

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

Student: Zachary Grosswiler

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)
06/20/2024	8	Forgot ID badge for Hospice clinical	06/20/2024 0700-1500
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		

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

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

OTHER

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

Objective										
	1. Apply the principles of psychiatric theory in the care of adolescent to geriatric patients with a mental illness diagnosis. (1, 2, 3, 5, 6, 7, 8)*									
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies:	NA	S	S	NA	NA	NA	NA S			
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. (noticing)	NA	S	S	NA	NA	NA	NA S			
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. (interpreting)	NA	S	S	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	S	S	NA	NA			
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care (noticing)	NA	S	S	NA	NA	NA	NA S			
e. Recognize social determinants of health and the relationship to mental health. (reflecting)	NA	S	S	NA	NA	NA	NA			
f. Develop and implement an appropriate nursing therapy group activity. (responding)	NA	NA	S	NA	NA	NA	NA			
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment) (responding)				NA						
Faculty Initials	HS	CB	HS	BL	CB	BL	CB			
Clinical Location	No Clinical	1S	1S	Hospice	Detox	No Clinical	Artisans			

Comments:

* End-of-Program Student Learning Outcomes

Week 2(1a,b,e,f): Zach, 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. CB

Week 3 (1a,b,c,d,e) You did a nice job this week identifying how mental health can be impacted by an individual's physical health, and also the environment in which they are a part of. You were also able to see how the spiritual component played a role in some of the patient's well-being. Nice job discussing the social determinants of health that impacted many of the patients this week. HS

(1f)-Nice job on your nursing therapy group this week! The patients seemed to enjoy the group and did a nice job participating, even those that stated it made them feel uneasy speaking in front of the group. HS

Week 4-1(c) Excellent job this week during your Hospice clinical experience in which you were able to provide culturally and spiritually competent care for end-of-life patients. BL

Week 5(1c): 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 7(1a,b,d): Great job discussing risk factors for individuals fighting addiction and how therapies/meetings help with sobriety. CB

Objective										
2. Synthesize concepts related to psychopathology, health assessment data, evidenced based practice and the nursing process using clinical judgment skills to plan and care for patients with mental illness. (1, 2, 3, 4, 5, 6, 7, 8)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
a. Competencies: Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. (noticing)	NA	S	S	S	S	NA	NA			
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. (noticing, recognizing)	NA	S	S	S	NA	NA	NA			
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. (noticing, interpreting)	NA	S	S	S	S	NA	NA S			
d. Formulate a prioritized nursing plan of care utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting)*	NA	S	S	S	NA	NA	NA			
e. Apply the principles of asepsis and standard precautions. (responding)	NA	S	S	S	S	NA	NA			
f. Practice use of standardized EBP tools that support safety and quality. (noticing, responding)	NA	S	S	S	S	NA	NA			

* End-of-Program Student Learning Outcomes

Faculty Initials	HS	CB	HS	BL	CB	BL	CB			
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*When completing the 1South Care Map CDG refer to the Care Map Rubric

Comments:

Week 2(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 discuss appropriate lab findings and tools that support a culture of safety. CB

Week 3 (2a,b,c)-You were able to obtain a health history along with the mental health issues impacting your patient. You were also able to use both subjective and objective findings to assist in developing a plan of care for the patient. HS

(2d)- Nice job on your care map this week! You did a nice job including all of the requirements and painting a picture of the patient's priority problem and the interventions and why each one is important. HS

(2f)-Nice job on your EBP article and discussing how it can impact patient care. HS

Week 4-2(d) Great job contributing to developing/carrying out the plan of care for each of the patients you helped care for while in hospice. BL

Week 5(2c): Great job discussing the support the staff at the detox unit give the patients in their time of need. CB

Week 7(2c): You did a good job discussing how individuals with substance abuse problems cope and handle situations they may encounter. CB

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

Comments:

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

Week 3 (3a,c,d,f)- You did a nice job using therapeutic communication skills when interacting with the patients this week. You successfully met the requirements for your CDG postings for both days. HS

* End-of-Program Student Learning Outcomes

Week 4-3(b) This week in Hospice you participated in the transition of care from night shift to day shift in which you observed SBAR handoff communication. 3(e) For the Nursing Process Study assignment, you received 75/100 points which is a “Needs Improvement.” Please review the Nursing Process Grading Rubric below for individualized feedback related to the assignment. You are required to revise and resubmit this assignment to your dropbox by 07/01/2024 at 0800. As a reminder, students are allowed one remediation attempt for this assignment in order to become satisfactory. If you have any questions, or need further clarification, please do not hesitate to reach out. 3(f) Satisfactory completion of your Hospice Reflection Journal. You provided a thoughtful reflection related to your experience and shared new knowledge related to the role of the hospice nurse when caring for the end-of-life patient. Great job! BL

Week 5(3f): Zach, great job on your cdg! You were very thorough answering each question, meeting all requirements. Zach, your revised Nursing Process Recording is Satisfactory, scoring 100/100. CB

Week 7(3f): Zach, great job on your cdg this week! Each question was answered thoroughly, meeting all requirements. CB

Objective										
4. Demonstrate knowledge of frequently prescribed medications utilized in treating mental illness. (1, 4, 5, 6, 7)*										
Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
a. Observe &/or administer medication while observing the six rights of medication administration. (responding)	NA	S	S	NA	NA	NA	NA			
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. (responding, reflecting)	NA	S	S	NA	NA	NA	NA			
c. Identify the major classification of psychotropic medications. (interpreting)	NA	S	S	NA	NA	NA	NA			
d. Identify common barriers to maintaining medication compliance. (reflecting)	NA	S	S	S	S	NA	NA			
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications. (responding, reflecting)	NA	S	S	NA	NA	NA	NA			
Faculty Initials	HS	CB	HS	BL	CB	BL	CB			

Comments:

Week 2(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 3 (4a-e)-You did a nice job this week administering medications. You followed the six rights of medication administration. You were able to discuss the prescribed medications for your patient, the implications for use, side effects, classification, related interventions and safety issues. HS

Week 5(4d): Great job this week identifying common barriers to medication compliance and the medication routine at the Erie County Detox Unit. CB

* End-of-Program Student Learning Outcomes

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

****Alternative Assignment**

Comments:

Week 1- (5a-d)- The listed competencies have received an Unsatisfactory evaluation because of failure to self-evaluate. Please refer to the highlighted area on page 2 of the clinical tool on how to address the “U”s for Week 2. Please let me know if you have any questions. HS

WEEK 2 ADDRESS OF UNSATISFACTORY MARKS: I am here addressing my unsatisfactory marks for all parts of Objective 5 for the Week 1 clinical tool. This was due to an error on my part in overlooking the objective itself. Now and in the future, I will take extra care to not skip over any page and double check all competencies to ensure I have evaluated them. CB

Week 2(5b): You were able to discuss and observe discussion related to resources in the community to help patients with mental health disorders. CB

Week 3 (5a,b)- You were able to discuss the community resources that are available to those individuals that are in need within the community. HS

* End-of-Program Student Learning Outcomes

Week 5(5a,b,c): You did a great job collaborating with members at the Erie County Detox Center, identifying the need for community resources. CB
Week 7(5a,b,d): Great job attending the Sandusky Artisan's and participating in a meeting with individuals facing substance abuse challenges. CB

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:	NA	S	S	NA	NA	NA	NA			
a. Demonstrate competence in navigating the electronic health record. (responding)	NA	S	S	NA	NA	NA	NA			
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. (responding)	NA	S	S	NA	NA	NA	NA			
c. Demonstrate the use of technology to identify mental health resources. (responding)	NA	S	S	NA	NA	NA	NA			
Faculty Initials	HS	CB	HS	BL	CB	BL	CB			

Comments:

Week 2(6a-c): Great job this week documenting medications given in the EMAR. CB

Week 3 (6a,b,c)- You were able to successfully navigate the electronic health record in order to obtain the information you needed. You were also able to document on group participation and document the medication administration. HS

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

Week 2 Strengths of Care: This week, some strengths related to delivery of care I felt I had this week were adjusting to the first experience I had with the floor and acknowledging my inherent biases, using that knowledge to form the way I communicate with the patients. The outcome was that I treated the patients whom I interacted with as an equal and like I was trying to become their friend like you might see in a usual setting, while making sure I stuck to therapeutic communication techniques.

Week 2(7a,b): Good job this week in clinical. I would say that was a strength for you and you were engaged with the patients, being active and communicating. You did a good job ensuring a culture of safety, and were able to discuss some of those in your cdg. CB

Week 3 Strengths of Care: This week, some strengths for care I felt I had this week were settling in with the flow of the milieu and understanding when I would have time with the patients. I was able to talk to more patients this week, and I even made some really great conversation about the actual issues a patient was having instead of shared

interests or small talk, which I didn't think I would be able to do. You did a nice job communicating with several patients this week. Patients were willing to open up and discuss some of the current problems that they were experiencing. Nice job! HS

Week 4 Address of unsatisfactory evaluation: for this week, I rated myself as "U" in objective 7e. This rating is accurate because I did not have my student badge with me when I started the hospice clinical experience. To prevent this, I will find my badge and keep it in a more secure place for every time that I am not using it. Zach, thank you for acknowledging your mistake and identifying a plan to prevent this from happening moving forward. BL

Week 4-7(c) Zach, your Hospice Reflection Journal was very well done and provided a great reflection related to your experience. Keep up all your hard work! BL

Week 5(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

Week 7(7c): Great job this week reflecting on your clinical experience and your thoughts/feelings related to substance abuse. CB

Care Map Evaluation Tool**
Psych

2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/15/24	Impaired Mood Regulation	S/HS	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: Zachary Grosswiler				Course Objective:			
Date or Clinical Week: 6/14/2024							
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	You included a nice list of the abnormal findings associated with the patient. Other risk factors to consider would be her triggers that she mentioned. HS
	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	Great job listing all of the potential nursing priorities, and identifying the priority. HS
	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	Nice job with your patient specific interventions. HS
	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	
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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	Nice job reassessing your priority nursing findings. HS
	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:						Total Points:45/45 Satisfactory HS	
						Faculty/Teaching Assistant Initials: Nice job on your care map this week. You included all patient specific findings and the appropriate priority problem and individualized interventions. HS	

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.	7
Criterion #3 Mental Health Nursing Diagnosis (priority problem)	8 Points Identifies priority mental health problem (not a medical diagnosis) providing at least 5 relevant/related data and potential complications.	5 Points Identifies Priority mental health problem provides at least 4 relevant/related data and potential complications.	3 Point Identifies priority mental health problem provides at least 3 relevant/related data and potential complications.	0 Points Does not provide priority mental health problem and/or less than 3 relevant/related data and potential complications.	8
Criterion #4 Nursing Interventions	10 Points Identifies at least 5 pertinent nursing interventions in priority order including a rationale and timeframe. Interventions must be individualized and realistic. Identifies a therapeutic	6 Points Identifies 4 or less nursing interventions in priority order including a rationale and time frame. Interventions are not individualized and/or	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame provided. Interventions are not individualized and	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic	10

	communication goal.	realistic. Identifies a therapeutic communication goal.	/or realistic. Identifies a therapeutic communication goal.	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.	10 15
Criterion #6 Process Recording	20 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic) and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 75% of interactions.	15 Points Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), and technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 50% of interactions.	10 Point Analysis of each interaction providing type of communication (therapeutic or nontherapeutic), no technique (exploring, focusing, reflecting, formulating a plan of action, etc.) Provides explanation of at least 25% of interactions.	0 Points Analysis not provided for each interaction	0 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 Evaluation	10 Points Identify at least 3 barriers to	6 Points Identify at least 2 barriers	4 Point Identify at least 2 barriers	0 Points Identify at least 1	10

	communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	to communication did not include interventions or communication that could have been done differently. Did not identify any pertinent social determinants of health.	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: Zach, you received a “Needs Improvement” per the Nursing Process Recording grading rubric. Please see my comments below. Criterion #5: Points were deducted from this section because you did not provide direct quotes for the interchanges. Criterion #6: Points were deducted from this section because you did not provide a <u>complete</u> analysis of the interaction for any of your interchanges. In order for the analysis to be <u>complete</u>, you need to provide the type of communication used (therapeutic or non-therapeutic), the technique used (exploring, focusing, etc.), and an explanation as to how you utilized the technique listed (exploring, focusing, etc.) for <u>all</u> interchanges. For reference, there is an example of a sample process recording on pg. 120 in your textbook (Table 5-5) that demonstrates how to correctly complete this section. You are required to revise and resubmit this assignment to your dropbox by 07/01/2024 at 0800. As a reminder, students are allowed one remediation attempt for this assignment in order to become satisfactory. If you have any questions, or need further clarification, please do not hesitate to reach out. Zach, your revised Nursing Process Recording is Satisfactory, scoring 100/100.					Total Points: 75/100 100/100
Faculty Initials: CB/CB					

Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2024
Simulation Evaluations

<u>vSim Evaluation</u> 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	CB	HS	BL	BL	CB	CB	BL	
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): Zachary Grosswiler (M), Nadia Drivas (A), Davondre Harper (A), Stevi Ward(M)

GROUP #: 3

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/26/2024 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	Attempts to seek out information related to patient's admission and substance use. Notices patient appears to be anxious. Notices patient's blood pressure is elevated. Recognizes the patient does not need any Lorazepam based on the CIWA Scale score. Notices patient is having visual hallucinations. Notices the patient is itching and anxious. Seeks out information related to patient's reason for admission. 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	Interprets the CIWA Scale score as 4. Prioritizes completing CIWA Scale. Interprets the 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. Assesses patient's pain (0/10). Obtains patient's vital signs (T-98.6, Spo2-98%, BP-154/90, HR-72, RR-24). Attempts to utilize therapeutic communication with the patient, sometimes uses non-therapeutic communication. Performs the CIWA Scale. Probes for information at times, hinders the therapeutic nurse-patient relationship. Be aware of facial expressions displayed in front of the patient. Attempts to complete the CAGE Questionnaire, then stops. After speaking with the patient more is able to complete it. Completes the Brief Mental Status Evaluation. Medication nurse reviews medications and educates patient. Medication nurse does not identify patient or scan, administers medications. Identifies self. Obtains vital signs (T-98.6, BP-143/90, SpO2-98%, HR-78, RR-22). Asks patient orientation questions. Performs CIWA Scale. Attempts to utilize therapeutic communication with the patient, provides resources. Medication nurse verifies patient and scans. Medication nurse administers Lorazepam 4 mg PO (per protocol), educates the patient on the medication. Works with case management to set up resources for the patient at discharge.
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: Focuses observation appropriately; regularly observes and monitors a wide variety of objective and subjective data to uncover any useful information. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Actively seeks subjective information about the patient’s situation from the patient and family to support planning interventions; occasionally does not pursue important leads. Interpreting: Generally focuses on the most important data and seeks further relevant information but also may try to attend to less pertinent data. In most situations, interprets the patient’s data patterns and compares with known patterns to develop an intervention plan and accompanying rationale; the exceptions are rare or in complicated cases where it is appropriate to seek the guidance of a specialist or a more experienced nurse. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Shows some communication ability (e.g., giving directions); communication with patients, families, and team members is only partly successful; displays caring but not competence. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to 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:

