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

Student: Paige Knupke

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)
6/3/2024	1 hour	Late Therapy Group Submission	6/3/2024 1 hour

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.

* 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)**	N/A	S	N/A	S	S					
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	N/A	S	N/A	S	N/A					
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)**	N/A	S	N/A	S	S					
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	N/A	S	N/A	S	S					
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	N/A	S	N/A	S	S					
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	N/A	S	N/A	N/A	N/A					
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				N/A						
Faculty Initials	MD	MD	CB	MD	FB					
Clinical Location	NA	1 South	N/A	1 South	Sandusky Artisan's & Hospice					

Comments:

* End-of-Program Student Learning Outcomes

Week 2 Objective 1A and E-This week you were able to demonstrate an understanding for mental, physical, and environmental health along with recognizing SDOH with your responses in your CDG posting. Great job! MD

Week 2Objective 1F-This week you were able to perform an appropriate nursing therapy group activity to encourage the patients to share and express themselves. Great job! MD

Week 4 Psych 3 & 4 Objective 1B-D-This week you were able to correlated prescribed therapies and identify appropriate methods to assist with independence of the patient in your CDG! MD

Week 5 (1a,c,d)- Great job with understanding the relationship between substance abuse and how this effects mental health of an individual. You provided the correlation of mental illness and the assistance of group therapy to assist patients in regaining independence as they start their life of sobriety. Great job noticing the need for culture and spiritual needs of the patient during their last journey of life. FB

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

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

Comments:

Week 2 Objective 2A-B, and F-This week you did a great job of assembling a health history, identifying subjective and objective findings, and using EBP tools to support safety and quality in your CDG post. MD

Week 4 Psych 3 & 4 Care Map 2B, D-You did a great job identifying subjective and objective findings in your care map this week! You also were able to formulate a prioritized nursing plan of care in your care map! Great job! MD

Week 5 (2c,e,f)- Identification of coping strategies and defense mechanisms were provided as you interpreted the objectives and effect of the SARCC meeting. Good use of asepsis and evidenced-based practice skills as you cared for the hospice patients. FB

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

Comments:

Week 2 Objective 3C-This week you were able to identify barriers to effective communication in your CDG posting. MD

Week 2 Objective 3F-You had a wonderful CDG this week with response! You were able to turn in your CDG on time, have the adequate word count for your post, and meet all of the objectives for the CDG! You were able to provide appropriate reference and in-text citations for your postings. Great job! MD

Week 4 Psych 3 & 4 Objective 3A, C, D-This week you were able to illustrate professionally appropriate therapeutic communication, identify barriers to communication, and develop therapeutic responses in your CDG! MD

* End-of-Program Student Learning Outcomes

Week 4 Psych 3 & 4 Objective 3F-You had a wonderful CDG this week! You were able to turn in your CDG on time, have the adequate word count for your post, and meet all of the objectives for the CDG! MD
Week 4 NPS 3E-You successfully completed the Nursing Process Study with a satisfactory rating! MD

Week 5 (3a,f,g) Great use of therapeutic communication as cared for patients and families during your hospice clinical rotation. Your CDG was submitted in a timely manner following all expectations of the CDG rubric. You also did a great job respecting the privacy and dignity of the patient at the end of life. FB

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

Comments:

Week 2 Objective 4B-E-In your CDG post this week you were able to provide information about implications of psychotropic medications, classifications of medications, barriers to medication compliance, and specific details about the medications you administered this week. Great job! MD

Week 4 Psych 3 & 4 Objective 4A-This week you were able to administer medications to a patient on 1S. You were able to follow the appropriate process for safe administration of the medications. Great job! MD

* 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)**	N/A	N/A	N/A	N/A	N/A					
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	N/A	N/A	N/A	N/A	S					
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) ****	N/A	N/A	N/A	N/A	N/A					
d. Recognize and describe the need for substance abuse recovery resources. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**	N/A	N/A	N/A	N/A	S					
Faculty Initials	MD	MD	CB	MD	FB					

****Alternative Assignment Comments:**

Week 4 (5b,d)- Great job discussing the need and benefits for referrals to the SARCC community resource. You also recognize the need for this type of resource in the community and the great asset it is to have available. FB

* 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)**	N/A	S	N/A	S	N/A					
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. **(responding)**	N/A	N/A	N/A	N/A	N/A					
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	N/A	N/A	N/A	~~N/A~~ S	S					
Faculty Initials	MD	MD	CB	MD	FB					

Comments:

Week 2 Objective 6A-You were able to proficiently navigate the EHR independently. MD

Week 4 Psych 3 & 4 Objective 6C-This week you were able to demonstrate the use of technology to identify mental health resources in your CDG! MD

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

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:

7a: N/A

7a: A strength I had for care delivery was to make sure my patient was feeling okay every morning and every few hours and getting progressively better even though I just seen her for two days. I would ask her how she was doing and if she was feeling okay and have a therapeutic conversation if she wasn't, she did feel okay whenever I asked but made sure to let her know if she was feeling a way she could talk to me. The first day she told me she was doing okay but they second day she told me she was feeling better and finally had a good night's sleep. Wonderful! MD

Week 2 **Objective 7B-In your CDG this week you were able to identify effective use of strategies to reduce risk of harm for the patient and others. Great job! MD**

Week 2 Objective 7E-This week you did not turn in your preparation assignment for the nursing therapy group in on time. You received 1 hour missed clinical for this late assignment. Please respond with how you will prevent this from occurring in the future. MD

Week 3 7E: Moving forward I will check my syllabus and calander twice a week plus every Sunday to ensure I have everything turned in and done when it is due to confirm I am not missing anything or forgetting anything to prevent this from happening again. Paige, great plan to ensure that everything is turned in on time. Due to you not having clinical this week, the competency will be a "NA," then "S" the next time you are scheduled for clinical. CB
7a: N/A

7a: A strength I had this week was therapeutic communication. I had a deeper conversation with my patient this week than I had before. I got to know what was going on in her head and I got to analyze her and see the defense mechanisms that she was using and use the knowledge that we learned in class. I got to know what happened before she was admitted and what her thought process was on her sitatuion. Awesome! MD
Week 4 Psych 3 & 4 Objective 7B-This week you were able to demonstrate effective use of strategies to reduce risk of harm to self of others in your CDG! MD

7a: A strength I had for each clinical was identifying the need for the places I observed at. At Sandusky Artisans I had really noticed the importance of the group because from sitting back and listening to the stories being told, the individuals that went have said multiple times that the group alone has made them rethink relapsing and have beyond helped them on their journey, so that made me realize the importance of NA or AA. In hospice I had noticed and identified that that is a very special place. It is a lot more than "going there to just pass away." They provide amazing comfort and care to the patients at all times, and everyone worked together to give the patients and family everything they needed to feel comfortable and sort of at a home away from home. Overall, they were both eye opening and amazing experiences. Paige, both of these clinicals are great learning experiences. FB
Week 5 (7c,d,e) Great job Karli for being actively engaged, having a great attitude, committing to learn and behaving in a professional manner. FB

Care Map Evaluation Tool**
Psych
2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/21/2024	Ineffective Denial	Satisfactory/MD	NA

**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:

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Paige Knupke				**Course Objective:**			
Date or Clinical Week: 6/21/2024							
	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	All criteria met. MD
	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	All criteria met. MD
	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	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	All criteria met. MD
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	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**	3	

	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**	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	All criteria met. MD
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

Reference

An in-text citation and reference are required. Satisfactory MD

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: 45/45 Satisfactory MD

Faculty/Teaching Assistant Initials: MD

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.	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 relevant/related data and potential complications.	5 Points Identifies Priority mental health problem provides at least 4 relevant/related data and potential complications.	3 Point Identifies priority mental health problem provides at least 3 relevant/related data and potential complications.	0 Points Does not provide priority mental health problem and/or less than 3 relevant/related data and potential complications.	5
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.	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.	
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	15
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	6 Points Identify at least 2 barriers to communication including interventions or communication that could have been done	4 Point Identify at least 2 barriers to communication did not include interventions or communication that could have been done	0 Points Identify at least 1 barrier to communication did not include interventions or communication that	10

	social determinants of health.	differently. Identify all pertinent social determinants of health.	differently. Did not identify any pertinent social determinants of health.	could have been done differently. Did not identify any pertinent social determinants of health.	
Total Possible Points= 100 points 77-100 points= Satisfactory completion. 76-53 points= Needs Improvement < 53 points= Unsatisfactory Faculty comments: Criterion #3- You provided 1 nursing priority for this section. You need to list ALL nursing priorities related to this patient. MD Criterion #6- You did not provide a complete analysis of the interaction for any of your interchanges. In order for the analysis to be complete, you need to provide the type of communication used (therapeutic or non-therapeutic), the technique used (exploring, focusing, etc.), and an explanation as to how you utilized the technique listed (exploring, focusing, etc.) for all interchanges. For reference, there is an example of a sample process recording on pg. 120 in your textbook (Table 5-5) that demonstrates how to correctly complete this section. MD **Faculty Initials:** MD				**Total Points:**	77/100 Satisfactory MD

Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2024
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)	Li Na Chen Part 1 (Major Depressive Disorder (*1,2,3,4,5)	Li Na Chen Part 2 (Major Depressive Disorder (*1,2,3,4,5)	Live Adult Mental Health Simulation (Alcohol Withdrawal) (*1,2,3,4,5)	Sandra Littlefield (Borderline Personality Disorder Scenario) (*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: 6/7/2024	**Date: 6/14/2024**	**Date: 6/21/2024**	**Date: 6/21/2024**	**Date: 6/26-27/2024**	**Date: 6/28/2024**	**Date: 7/5/2024**	**Date: 7/19/2024**
Evaluation	S	S	S	S	S	S		
Faculty Initials	MD	CB	MD	MD	FB	FB		
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA		

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

STUDENT NAME(S) AND ROLE(S): Andrea Pulizzi (A), Molly Plas (M), Dylan Wilson (A), Paige Knupke (M)
GROUP #: 7
SCENARIO: Alcohol Substance Use Simulation
OBSERVATION DATE/TIME(S): 06/27/2024 1040-1155

CLINICAL JUDGMENT COMPONENTS	**OBSERVATION NOTES**
NOTICING: (1,2,5)*	Notices patient's blood pressure is elevated.
• Focused Observation: E A D B	Attempts to seek out information related to why patient is hospitalized and fall.
• Recognizing Deviations from Expected Patterns: E A D B	Recognizes that the patient does not need Lorazepam based on the CIWA scale score.
• Information Seeking: E A D B	Notices patient appears to be anxious.

	Notices patient's blood pressure is elevated. Recognizes the patient needs Lorazepam based on the CIWA Scale score. Attempts to seek out information related to fall and laceration and bruising. Attempts to seek out information related to support system and resources used.
INTERPRETING: (2,4)* • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritizes performing CIWA Scale. Interprets CIWA Scale score as 4. Interprets CIWA Scale score as 22. Interprets CIWA protocol accurately for Lorazepam dose (4 mg PO).
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	Introduces self and identifies patient. Obtains vital signs (T-98.6, HR-84, BP-154/92, SpO2-98%, RR-18). Assesses patient's anxiety (4/10). Performs CIWA Scale. Performs CAGE Questionnaire. Medication nurse verifies patient, DOB, allergies and scans. Safety check completed after medications given (looking into patients mouth). Provides education related to community resources and self-help groups. Great therapeutic communication, offering self if patient needed to talk. Identifies self and patient. Obtains vital signs (HR-80, BP-142/86, RR-20, SpO2-98%). Assesses patient's pain level (0/10). Assesses patient's anxiety level (6/10). Performs CIWA Scale. Medication nurse verifies patient, DOB, allergies and scans. Medication nurse administers Lorazepam 4 mg PO (per protocol).

	Safety check completed after medications given (looking into patients mouth).
REFLECTING: (1,2,5)* • 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** **Scenario Objectives:** • **Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)*** • **Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)*** • **Determine appropriate medication administration steps utilizing the CIWA scale. (4)*** • **Provide patient with appropriate education on community support and resources. (5)***	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 most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Focuses on the most relevant and important data useful for explaining the patient's condition. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: nerally, displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Communicates effectively; explains interventions; calms and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. 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. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. Satisfactory completion of the simulation scenario. Great job! CB

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: