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

Student: Tylie Dauch

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)
5/28/2024	3 hours	Missed clinical orientation	5/30/2024 3 hours

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

Comments:

* End-of-Program Student Learning Outcomes

Week 2 (1c) Great job providing cultural and spiritual care during your hospice clinical rotation. (1e)- Great job recognizing the effects social determinants of health can have on an individual and their family at the end of life. FB

Week 3(1c,d): Great job discussing ways barriers to culturally competent care in your cdg. You were also able to discuss how individuals are assisted in gaining independence. CB

Week 4 (1g)- Satisfactory completion of Geriatric Assessment Assignment, please see rubric below. FB
Week 6 Psych 1 & 2 Objective 1A and E-This week you were able to demonstrate an understanding for mental, physical, and environmental health along with recognizing SDOH with your responses in your CDG posting. Great job! MD
Week 6 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

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

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

* End-of-Program Student Learning Outcomes

Comments:
Sandusky Artisans Objective 2C-This week you were able to recognize the importance of using different coping/defense mechanisms for every patient. You were able to identify how different each patient can be in what coping skills work for them. MD
Week 2 (2e)- Good job with application of the precautions while caring for the patient going through the dying process. FB
Week 3(2c): Great job discussing the support the staff at the detox unit give the patients in their time of need. CB
Week 6 Psych 1 & 2 Objective 2A-B, and F-This week you did a great job of assembling a health history, identifying subjective and objective findings, and using EBP tools to support safety and quality in your CDG post. MD

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

* End-of-Program Student Learning Outcomes

Faculty Initials	MD	FB	CB	FB	MD	MD				

Comments:

Sandusky Artisans Objective 3F-You did a wonderful job with your CDG this week! You were able to identify all of the important areas of the Sandusky Artisans organization and how impactful they are to the community. The only suggestion I would have is to make sure your references are within the last 5 years. Your reference was from 2013. If you have any additional questions let me know! MD

Week 2 (3a,c,d)- Great job with communication skills during the hospice clinical experience. You identified many barriers that can occur including culture, spirituality, and family dynamics. You participated responding in a therapeutic manner as you participated in care of the end of life patient. Great job! (3f) Good job, you posted your CDG on time following all expectations of CDG rubric. FB

Week 3(3f): Tylie, great job on your cdg! You were very thorough answering each question, meeting all requirements. CB
Week 6 Psych 1 & 2 Objective 3C-This week you were able to identify barriers to effective communication in your CDG posting. MD

Week 6 Psych 1 & 2 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 had a reference and in-text citation for both of your CDGs this week. I would like to remind you that resources used for references and in-text citations should be less then 5 years old. Let me know if you have any questions. 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)**	NA	NA	NA	NA	NA	U				
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. **(responding, reflecting)**	NA	NA	NA	NA	NA	S				
c. Identify the major classification of psychotropic medications. **(interpreting)**	NA	NA	NA	NA	NA	S				
d. Identify common barriers to maintaining medication compliance. **(reflecting)**	NA	NA	S	NA	NA	S				
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. **(responding, reflecting)**	NA	NA	NA	NA	NA	S				
Faculty Initials	MD	FB	CB	FB	MD	MD				

Comments:

Week 3(4d): Great job this week identifying common barriers to medication compliance and the medication routine at the Erie County Detox Unit. CB

Week 6: I gave myself a U for this competency because I did not scan my medications before opening them and putting them in the medication cup. I will work on this by slowing down and reviewing the proper steps of medication administration for next week and all future medication passes. I agree with your assessment in this competency. It is really important to scan medications prior to administration. This is one of the 6 rights and 3 checks for medication administration. Thank you for addressing how you will prevent this from occurring in the future. MD

Week 6 Psych 1 & 2 Objective 4B-E-In your CDG post this week you were able to provide information about implications of psychotropic medications, classifications of medications, barriers to medication compliance, and specific details about the medications you administered this week. Great job! MD

* End-of-Program Student Learning Outcomes

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

****Alternative Assignment Comments:**

Week 2 (5b)- Great job discussing the need and benefits for the services of hospice and how it is needed in the community. Hospice is a great asset to have available for any individual and families during such a difficult time. FB

Week 3(5a,b,c): You did a great job collaborating with members at the Erie County Detox Center, identifying the need for community resources. CB

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

Comments:

Week 6 Psych 1 & 2 Objective 6A-You were able to proficiently navigate the EHR independently. 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)**	NA	NA	NA	NA	NA	S				
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care. **(responding)**	NA	NA	NA	NA	NA	S				
c. Illustrate active engagement in self-reflection and debriefing. **(reflecting)**	S	S	S	NA	NA	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	NA	NA	S				
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. **(responding)**	S	S	S	NA	NA	S				
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." **(responding)**	S	S	S	NA	NA	S				
Faculty Initials	MD	FB	CB	FB	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 2 (7c-f)-Great job, you demonstrated active engagement and participation with an ACE attitude, professional behavior, and excellent student code of conduct. FB

Week 3(7c): Great job reflecting on your experience at the Erie County Detox Center. You were able to talk about your thoughts and feelings and how this available resource is key to individuals with substance abuse needs. CB

I feel as though I demonstrated many strengths this week on one south. One in particular though was that I was successfully able to carry on a full therapeutic conversation. I found this to be very challenging for many reasons. One reason being that many of the patients did not really want to talk us. Also, because it is much more difficult to keep things therapeutic than one might think. For these reasons, I consider it a strength to be able to have had a therapeutic conversation this week. I agree with you! You did a wonderful job with therapeutic conversations this week! MD

Week 6 Psych 1 & 2 Objective 7B-In your CDG this week you were able to identify effective use of strategies to reduce risk of harm for the patient and others. Great job! MD

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

Care Map Evaluation Tool**
Psych
2024

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

Comments:

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**
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)**		
	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)**		
Interpreting	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	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**		

	complication.						
Responding	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**		
Reflecting	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: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**		

Reference

An in-text citation and reference are required.
The care map will be graded "needs improvement" if missing either the in-text citation or reference, but not both.
The care map will be graded "unsatisfactory" if no in-text citation or reference is included.

Total Possible Points= 45 points
45-35 points = Satisfactory
34-23 points = Needs Improvement*
< 23 points = Unsatisfactory*
***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

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

Faculty/Teaching Assistant Comments:

Total Points:

Faculty/Teaching Assistant Initials:

Geriatric Assessment Rubric
2024

Student Name: Tylie Dauch Date: ____6/20/2024_____

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_____

Tylie, Excellent job on your geriatric assessment. You received a Satisfactory completion per the grading rubric. Keep up all of your hard work! CB

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	10 Points	6 Points	4 Point	0 Points	

Nursing Interventions	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.	Identifies 4 or less nursing interventions in priority order including a rationale and time frame. Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.	
Criterion #5 Process Recording	15 Points Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.	10 Points Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 7 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	5 Point Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 5 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	0 Points Direct quotes are not provided. Nonverbal and Verbal behavior is not described for less than half of the interactions. Student thoughts and feelings for less than half of the interactions provided.	
Criterion #6 Process Recording	20 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic) and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 75% of interactions.	15 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 50% of interactions.	10 Point Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), no technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 25% of interactions.	0 Points Analysis not provided for each interaction	
Criterion #7 Process Recording	10 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 10 interchanges between patient and student.	6 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 7 interchanges between patient and student.	4 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 5 interchanges between patient and student.	0 Points There was less than 5 interchanges between patient and student provided.	
Criterion #8 Evaluation	15 Points Self-evaluation of communication with patient. Identify at least 3 strengths and 3	10 Points Self-evaluation of communication with patient. Identified 2	5 Point Self-evaluation of communication with patient. Identified 1	0 Points No self-evaluation was provided.	

	weaknesses of therapeutic communication.	strengths and 2 weaknesses of therapeutic communication.	strength and 1 weakness of therapeutic communication.		
Criterion #9 Evaluation	10 Points Identify at least 3 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	6 Points Identify at least 2 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	4 Point 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.	0 Points 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:				**Total Points:** **Faculty Initials:**	

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	CB	FB	FB	MD	MD	MD	
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): Kennedy Baker (M), Anthony Drivas (A), Tylie Dauch (M), Lindsey Steele (A)

GROUP #: 1
SCENARIO: Alcohol Substance Use Simulation
OBSERVATION DATE/TIME(S): 06/26/2024 0800-0915

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 the patient's blood pressure is elevated. Notices the patient appears anxious. Seeks out information related to patient's substance use history. Recognizes the patient does not need Lorazepam based on the CIWA Scale score. Notices the patient is complaining of visual hallucinations. Notices the patient is complaining of itching. Seeks out information related to the patient's support system and 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 the CAGE Questionnaire as negative. Interprets the CIWA Scale score as 5. Interprets the CIWA Scale score as 12. 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, BP-150/90, SpO2-99%, HR-84, RR-12). Asks the patient questions related to reason for admission. Performs the CAGE Questionnaire. Performs the CIWA Scale. Utilizes therapeutic communication with the patient. Medication nurse educates the patient on medications to be

	administered. Medication nurse does not identify or scan patient. Medication nurse administers ordered daily medications. Introduces self and identifies patient. Performs CIWA Scale. Obtains vital signs. Medication nurse verifies patient and scans. Administers Lorazepam 4 mg PO (per protocol). Attempts to utilize therapeutic communication with the patient. Provides education related to withdrawal symptoms and substitution therapy. No education provided related to community resources or support 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**	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 most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Focuses on the most relevant and important data useful for explaining the patient's condition. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: 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,

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)***	explaining and giving directions; checks for understanding. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. Satisfactory completion of the simulation scenario. Great job! 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: