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

Student: Andrea Pulizzi

Final Grade: Satisfactory/Unsatisfactory

Semester: Summer Session

Date of Completion:

Faculty: Chandra Barnes MSN, RN, Fran Brennan MSN, RN, Monica Dunbar, DNP, RN
Brittany Lombardi MSN, RN, CNE, Heather Schwerer, MSN, RN

Faculty eSignature:

DIRECTIONS FOR USE:

Each week the students evaluate themselves based on the competencies using the performance code on page 2. The performance code includes the terms **Satisfactory (S), Needs Improvement (NI), Unsatisfactory (U), and Not Available (NA).** The faculty member will initial if in agreement with the student's evaluation. If there is a discrepancy in the performance code evaluation between the student and the faculty member, a note is written in the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, U, or NA". If the student does not self-rate, then it is an automatic "U". A student who submits the clinical evaluation tool late will be rated as "U" in the appropriate competency(s) for that clinical week. Whenever a student receives a "U" in a competency, it must be addressed with a comment as to why it is no longer a "U" the following week. If the student does not state why the "U" is corrected, it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. **An unsatisfactory or needs improvement as a final evaluation in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. Patterns of performance over the course of the semester will be utilized to determine the final competency evaluations. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.**

METHODS OF EVALUATION:

Clinical Patient Profile
Meditech Documentation
Evaluation of Clinical Performance Tool
Onsite Clinical Debriefing
Online Discussion Rubric
Nursing Process Recording Rubric
Geriatric Assessment Rubric
Lasater Clinical Judgment Rubric
Virtual Simulation scenarios
EBP Presentations
Hospice Reflection Journal
Observation of Clinical Performance
Clinical Nursing Therapy Group
Nursing Care Map Rubric

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)

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

* End-of-Program Student Learning Outcomes

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

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

OTHER

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

* End-of-Program Student Learning Outcomes

Objective										
	1. Apply the principles of psychiatric theory in the care of adolescent to geriatric patients with a mental illness diagnosis. (1, 2, 3, 5, 6, 7, 8)*									
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
Competencies: a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. **(noticing)**	N/A	S	S	S	N/A	S	N/A			
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	N/A	N/A	N/A	S	N/A	S	N/A			
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**	S	N/A	S	S	N/A	S	N/A			
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	N/A	N/A	S	S	N/A	S	N/A			
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	S	S	S	S	N/A	S	N/A			
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	N/A	N/A	N/A	S	N/A	N/A	N/A			
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				S						
Faculty Initials	HS	HS	MD	CB	FB	MD	BL			
Clinical Location	Hospice	Artisans	Detox	1S	N/A	1S	N/A			

Comments:

* End-of-Program Student Learning Outcomes

Week 2 (1a, d)- You did a nice job discussing the relationship between substance abuse and how it impacts mental health of an individual. You also identified the social determinants of health and their relationship with an individual's mental health. HS
Week 3 Detox Objective 1C-D-This week you were able to provide culturally and spiritually competent care and identify appropriate methods that will assist the patient to regain independence in your CDG post for the detox center. Great job! MD
Week 4(1a,b,e,f): Andrea, you did a great job this week in clinical, caring for patients diagnosed with a mental health disorder. Great explanation of social determinants of health related to your patient this week. You did an excellent job, planning and preparing an appropriate nursing therapy group activity for the patients of the milieu. CB
Week 4(1g): You received a Satisfactory on your geriatric assessment, please see the grading rubric attached below. CB
Week 6 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

Objective

2. Synthesize concepts related to psychopathology, health assessment data, evidenced based practice and the nursing process using clinical judgment skills to plan and care for patients with mental illness. (1, 2, 3, 4, 5, 6, 7, 8)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
Competencies: a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. **(noticing)**	N/A	N/A	N/A	S	N/A	S	N/A			
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. **(noticing, recognizing)**	N/A	N/A	N/A	S	N/A	S	N/A			
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. **(noticing, interpreting)**	N/A	S	S	S	N/A	S	N/A			
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. **(noticing, interpreting, responding, reflecting)***	N/A	N/A	N/A	S	N/A	S	N/A			
e. Apply the principles of asepsis and standard precautions. **(responding)**	S	N/A	S	S	N/A	S	N/A			
f. Practice use of standardized EBP tools that support safety and quality. **(noticing, responding)**	N/A	N/A	S	S	N/A	S	N/A			
Faculty Initials	HS	HS	MD	CB	FB	MD	BL			

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

Comments:

* End-of-Program Student Learning Outcomes

Week 2 (2c)-You discussed the coping/defense mechanisms used by individuals within your CDG post this week. HS
Week 4(2a,b,f): Great job this week in the clinical, researching and discussing your patient's mental health and medical history. You were able to research and talk about an EBP article titled "Mental health and self-esteem of active athletes." related to mental health during clinical debriefing. CB
Week 6 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

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

Comments:

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

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

Week 3 Detox Objective 3F-You had a wonderful CDG this week! You were able to turn in your CDG on time, have the adequate word count for your post, and meet all of the objectives for the CDG! You provided an appropriate reference and in-text citation as well! Great job! MD

* End-of-Program Student Learning Outcomes

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

Week 6 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
Week 6 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! You also included an appropriate reference and in-text citation for your 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)**	~~N/A~~ S	N/A	S	S	N/A	S	N/A			
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. **(responding, reflecting)**	N/A	N/A	N/A	S	N/A	S	N/A			
c. Identify the major classification of psychotropic medications. **(interpreting)**	N/A	N/A	N/A	S	N/A	S	N/A			
d. Identify common barriers to maintaining medication compliance. **(reflecting)**	N/A	N/A	N/A	S	N/A	S	N/A			
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. **(responding, reflecting)**	N/A	N/A	N/A	S	N/A	S	N/A			
Faculty Initials	HS	HS	MD	CB	FB	MD	BL			

Comments:

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

Week 4(4a-e): Great job this week administering medications following the six rights of medication administration. You were able to research the prescribed medications for your patient, and discuss implications for use, side effects, classification, related interventions and safety issues. CB

Week 6 Psych 3 & 4 Objective 4A-This week you were able to administer medications to a patient on 1S. You were able to follow the appropriate process for safe administration of the medications. Great job! MD

* End-of-Program Student Learning Outcomes

Objective

5. Develop an awareness of community Mental Health resources and services. (5, 6, 7, 8)*

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

****Alternative Assignment**

Comments:

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

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

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

* End-of-Program Student Learning Outcomes

* End-of-Program Student Learning Outcomes

Objective

6. Demonstrate satisfactory proficiency when using informatics and techniques in the assessment of patients with a mental illness diagnosis. (1, 2, 3, 4, 6, 8)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
Competencies: a. Demonstrate competence in navigating the electronic health record. **(responding)**	N/A	N/A	N/A	S	N/A	S	N/A			
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. **(responding)**	N/A	N/A	N/A	S	N/A	N/A	N/A			
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	N/A	N/A	N/A	S	N/A	S	N/A			
Faculty Initials	HS	HS	MD	CB	FB	MD	BL			

Comments:

Week 4(6a-c): Great job this week documenting medications given in the EMAR. You were able to document on all patients after completion of your nursing therapy group. CB

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

* End-of-Program Student Learning Outcomes

Objective

7. Evaluate self-participation in patient care experiences with the focus on safety, ethical, legal, and professional responsibilities. (7)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
a. Identify your strengths for care delivery of the patient with mental illness. **(reflecting)**	N/A	N/A	N/A	S	N/A	S	N/A			
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care. **(responding)**	N/A	N/A	S	S	N/A	S	N/A			
c. Illustrate active engagement in self-reflection and debriefing. **(reflecting)**	~~N/A~~ S	S	S	S	N/A	S	N/A			
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE" – attitude, commitment, and enthusiasm during all clinical interactions. **(responding)**	S	S	S	S	N/A	S	N/A			
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. **(responding)**	S	S	S	S	N/A	S	N/A			
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." **(responding)**	S	S	S	S	N/A	S	N/A			
Faculty Initials	HS	HS	MD	CB	FB	MD	BL			

Objective 7a: Provide a comment for the highlighted competency each week of your 1 South clinical. Put "NA" for the weeks not assigned to 1 South.

Comments:

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

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

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

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

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

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

Week 6 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

Care Map Evaluation Tool**
Psych

2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
7/6/2024	Social Isolation	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: Andrea Pulizzi				**Course Objective:**			
Date or Clinical Week: 7/6/2024							
	Criteria	**3**	**2**	**1**	**0**	**Points Earned**	**Comments**
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	**(lists at least 7*) *provides explanation if < 7**	**(lists 5-6)**	**(lists 5-7 but no specific patient data included)**	**(lists < 5 or gives no explanation)**	3	All criteria met. MD
	2. Identify all abnormal lab findings/diagnostic tests; include specific patient data.	**(lists at least 3*) *provides explanation if < 3**		**(lists 3 but no specific patient data included)**	**(lists < 3 or gives no explanation)**	3	
	3. Identify all risk factors relevant to the patient.	**(lists at least 5*) *provides explanation if < 5**	**(lists 4)**	**(lists 3)**	**(lists < 3 or gives no explanation)**	3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	All criteria met. MD
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	All criteria met. MD
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	

	Criteria	3	2	1	0	Points Earned	Comments
	13. An appropriate rationale is included for each intervention	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	3	All criteria met. MD
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	3	

Reference

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

The care map will be graded "needs improvement" if missing either the in-text citation or reference, but not both.

The care map will be graded "unsatisfactory" if no in-text citation or reference is included.

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

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

Faculty/Teaching Assistant Comments:

Total Points: 45/45 Satisfactory MD

Faculty/Teaching Assistant Initials: MD

Geriatric Assessment Rubric
2024

Student Name: _Andrea Pulizzi_____ Date: _06/20/2024_____

Clinical Assessment Rubric

Mental/Physical Health Status Assessment

	Points Possible	Points Received
Physical Assessment	4	4
Geriatric Depression Scale (short form) Assessment	4	4
Short Portable mental status questionnaire	4	4
Geriatric Health Questionnaire	2	2
Time and change test	4	4
Cognitive Assessment (Clock Drawing)	4	4
Falls Risk Assessment (Get Up and Go)	4	4
Brief Pain inventory (Short form)	2	2
Nutrition Assessment (Determine Your Nutritional Health)	4	4
Instrumental ADL/ Index of Independence in ADL	4	4
Medication Assessment	4	4
Points	40	40

Education Assessment

	Points Possible	Points Received
Learning Needs Identified and Prioritized (3)	10	10
Priorities pertinent to learning needs (3)	5	5
Nursing interventions related to learning needs (5)	10	10
Points	25	25

Education Plan

	Points Possible	Points Received
Education Prioritization and Barriers to Education	5	5
Teaching Content and Methods used for Education	10	10
Evaluation of Education Plan	10	10
Education Resources attached	10	10
Points	35	35

Total Points __100/100_____

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

You must receive a total of 77 out of 100 points to receive a “S” grade on the Evaluation of Clinical Performance tool. Due date can be located on the clinical schedule.

Firelands Regional Medical Center School of Nursing
Nursing Process Grading Rubric- Psychiatric Nursing 2024

Criteria	**Ratings**				**Points Earned**
Criterion #1 Process Recording is organized and neatly completed	5 Points Typed process recording with spelling and grammar correct.	3 Points Typed process recording with 5 or less spelling and grammar mistakes.	1 Points Typed process recording with 5 or more spelling and grammar mistakes.	0 Points Process recording is not typed with 10 or more spelling and grammar mistakes.	
Criterion #2 Assessment	7 Points Identifies pertinent patient background, current medical and psychiatric history. Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.	5 Points Identifies areas of assessment but incomplete data provided in 2 of the 4 areas. Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.	3 Point Identifies areas of assessment but incomplete data provided in 3 of the 4 areas. Provides a self-assessment of thoughts and feelings prior and during therapeutic communication interaction with patient. Identifies the milieu and effects on patient.	0 Points Missing data in all 4 areas of assessment.	
Criterion #3 Mental Health Nursing Diagnosis (priority problem)	8 Points Identifies priority mental health problem (not a medical diagnosis) providing at least 5 relevant/related data and potential complications.	5 Points Identifies Priority mental health problem provides at least 4 relevant/related data and potential complications.	3 Point Identifies priority mental health problem provides at least 3 relevant/related data and potential complications.	0 Points Does not provide priority mental health problem and/or less than 3 relevant/related data and potential complications.	
Criterion #4 Nursing Interventions	10 Points Identifies at least 5 pertinent nursing interventions in priority order including a rationale and timeframe. Interventions must be individualized and realistic. Identifies a therapeutic communication goal.	6 Points Identifies 4 or less nursing interventions in priority order including a rationale and time frame. Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.	
Criterion #5	15 Points	10 Points	5 Point	0 Points	

Process Recording	Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.	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.	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.	Direct quotes are not provided. Nonverbal and Verbal behavior is not described for less than half of the interactions. Student thoughts and feelings for less than half of the interactions provided.	
Criterion #6 Process Recording	20 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic) and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 75% of interactions.	15 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 50% of interactions.	10 Point Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), no technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 25% of interactions.	0 Points Analysis not provided for each interaction	
Criterion #7 Process Recording	10 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 10 interchanges between patient and student.	6 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 7 interchanges between patient and student.	4 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 5 interchanges between patient and student.	0 Points There was less than 5 interchanges between patient and student provided.	
Criterion #8 Evaluation	15 Points Self-evaluation of communication with patient. Identify at least 3 strengths and 3 weaknesses of therapeutic communication.	10 Points Self-evaluation of communication with patient. Identified 2 strengths and 2 weaknesses of therapeutic communication.	5 Point Self-evaluation of communication with patient. Identified 1 strength and 1 weakness of therapeutic communication.	0 Points No self-evaluation was provided.	
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	4 Point Identify at least 2 barriers to communication did not include interventions or communication that could have been done differently. Did not	0 Points Identify at least 1 barrier to communication did not include interventions or communication that could have been done	

		pertinent social determinants of health.	identify any pertinent social determinants of health.	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	HS	MD	CB	FB	FB	FB	MD	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	NA	NA	

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

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

CLINICAL JUDGMENT COMPONENTS	OBSERVATION NOTES
NOTICING: (1,2,5)*	
• 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. Attempts to seek out information related to why patient is hospitalized and fall. Recognizes that the patient does not need Lorazepam based on the CIWA scale score. Notices patient appears to be anxious. Notices patient's blood pressure is elevated. Recognizes the patient needs Lorazepam based on the CIWA Scale score. Attempts to seek out information related to fall and laceration and bruising. Attempts to seek out information related to support system and resources used.
INTERPRETING: (2,4)*	Prioritizes performing CIWA Scale.
• Prioritizing Data: E A D B • Making Sense of Data: E A D B	Interprets CIWA Scale score as 4. Interprets CIWA Scale score as 22. Interprets CIWA protocol accurately for Lorazepam dose (4 mg PO).
RESPONDING: (1,2,3,5)*	Introduces self and identifies patient.
• Calm, Confident Manner: E A D B • Clear Communication: E A D B	Obtains vital signs (T-98.6, HR-84, BP-154/92, SpO2-98%, RR-18). Assesses patient's anxiety (4/10).

• Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Performs CIWA Scale. Performs CAGE Questionnaire. Medication nurse verifies patient, DOB, allergies and scans. Safety check completed after medications given (looking into patients mouth). Provides education related to community resources and self-help groups. Great therapeutic communication, offering self if patient needed to talk. Identifies self and patient. Obtains vital signs (HR-80, BP-142/86, RR-20, SpO2-98%). Assesses patient's pain level (0/10). Assesses patient's anxiety level (6/10). Performs CIWA Scale. Medication nurse verifies patient, DOB, allergies and scans. Medication nurse administers Lorazepam 4 mg PO (per protocol). Safety check completed after medications given (looking into patients mouth).
REFLECTING: (1,2,5)* • Evaluation/Self-Analysis: E A D B • Commitment to Improvement: E A D B	Group members actively participated during debriefing. Appropriate questions were asked. Each group member discussed what they felt were strengths and weaknesses in their performance. Alternate choices were discussed for improvement in the future. Each member verbalized something they would do differently if they were to do the scenario again.
SUMMARY COMMENTS: * = Course Objectives **Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.** **E= Exemplary** **A= Accomplished** **D= Developing** **B= Beginning**	Lasater Clinical Judgement Rubric Comments: Noticing: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes most obvious patterns and deviations in data and uses these to continually assess. Assertively seeks information to plan intervention; carefully collects useful subjective data from observing and interacting with the patient and family. Interpreting: Focuses on the most relevant and important data useful for explaining the patient's condition. In most situations, interprets the patient's data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more

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

EVALUATION OF CLINICAL PERFORMANCE TOOL
Psychiatric Nursing

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

I was given the opportunity to review my final clinical ratings in each course competency. I was given the opportunity to ask questions about my clinical performance. I have the following comments to make about my clinical performance/final clinical evaluation:

Student eSignature & Date: