

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

Student: Andrea Pulizzi

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)
Initials	Faculty Name		
<b>CB</b>	<b>Chandra Barnes, MSN, RN</b>		
<b>FB</b>	<b>Frances Brennan, MSN, RN</b>		
<b>MD</b>	<b>Monica Dunbar, DNP, RN</b>		
<b>BL</b>	<b>Brittany Lombardi MSN, RN, CNE</b>		
<b>HS</b>	<b>Heather Schwerer, MSN, RN</b>		

\* End-of-Program Student Learning Outcomes

## **PERFORMANCE CODE**

### **SATISFACTORY CLINICAL PERFORMANCE**

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

### **UNSATISFACTORY CLINICAL PERFORMANCE**

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

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

### **OTHER**

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

Objective										
1. Apply the principles of psychiatric theory in the care of adolescent to geriatric patients with a mental illness diagnosis. (1, 2, 3, 5, 6, 7, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
<b>Competencies:</b>	N/A	S	S	S	N/A	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>	N/A	S	S	S	N/A	S				
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. <b>(interpreting)</b>	N/A	N/A	N/A	S	N/A	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	N/A	S	S	N/A	S				
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care <b>(noticing)</b>	N/A	N/A	S	S	N/A	S				
e. Recognize social determinants of health and the relationship to mental health. <b>(reflecting)</b>	S	S	S	S	N/A	S				
f. Develop and implement an appropriate nursing therapy group activity. <b>(responding)</b>	N/A	N/A	N/A	S	N/A	N/A				
g. Develop a geriatric physical/mental health assessment and education plan. <b>(Geriatric Assessment) (responding)</b>				S						
Faculty Initials	HS	HS	MD	CB	FB					
Clinical Location	Hospice	Artisans	Detox	1S	N/A	1S				

**Comments:**

\* End-of-Program Student Learning Outcomes

Week 2 (1a, d)- You did a nice job discussing the relationship between substance abuse and how it impacts mental health of an individual. You also identified the social determinants of health and their relationship with an individual's mental health. HS

Week 3 Detox Objective 1C-D-This week you were able to provide culturally and spiritually competent care and identify appropriate methods that will assist the patient to regain independence in your CDG post for the detox center. Great job! MD

**Week 4(1a,b,e,f): Andrea, 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 and preparing an appropriate nursing therapy group activity for the patients of the milieu. CB**

**Week 4(1g): You received a Satisfactory on your geriatric assessment, please see the grading rubric attached below. CB**

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

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

**Comments:**

Week 2 (2c)-You discussed the coping/defense mechanisms used by individuals within your CDG post this week. HS

**Week 4(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 "Mental health and self-esteem of active athletes." related to mental health during clinical debriefing. CB**

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

**Comments:**

Week 1 (3f)-You did a nice job on your reflection journal for this week discussing your experience at hospice. HS

Week 2 (3f)- You satisfactorily met the requirements for the CDG posting for this week. Your response was thorough and included an in-text citation and a reference. Nice job! HS

Week 3 Detox 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! You provided an appropriate reference and in-text citation as well! Great job! MD

\* End-of-Program Student Learning Outcomes

**Week 4(3a,c,d,f): Andrea, you did a great job with therapeutic communication this week. You completed day 1 and 2 cdgs Satisfactorily, meeting all requirements.  
CB**

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

**Comments:**

Week 1 (4a)-This competency was changed to a Satisfactory evaluation, as you mentioned that you observed the nurse administering medications via different routes on your reflection journal. HS.

**Week 4(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**

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

**\*\*Alternative Assignment**

**Comments:**

Week 2 (a,d)- You were able to identify the resources available within the community for those individuals in need. HS

Week 3 Detox 5A-C-In your CDG posting for this week you were able to identify community resource needs, appropriate referral options, and discuss your observations at the Detox center. MD

Week 4(5b): You were able to discuss and observe discussion related to resources in the community to help patients with mental health disorders. CB

\* 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
<b>Competencies:</b>	N/A	N/A	N/A	S	N/A	S				
a. Demonstrate competence in navigating the electronic health record. <b>(responding)</b>	N/A	N/A	N/A	S	N/A	S				
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. <b>(responding)</b>	N/A	N/A	N/A	S	N/A	N/A				
c. Demonstrate the use of technology to identify mental health resources. <b>(responding)</b>	N/A	N/A	N/A	S	N/A	S				
Faculty Initials	HS	HS	MD	CB	FB					

### Comments:

**Week 4(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 therapy group. CB**

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

Week 1 (7c)-Student evaluation form completed by RN all areas rated excellent, no comments provided per RN. Nice job on your reflection journal, it sounds like you were able to see different types of medication administration within the hospice setting as well as learn new information from a hospice perspective. Great job! HS

Week 2 (7c)-You did a nice job self-reflecting on your experience at the Artisan’s Recovery Center within your CDG post this week. HS

Week 3 Detox 7C-In your discussion post, you provided great information on a reflection of your time at the Detox center. Great job! MD

Week 4 (7a) – My strength in patient care this week was the med pass I performed. I had 8 medications that I was able to successfully name the therapeutic effect, side effects, and nursing interventions. I verified my patient’s name, date of birth, and allergies. I offered to review his medications with him if he wished and informed him that I had the 2 PRN medications that he requested. I felt confident using the MAR and scanning the medications.

Week 4(7a,b): Andrea, you did a great job in clinical this week! You did a great job administering medications to your patient, being prepared and looking up all pertinent information. You did a great job creating a culture of safety, as well as discussing them in your cdg. CB

Week 6 (7a) – My strength this week in clinical was identifying increasing agitating behavior in a patient. I decided to use this patient as my care map patient due to having a conversation with him in the morning on the first day; I continued to watch his behavior as research for my care map and to use him for my day 4 CDG. Over the course of the two days, I watched as he became more isolated, and his hallucinations became more prominent. It is important that I am able to assess and notice that a patient is mentally declining as I can provide them interventions through medication and therapy.

Care	Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials	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:

Firelands Regional Medical Center School of Nursing  
Nursing Care Map Rubric

Student Name:		Course Objective:					
Date or Clinical Week:							
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)		
	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. 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)		
<b>Interpreting</b>	4. List all nursing priorities and highlight the top priority problem.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	5. State the goal for the top nursing priority.	Complete			Not complete		
	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		
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)		
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)		

<b>Responding</b>	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete		
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete		
	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete		
	12. All interventions are individualized and realistic	> 75% complete	50-75% complete	< 50% complete	0% complete		

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		
<b>Reflecting</b>	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete		
	15. 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>	<b>Complete</b>			<b>Not complete</b>		

**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:

<b>Total Points:</b>
<b>Faculty/Teaching Assistant Initials:</b>

Geriatric Assessment Rubric  
2024

Student Name: Andrea Pulizzi

Date: 06/20/2024

### 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	4
Geriatric Health Questionnaire	2	2
Time and change test	4	4
Cognitive Assessment (Clock Drawing)	4	4
Falls Risk Assessment (Get Up and Go)	4	4
Brief Pain inventory (Short form)	2	2
Nutrition Assessment (Determine Your Nutritional Health)	4	4
Instrumental ADL/ Index of Independence in ADL	4	4
Medication Assessment	4	4
Points	40	40

#### 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 100/100

Satisfactory completion of the Geriatric Assessment. Excellent job, Andrea! Keep up all your hard work. BL

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 (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.	
Criterion #4 Nursing Interventions	10 Points Identifies at least 5 pertinent nursing interventions in priority order including a rationale and timeframe. Interventions must be	6 Points Identifies 4 or less nursing interventions in priority order including a rationale and time frame.	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale,	

	individualized and realistic. Identifies a therapeutic communication goal.	Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	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.	
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.	



Firelands Regional Medical Center School of Nursing  
Psychiatric Nursing 2024  
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)	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)
	<b>Date:</b> 6/7/2024	<b>Date:</b> 6/14/2024	<b>Date:</b> 6/21/2024	<b>Date:</b> 6/21/2024	<b>Date:</b> 6/26-27/2024	<b>Date:</b> 6/28/2024	<b>Date:</b> 7/5/2024	<b>Date:</b> 7/19/2024
Evaluation	S	S	S	S	S	S		
Faculty Initials	HS	MD	CB	FB	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	<u>OBSERVATION NOTES</u>
<p><b>NOTICING: (1,2,5)*</b></p> <ul style="list-style-type: none"> <li>• Focused Observation:           E     A     D     B</li> <li>• Recognizing Deviations from   Expected Patterns:           E     A     D     B</li> <li>• Information Seeking:         E     A     D     B</li> </ul>	<p>Notices patient's blood pressure is elevated.</p> <p>Attempts to seek out information related to why patient is hospitalized and fall.</p> <p>Recognizes that the patient does not need Lorazepam based on the CIWA scale score.</p> <p>Notices patient appears to be anxious.</p> <p>Notices patient's blood pressure is elevated.</p> <p>Recognizes the patient needs Lorazepam based on the CIWA Scale score.</p> <p>Attempts to seek out information related to fall and laceration and bruising.</p> <p>Attempts to seek out information related to support system and resources used.</p>
<p><b>INTERPRETING: (2,4)*</b></p> <ul style="list-style-type: none"> <li>• Prioritizing Data:           E     A     D     B</li> <li>• Making Sense of Data:       E     A     D     B</li> </ul>	<p>Prioritizes performing CIWA Scale.</p> <p>Interprets CIWA Scale score as 4.</p> <p>Interprets CIWA Scale score as 22.</p> <p>Interprets CIWA protocol accurately for Lorazepam dose (4 mg PO).</p>

<p><b>RESPONDING: (1,2,3,5)*</b></p> <ul style="list-style-type: none"> <li>• Calm, Confident Manner: E A D B</li> <li>• Clear Communication: E A D B</li> <li>• Well-Planned Intervention/ Flexibility: E A D B</li> <li>• Being Skillful: E A D B</li> </ul>	<p>Introduces self and identifies patient.</p> <p>Obtains vital signs (T-98.6, HR-84, BP-154/92, SpO2-98%, RR-18).</p> <p>Assesses patient’s anxiety (4/10).</p> <p>Performs CIWA Scale.</p> <p>Performs CAGE Questionnaire.</p> <p>Medication nurse verifies patient, DOB, allergies and scans.</p> <p>Safety check completed after medications given (looking into patients mouth).</p> <p>Provides education related to community resources and self-help groups.</p> <p>Great therapeutic communication, offering self if patient needed to talk.</p> <p>Identifies self and patient.</p> <p>Obtains vital signs (HR-80, BP-142/86, RR-20, SpO2-98%).</p> <p>Assesses patient’s pain level (0/10).</p> <p>Assesses patient’s anxiety level (6/10).</p> <p>Performs CIWA Scale.</p> <p>Medication nurse verifies patient, DOB, allergies and scans.</p> <p>Medication nurse administers Lorazepam 4 mg PO (per protocol).</p> <p>Safety check completed after medications given (looking into patients mouth).</p>
<p><b>REFLECTING: (1,2,5)*</b></p> <ul style="list-style-type: none"> <li>• Evaluation/Self-Analysis: E A D B</li> <li>• Commitment to Improvement: E A D B</li> </ul>	<p>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.</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>Lasater Clinical Judgement Rubric Comments:</p> <p>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.</p>

<p><b>D= Developing</b> <b>B= Beginning</b></p> <p><b>Scenario Objectives:</b></p> <ul style="list-style-type: none"> <li>• <b>Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)*</b></li> <li>• <b>Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)*</b></li> <li>• <b>Determine appropriate medication administration steps utilizing the CIWA scale. (4)*</b></li> <li>• <b>Provide patient with appropriate education on community support and resources. (5)*</b></li> </ul>	<p>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.</p> <p>Responding: Generally 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.</p> <p>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.</p> <p>Satisfactory completion of the simulation scenario. Great job! CB</p>
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**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: