outcomes

Objective

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

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

Comments:

Week 2(6a-c): Great job this week documenting medications given in the EMAR. You were able to document on all patients after completion of your nursing group therapy. CB

Week 3 (6a,b)- You were able to successfully navigate the electronic health record in order to obtain the information you needed. You were also able to document medication administration. HS

* 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)	NA	S	S	NA						
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care. (responding)	NA	S	S	NA						
c. Illustrate active engagement in self-reflection and debriefing. (reflecting)	NA	S	S	NA						
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE" – attitude, commitment, and enthusiasm during all clinical interactions. (responding)	NA	S	S	NA						
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (responding)	NA	S U	S	NA						
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." (responding)	NA	S	S	NA						
Faculty Initials	HS	CB	HS							

Objective 7a: Provide a comment for the highlighted competency each week of your 1 South clinical. Put "NA" for the weeks not assigned to 1 South.

Comments:

Week 2- My strength this week was getting comfortable around the patients in 1S. Being a new environment and having to learn what you can and cannot do/say was a struggle during day 1, but by day 2 I felt more understanding about what 1S was about. At first I wasn't sure if we could even sit next to the patients, but by the end of the day all the students were confidently playing games and talking to the patients.

Week 2(7a,b,e): Good job this week in clinical. I would say that was a strength for you and you were engaged with the patients, being active and communicating. You did a good job ensuring a culture of safety, and were able to discuss some of those in your cdg. 7E was changed to an "U" because you did not have your EBP article presentation prepared on the correct day. Please make sure you address this "U". "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. CB

7E- Day 2 of week 2 I presented by article in full during debriefing proving it to be satisfactory. I will continue to double check all needed information before going to my next clinicals by using my calendar. HS

Week 3 Strength- My strength this week on 1S was using better communication techniques appropriately. I felt more knowledgeable knowing how to address the patient concerns or problems with a more therapeutic technique such as, exploring ideas, active listening, and using SOLER. You did a nice job effectively communicating with several of the patients this week in clinical. HS

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/15/2024	Ineffective Coping	NI/HS	

Care Map Evaluation Tool**
Psych
2024

**Psych students are required to submit one satisfactory care map (CDG) during the 4-day 1 South clinical rotation. If the care map is not evaluated as satisfactory upon initial submission, the student has one opportunity to revise the care map based on instructor feedback.

Comments: You did not include an in-text citation on the care map which is a requirement. You also did not meet a total score of 35 to be considered satisfactory on the rubric for the total points, and therefore revisions must be completed prior to resubmission. Please add an in-text citation and read the comments within the rubric to make additional corrections to become satisfactory for the care map assignment. Please reach out for any questions or concerns regarding this assignment. HS

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Dylan Wilson		Course Objective:					
Date or Clinical Week: 6/15/2024							
Criteria		3	2	1	0	Points Earned	Comments
Noticing	1. Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	3	Nice job! You included a thorough list of abnormal assessment findings, abnormal lab findings, and risk factors. HS
	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	2	You listed 4 appropriate nursing priorities however, since the patient had a history of schizo-affective disorder and was homeless there are other nursing priorities that could also apply to the patient. You set an appropriate goal. You identified 3 potential complications and included signs and symptoms to monitor the patient for. HS
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. 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	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Respo	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	The list of nursing interventions is not thorough. Remember to assess, do, and educate in the interventions. Think specifically about the patient and how you
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	2	

n d i n	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete	2	

plan to assist in meeting the goal. Were there any medications ordered to assist with his abnormal assessment findings, that may impact his mood and ultimately assist with his ability to cope. You stated

Criteria		3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	0	The rationale does not state why you plan to perform each specific intervention or why that intervention is imperative to the plan of care. For example, why are you going to determine the use of defense mechanisms for this patient? You would state something such as: to determine if the patient is using maladaptive coping mechanisms which can negatively impact decision making.
R e f l e c t i n g	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	1	You did not reassess the abnormal findings from the noticing/recognizing portion of the care map, if they are unchanged you put the unchanged information in the evaluation if there is new or different information you would put that there as well. You did not state if the care plan should be continued, modified, or terminated.
	15. Evaluation includes one of the following statements: <ul style="list-style-type: none"> Continue plan of care Modify plan of care Terminate plan of care 	Complete			Not complete	0	

Reference

An in-text citation and reference are required.

The care map will be graded “needs improvement” if missing either the in-text citation or reference, but not both.

The care map will be graded “unsatisfactory” if no in-text citation or reference is included.

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

*****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. *****

Faculty/Teaching Assistant Comments:

Total Points:33/45 Needs Improvement

Faculty/Teaching Assistant Initials: HS

You did a nice job in the noticing/recognizing cues, and interpreting sections of the care map. You need to review the responding and reflecting section of the care map. Please refer to the care map guidelines and utilize skyscape and the Psychiatric Nursing Pocket Guide to assist you in completing those areas. You did not include an intext citation within the care map, this is a requirement you must add that

Geriatric Assessment Rubric
2024

Student Name: _____

Date: _____

Clinical Assessment Rubric

Mental/Physical Health Status Assessment

	Points Possible	Points Received
Physical Assessment	4	
Geriatric Depression Scale (short form) Assessment	4	
Short Portable mental status questionnaire	4	
Geriatric Health Questionnaire	2	
Time and change test	4	
Cognitive Assessment (Clock Drawing)	4	
Falls Risk Assessment (Get Up and Go)	4	
Brief Pain inventory (Short form)	2	
Nutrition Assessment (Determine Your Nutritional Health)	4	

Instrumental ADL/ Index of Independence in ADL	4	
Medication Assessment	4	
Points	40	

Education Assessment

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

Education Plan

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

Total Points _____

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
Nursing Process Grading Rubric- Psychiatric Nursing 2024

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.	
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.	
Criterion #3 Mental Health Nursing Diagnosis	8 Points Identifies priority mental health problem (not a medical diagnosis) providing at least 5	5 Points Identifies Priority mental health problem provides at least 4 relevant/related	3 Point Identifies priority mental health problem provides at least 3 relevant/related	0 Points Does not provide priority mental health problem and/or less	

(priority problem)	relevant/related data and potential complications.	data and potential complications.	data and potential complications.	than 3 relevant/related data and potential complications.	
Criterion #4 Nursing Interventions	10 Points Identifies at least 5 pertinent nursing interventions 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.	
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.	
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.) Provides explanation of at least 75% of 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.) Provides explanation of at least 50% of interactions.	10 Point Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), no technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 25% of interactions.	0 Points Analysis not provided for each interaction	
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.	

Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2024
Simulation Evaluations

<p><u>vSim Evaluation</u></p> <p>Performance Codes:</p> <p>S: Satisfactory</p> <p>U: Unsatisfactory</p>	<p>Linda Waterfall (Anxiety/Cultural Scenario) (*1,2,3,4,5)</p>	<p>Sharon Cole (Bipolar Scenario) (*1,2,3,4,5)</p>	<p>Li Na Chen Part 1 (Major Depressive Disorder) (*1,2,3,4,5)</p>	<p>Li Na Chen Part 2 (Major Depressive Disorder) (*1,2,3,4,5)</p>	<p>Live Adult Mental Health Simulation (Alcohol Withdrawal) (*1,2,3,4,5)</p>	<p>Sandra Littlefield (Borderline Personality Disorder Scenario) (*1,2,3,4,5)</p>	<p>George Palo (Alzheimer's Disorder) (*1,2,3,4,5)</p>	<p>Randy Adams (PTSD Scenario) (*1,2,3,4,5)</p>
	<p>Date: 6/7/2024</p>	<p>Date: 6/14/2024</p>	<p>Date: 6/21/2024</p>	<p>Date: 6/21/2024</p>	<p>Date: 6/26-27/2024</p>	<p>Date: 6/28/2024</p>	<p>Date: 7/5/2024</p>	<p>Date: 7/19/2024</p>
Evaluation	S	S						
Faculty Initials	CB	HS						
Remediation: Date/Evaluation/Initials	NA	NA						

* Course Objectives

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: