6EVALUATION OF CLINICAL PERFORMANCE TOOL

Psychiatric Nursing- 2024
Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student: Kylee Cheek

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)
6/17/2024	1 hour	Late Therapy Group Assignment Submission	6/17/2024 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)**	S	NA	NA	S	S	S				
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	S	NA	NA	S	NA	NA				
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**	S	NA	NA	S	S	S				
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	S	NA	NA	S	S	S				
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	S	NA	NA	S	S	S				
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	NA	NA	NA	S	NA	NA				
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				NA						
Faculty Initials	BL	FB	CB	MD	MD					
Clinical Location	1 South	NA	NA	1 South	Sandusky Artisans	Detox				

Comments:

* End-of-Program Student Learning Outcomes

Week 1-1(a,b,e) Kylee, excellent job with both of your CDGs this week in which you described the relationship between your patient's mental health, physical health, and environment. You were able to correlate the patient's prescribed therapies to their current diagnosis, and you did a great job discussing social determinants of health that play a role in your patient's mental health. Nice job! BL
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 4 Objective 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 5 Sandusky Artisans Objective 1A-B, D-In your CDG this week for your clinical experience you were able to demonstrate an understanding of the relationship between mental, physical health and the environment. You were also able to correlate prescribed therapies and identify appropriate methods assisting the patient to regain independence and achieve self-care. Great job! MD

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

* End-of-Program Student Learning Outcomes

Faculty Initials	BL	FB	CB	MD	MD					

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

Comments:

Week 1-2(a,b,f) Great job discussing your patient's past medical and mental health history in your CDG, as well as describing factors that create a culture of safety in the psychiatric unit. BL

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 Sandusky Artisans Objective 2C-You were able to demonstrate the ability to identify the patient's use of coping/defense mechanisms in your CDG this week. MD

Objective

3. Refine basic verbal and nonverbal therapeutic communication skills when interacting with patients, families, and members of the health care team. (1, 2, 3, 5, 7, 8)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
a. Illustrate professionally appropriate and therapeutic communication skills in interactions with patients, and families. **(responding)**	S	NA	NA	S	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)**	S	NA	NA	S	NA	NA				
c. Identify barriers to effective communication. **(noticing, interpreting)**	S	NA	NA	S	S	S				
d. Develop effective therapeutic responses. **(responding)**	S	NA	NA	S	S	S				
e. Develop a satisfactory patient-nurse therapeutic communication. (**Nursing Process Study) (responding, reflecting)**				~~S~~ NI	S					
f. Posts respectfully and appropriately in clinical discussion groups. **(responding, reflecting)**	S	NA	NA	S	S	S				
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. **(responding)**	S	NA	NA	S	S	S				
h. Teach patient/family based on readiness to learn and patient needs. **(responding, reflecting)**	S	NA	NA	S	NA	NA				
Faculty Initials	BL	FB	CB	MD	MD					

Comments:

Week 1-3(a,d,f) Kylee, you did an excellent job therapeutically communicating with all the patients this week. You also did an excellent job with your CDG posts. Keep up all your hard work! BL

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 received an NI on your Nursing Process Study. Please be sure to read the comments on your rubric within this tool and resubmit it to your Dropbox by 7/1/2024 at 0800 for regrading. MD**
Week 5 Objective 3E-You were able to satisfactorily remediate your NPS assignment. MD
Week 5 Sandusky Artisans 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

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

Comments:

Week 1-4(a-e) Excellent job demonstrating knowledge of frequently prescribed medications utilized in treating mental illness through one-on-one discussion with your instructor during clinical. You administered medications to your patient following all six rights of medication administration. Great discussion of common barriers to maintaining medication compliance in your CDG this week. BL

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

****Alternative Assignment**

Comments:

Week 5 Sandusky Artisans Objective 5B, D-In your CDG, you discussed recommendations for referrals to appropriate community resources and recognized and described the need for substance abuse recovery resources. MD

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

Comments:

Week 1-6(a) Great job navigating the electronic health record to research information on your patient. BL

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

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 (7a): For my strengths I did a good job communicating with the patients. It was very evident that the patients really like to talk and have someone to just listen to what they have to say. Over the past two days the patients really enjoyed having us there and were sad when our time there was done. Excellent job, Kylee! BL

Week 1-7(b) Excellent discussion related to factors that create a culture of safety while in the psychiatric unit in your CDG this week. BL

Week 4 (7a): For my strengths I did a good job at talking to more patients this clinical. There were more patients out in the milieu, and I was able to have pretty good conversations with different patients. This helped me explore and understand the different types of mental health problems. 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

Week 4 Psych 3 & 4 Objective 7E-You did not turn in your therapy group assignment in on time. Please respond with how you will prevent this from occurring in the future. MD

Week 5 (7e U): For the U I received in week 4 I take full responsibility for turning it in late. For future assignments I will double check the schedule and make sure I turn it in on time. MD

Week 5 Sandusky Artisans Objective 7C-You illustrated active engagement in self-reflection and debriefing in your CDG this week! I am glad you were able to have this experience! MD

Care Map Evaluation Tool**
Psych
2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/21/2024	Risk for Suicide	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: Kylee Cheek				**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	

g							

	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	10	

(5)		
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.	8
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	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	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.	8

		therapeutic communication goal.	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.	15
Criterion #6 Process Recording	20 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic) and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) 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	20
Criterion #7 Process Recording	10 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 10 interchanges between patient and student.	6 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 7 interchanges between patient and student.	4 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 5 interchanges between patient and student.	0 Points There was less than 5 interchanges between patient and student provided.	10
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.	0/13
Criterion #9 Evaluation	10 Points Identify at least 3 barriers to communication including	6 Points Identify at least 2 barriers to communication	4 Point Identify at least 2 barriers to communication did not	0 Points Identify at least 1 barrier to	2/8

	interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	include interventions or communication that could have been done differently. Did not identify any pertinent social determinants of health.	communication did not include interventions or communication that 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: Kylee, Overall Good job with your Nursing Process Study! Criterion 4- You did not provide a timeframe for each of the nursing interventions listed. Frequently is not descriptive enough is too vague, that could be interpreted differently by individuals. Timeframes should be specific. Therefore, there was a deduction for this criterion. Criterion 8- You did not provide strengths and weaknesses of the communication interaction that **you** had with your patient. The information provided was general information regarding therapeutic communication. Therefore, a deduction of points for this criterion are reflected. Strengths and weakness of the communication interaction you had with your assigned patient were specific and followed information regarding therapeutic communication. Criterion 9- You did not provide communication barriers that your patient might have. Resulting in a deduction in points for this criterion. Barriers were provided, they were specific to your assigned patient and the communication that you had with the patient. **You are required to revise and resubmit this assignment to your dropbox by 07/01/2024 at 0800. As a reminder, students are allowed one remediation attempt for this assignment in order to become satisfactory. If you have any questions, or need further clarification, please do not hesitate to reach out.** **Satisfactory completion of Nursing Process Study Assignment, 94/100 points with resubmission of assignment.** **Faculty Initials:** FB				**Total Points:**	**75/100** **94/100** **Needs Improvement** **Satisfactory completion**

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	FB	CB	MD	MD	MD	MD		
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA		

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

STUDENT NAME(S) AND ROLE(S): Kylee Cheek (A), Katherine Shirley (M), Hannah Castro (A), Destiny Houghtlen (M)
GROUP #: 4
SCENARIO: Alcohol Substance Use Simulation
OBSERVATION DATE/TIME(S): 06/26/2024 1230-1345

CLINICAL JUDGMENT COMPONENTS					**OBSERVATION NOTES**
NOTICING: (1,2,5)*					
●Focused Observation:	E	**A**	D	B	Notices patient's blood pressure is elevated.
●Recognizing Deviations from Expected Patterns:	**E**	A	D	B	Notices patient appears to be anxious. Recognizes the patient needs Lorazepam based on the CIWA Scale score.
● Information Seeking:		E	**A**	D	Notices patient is having visual hallucinations.

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 the patient's substance use.
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 8. Interprets CIWA protocol accurately for Lorazepam dose (2 mg PO). Interprets the CAGE Questionnaire as negative. Interprets CIWA Scale score as 23. 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-82, BP-154/90, SpO2-98%, RR-14). Performs CIWA Scale. Assesses patient's pain. Performs the Brief Mental Status Evaluation. Medication nurse reviews medication with the patient and administers them. Medication nurse administers Lorazepam 2 mg PO (per protocol). Performs the CAGE Questionnaire. Does not attempt to have a therapeutic conversation with the patient outside of performing assessments/interventions. Identifies self and patient. Asks patient about visual hallucinations. Obtains vital signs (T-98.6, SpO2-98%, BP-145/89). Assesses patient's anxiety level (6/10). Performs CIWA Scale.

	Attempts to distract patient and relocate her from the nurse's station. Medication nurse verifies patient and scans. Medication nurse administers Lorazepam 4 mg PO (per protocol). Attempts to communicate with patient and utilize therapeutic techniques. Provides education related to community resources and self-help groups.
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)***	Lasater Clinical Judgement Rubric Comments: Noticing: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads. 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: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Shows some communication ability (e.g., giving directions); communication with patients, families, and team members is only partly successful; displays caring but not competence. 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

● **Provide patient with appropriate education on community support and resources. (5)***	eliminate weaknesses. Satisfactory completion of the simulation scenario. Great job! BL

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: