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

Student: Cameron Beltran

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)
06/21/2024	1	Missed Sandusky Artisan's clinical due to illness	7/1/2024-1700
6/29/2024	**1**	**Late Hospice survey**	**7/1/2024- 1200**
6/29/2024	**1**	**Late Simulation Survey**	**7/1/2024- 1200**

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	S	NA	S	~~NA~~ S				
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	S	NA	S	NA	S	~~NA~~ S				
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**	S	NA	S	NA	S	~~NA~~ S				
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	S	NA	S	NA	NA	~~NA~~ S				
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	S	NA	S	NA	S	NA				
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	NA	NA	S	NA	NA	NA				
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				NA						
Faculty Initials	BL	FB	FB	BL	MD	CB				
Clinical Location	1 South	NA	1 South	No Clinical		Detox/ Artisan's				

Comments:

* End-of-Program Student Learning Outcomes

Week 1-1(a,b,e) Cameron, 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 3 (1a,c,d,f) Great job with understanding the relationship of mental illness, physical signs and symptoms, and risk factors as identified on your care map. You demonstrated empathy towards your assigned patient while meeting cultural and any spiritual needs during this week's clinical rotation. Appropriate methods to assist your patient in regaining an independence and regaining self-care was also displayed during clinical this week, great job! You did a great job leading a nursing therapy group activity with the use of guided imagery as an adaptive coping skills. FB
Week 6(1a,b,c,d): Great job discussing risk factors for individuals fighting addiction and how therapies/meetings help with sobriety. You were able to discuss barriers to culturally competent care at the detox center in your cdg, good job. CB

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

*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 3 (2a,b,d) Great job identifying your patient's mental health history, reason for this admission, and correlating with medical health issues. You were able to assess for subjective and objective data including labs, diagnostic testing, and risk factors to provide a priority problem for your assigned patient. Great job with the use of clinical judgment skills to develop a plan of care as evidenced by the care map. FB

Week 6(2c): Great job discussing the support the staff at the detox unit give the patients in their time of need. 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. **(responding)**	S	NA	S	NA	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)**	NA	NA	S	NA	S	NA				
c. Identify barriers to effective communication. **(noticing, interpreting)**	S	NA	S	NA	S	S				
d. Develop effective therapeutic responses. **(responding)**	S	NA	S	NA	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)**	S	NA	S	NA	S	S				
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. **(responding)**	S	NA	S	NA	S	S				
h. Teach patient/family based on readiness to learn and patient needs. **(responding, reflecting)**	S	NA	S	NA	S	NA				
Faculty Initials	BL	FB	FB	BL	MD	CB				

Comments:

Week 1-3(a,d,f) Cameron, 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 3 (3c,f,h) Great job with the identification of barriers for your assigned patient that may hamper their communication skills. You did a great job with CDG post, following all expectations of CDG rubric. Great job with assessing your patient for the readiness to learn and comprehension of adaptive coping skills and behaviors. FB

* End-of-Program Student Learning Outcomes

Week 4-3(e) Satisfactory completion of the Nursing Process Recording assignment. Please see the Nursing Process Grading Rubric at the end of this document for individualized feedback on the assignment. Great job! BL
Week 6(3f): Cameron, great job on your cdg's! You were very thorough answering each question, meeting all requirements. CB

* End-of-Program Student Learning Outcomes

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

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 3 (4a-e) Excellent job with medication administration following all six rights of administration. You demonstrated knowledge and implications for each medication administered, identified classification, significant signs and symptoms, pertinent nursing interventions, and any safety concerns, great job! FB

* 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	NA	S				
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	NA	NA	NA	NA	NA	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	NA	S				
Faculty Initials	BL	FB	FB	BL	MD	CB				

****Alternative Assignment**

Comments:

Week 6(5a,b,c,d): You did a great job collaborating with members at the Erie County Detox Center and Sandusky Artisan's, identifying the need for community resources. 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**
Competencies: a. Demonstrate competence in navigating the electronic health record. **(responding)**	S	NA	S	NA	NA	NA				
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. **(responding)**	NA	NA	S	NA	NA	NA				
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	~~NA~~ S	NA	S	NA	NA	S				
Faculty Initials	BL	FB	FB	BL	MD	CB				

Comments:

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

Week 3(6a-c) Great job using the electronic health record to gather information on your assigned patient. You also did a great job demonstrating the appropriate documentation on all individuals regarding the attendance to nursing group therapy activity. FB

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

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:

I think my strength was patient communication. I really enjoyed forming a relationship with each of the patients that I encountered. You did an excellent job communicating with all the patients this week on 1 south. Keep up all your hard work! 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 3 (7a)-I think my strength was leading group therapy. I was able to explain the exercise to the group and teach them a new coping strategy. You did an awesome job leading your group through guided imagery and how to use this as a coping strategy. FB

Week 3 (7e)- This competency is rated a "U" for not submitting the correct tool, for your first submission. You will need to address the unsatisfactory rating as stated in the beginning of the tool. **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. FB **The competency will no longer be a U because I will make sure that the document that I turn has the boxes filled out in future weeks. BL**

Week 5 Hospice Objective 7C-You had a wonderful reflection journal this week! You were able to turn in your reflection journal on time, have the adequate word count, and meet all of the objectives! It really was evident that you had an eye-opening experience with this type of nursing. I appreciated reading your reflection journal and all you were able to learn about this clinical setting. MD
Week 5 Hospice Objective 7E-This week in hospice clinical you were rated excellent in all areas by your nurse you were working with. Great job! MD
Week 5 Objective 7E-You did not submit your Hospice and Simulation surveys by the stated date and time. Please respond with how you will prevent this from occurring in the future. MD
7e. The competency will no longer be a U because I made sure to do my surveys on time right after the clinical was over. I also set an alarm on my phone to make sure that I did not forget. I will continue to this from now on. CB
Week 6(7c): Great job reflecting on your experience at the Erie County Detox Center and Sandusky Artisan's. You were able to talk about your thoughts and feelings and how these available resources are key to individuals with substance abuse needs. CB

Care Map Evaluation Tool**

Psych 2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/11/2024	Risk for suicidal behavior	S/FB	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: Satisfactory completion of psychiatric nursing care map. Total score of 44/45. See care map grading rubric for details. FB

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Cameron Beltran **Date or Clinical Week:** 6/11/2024 Week 3				**Course Objective:**	2. Synthesize concepts related to psychopathology, health assessment data, evidenced based practice and nursing process using clinical judgment skills to plan and care for patient with mental illness. (1, 2, 3, 4, 5, 6, 7, 8)*		
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	Great job with identification of all subjective and objective assessment findings, abnormal laboratory data, diagnostic testing, and risk factors. Great job with noticing abnormalities and there relationship to the priority problem.
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	Nice job distinguishing the appropriate abnormal findings as they relate to the priority problem. Two of the nursing priorities provided were very similar. Some priority problems that could have been used for your patient are situational low self-esteem, or disturbed thought process. Possible complications were appropriate with signs and symptoms provided.
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Respo	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Nursing interventions were prioritized, frequencies provided, individualized, and realistic for the patient. Great job with providing rationales for each of the
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	

n d i	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	nursing interventions.
	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	Evaluation of your priority problem identified was done appropriately, great job!
	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.
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:
Satisfactory completion of psychiatric nursing care map. Excellent job with care map!

Total Points: 44/45 points

Faculty/Teaching Assistant Initials:
Fran Brennan MSN, RN/ FB

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.	5
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	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,	10

	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.	7
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.	15
Criterion #9	10 Points	6 Points	4 Point	0 Points	10

Evaluation	Identify at least 3 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	Identify at least 2 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	Identify at least 2 barriers to communication did not include interventions or communication that could have been done differently. Did not identify any pertinent social determinants of health.	Identify at least 1 barrier to communication did not include interventions or communication that could have been done differently. Did not identify any pertinent social determinants of health.	
Total Possible Points= 100 points 77-100 points= Satisfactory completion. 76-53 points= Needs Improvement < 53 points= Unsatisfactory Faculty comments: Cameron, Overall Great job with your Nursing Process Study! Satisfactory completion. Criterion 2- You did not provide a descriptive paragraph related to the patient's admission to the inpatient psychiatric unit. Therefore, there was a deduction for this criterion. Criterion 5- You did not provide direct quotes from the patient for your communication portion of the nursing process assignment. You did provide good description of your thoughts and feelings for each of the interactions. **Faculty Initials:** FB				**Total Points:**	90/100 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	S	
Faculty Initials	FB	FB	BL	BL	MD	MD	CB	
Remediation: Date/Evaluation/Initials	NA	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): Cameron Beltran (A), Caitlin Gresh (A), Leah McNeely (M), Lynnette Swinehart (M)

GROUP #: 2

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/26/2024 0920-1035

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (1,2,5)* • Focused Observation: E **A** D B • Recognizing Deviations from Expected Patterns: **E** A D B • Information Seeking: **E** A D B	Notices patient's blood pressure is elevated. Notices the patient appears anxious. Recognizes the patient does not need any Lorazepam based on the CIWA Scale score. Attempts to seek out information related to the patient's substance use. Notices the patient is having visual hallucinations. Notices the patient appears anxious. Seeks out information related to the patient's substance use. Recognizes the patient needs Lorazepam based on the CIWA Scale score.
INTERPRETING: (2,4)* • Prioritizing Data: E **A** D B • Making Sense of Data: **E** A D B	Prioritizes performing the CAGE Questionnaire and CIWA Scale. Interprets CAGE Questionnaire as negative. Interprets CIWA Scale score as 5. Initially does not prioritize the CIWA Scale. Interprets CIWA Scale score as 18. 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. Asks patient orientation questions. Obtains vital signs (T-98.6, BP-150/90, HR-70, SpO2-97%). Performs the CAGE Questionnaire. Performs CIWA Scale. Medication nurse verifies patient and scans wristband. Medication nurse reviews medications with the patient and administers them. Attempts to utilize therapeutic communication with the patient. Offers to educate the patient on how to practice deep breathing (Coping Skills). Introduces self and identifies patient. Asks patient about the abrasion on her forehead. Obtains vital signs (BP-154/90, SpO2-98%, T-98.6, HR-85). Asks patient to rate anxiety level (6/10). Assesses patient's pain (0/10). Performs the CIWA Scale. Initially does not complete the entire assessment. Attempts to utilize therapeutic communication with the patient. Be aware of facial expressions displayed in front of the patient. Attempts to provide education to the patient regarding substance use. Medication nurse verifies patient and scans. Administers Lorazepam 4 mg PO (per protocol). Provides education to the patient 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)*** • **Provide patient with appropriate education on community support and resources. (5)***	Lasater Clinical Judgement Rubric Comments: 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. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. Even when facing complex, conflicting, or confusing data, is able to (a) note and make sense of patterns in the patient's data, (b) compare these with known patterns (from the nursing knowledge base, research, personal experience, and intuition), and (c) develop plans for interventions that can be justified in terms of their likelihood of success. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Generally communicates well; explains carefully to patients; gives clear directions to team; could be more effective in establishing rapport. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. 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! 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: