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

Student: | Davondre Harper | **Final Grade: Satisfactory/Unsatisfactory**

Semester: Summer Session   **Date of Completion:**

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

         Faculty eSignature:

DIRECTIONS FOR USE:

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

METHODS OF EVALUATION:

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

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
6/15/2024	1 hour	Incomplete Hospice Survey	6/17/2024 1600

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

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)**	~~Na~~ S	na	na	na	s	na	s	na	na	
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	~~Na~~ S	na	na	na	s	na	s	na	na	
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**	na	s	na	na	~~na~~ S	na	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	s	na	s	na	na	
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	na	na	na	na	s	na	s	na	na	
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	na	na	na	na	s	na	n/a	na	na	
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				~~S~~ U	S			na		
Faculty Initials	MD	HS	CB	BL	BL	CB	FB			
Clinical Location	Sandusky Artisans	Erie County Health Depart. Detox Unit	Hospice	na	1-South	na	1-South	na	na	

Comments:

* End-of-Program Student Learning Outcomes

Sandusky Artisans Objective 1A, B, D-You successfully completed these objectives by describing them in your CDG this week. MD

Week 2 (1c, d)-You discussed culturally and spiritually competent care within your CDG posting, as well as how the patient is able to achieve self- care in the detox center. HS

Week 4-1(g) For the Geriatric Assessment assignment, you received 68/100 points which is a "Unsatisfactory." Please review the Geriatric Assessment Grading Rubric below for individualized feedback related to the assignment. You are required to revise and resubmit this assignment to the Psychiatric Nursing Course mailbox 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. Remember to address this "U" on your Week 5 Clinical Tool. BL

Week 5-1(e,f) Davondre, excellent job with both of your CDGs this week in which you described the relationship between your patient's mental health, physical health, and environment. You were able to correlate the patient's prescribed therapies to their current diagnosis, and you did a great job discussing social determinants of health that play a role in your patient's mental health. You also did an excellent job facilitating nursing therapy group for the patients this week. Your "Dice breaker" activity was engaging and a great way for the patients to learn more about each other and the students. BL 1(g) Davondre, you successfully remediated on all areas that needed adjustments and received a satisfactory rating. Great job! MD

Week 7 (1a,c,d) Great job with understanding the relationship of mental illness, physical signs and symptoms, and risk factors as identified on your care map. You demonstrated empathy towards your assigned patient while meeting cultural and any spiritual needs during this week's clinical rotation. Appropriate methods to assist your patient in regaining an independence and regaining self-care was also displayed during clinical this week, great job! FB

* End-of-Program Student Learning Outcomes

Objective

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

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

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

Comments:

Sandusky Artisans Objective 2C-You did a great job discussing current trends in substance abuse in your CDG this week. MD

Week 5-2(a,b,f) Excellent job discussing your patient's past medical and mental health history in your CDG, as well as describing factors that create a culture of safety in the psychiatric unit. You did a nice job discussing your EBP article titled "Antidepressant Efficacy of Ketamine in Treatment-Resistant Major Depression" during debriefing. Keep up the great work! BL

Week 7 (2a,b,d) Great job identifying your patient's mental health history, reason for this admission, and correlating with medical health issues. You were able to assess for subjective and objective data including labs, diagnostic testing, and risk factors to provide a priority problem for your assigned patient. Great job with the use of clinical judgment skills to develop a plan of care as evidenced by the care map. FB

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

Comments:

Sandusky Artisans Objective 3F-You satisfactorily completed the CDG this week in full detail. You had an appropriate reference and in-text citation. It was very interesting to read your comments about this experience. MD
Week 2- (3f)- This competency was changed to an unsatisfactory due to the fact that you did not meet the minimum word requirement per question which also resulted in minimal effort displayed in several of the responses to the questions. Be sure to address this U for the Week 3 submission and read the requirements prior to submitting the

* End-of-Program Student Learning Outcomes

- ***Week 2/3 (3f):*** I understand that I received this U due to me not meeting the word count requirement per question for Week 2's CDG. I will correct this in the future by making sure to read and not skim over the word count requirements in the CDG Directions moving forward. Unfortunately, I misread the 200-word count per question as 200-word count overall. I will be more attentive to the requirements for the future CDGs. I apologize for the inconvenience this discrepancy might have caused. This sounds like a great plan to ensure that all requirements are met. CB

Week 3(3f): Davondre, great job meeting all requirements for you cdg. CB

Week 5-3(a,d,f) Davondre, you did an excellent job therapeutically communicating with all the patients this week. Satisfactory completion of both CDG posts this week. Great job! BL

Week 7 (3c,f) Great job with the identification of barriers for your assigned patient that may hamper their communication skills. You did a great job with CDG post, following all expectations of CDG rubric. (b,h,) You demonstrated a professional manner while obtaining and participating in shift report, therefore this competency was changed to a "S". You also did a great job with assessing your patient for the readiness to learn and comprehension of adaptive coping skills and behaviors during this clinical rotation. FB

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

Comments:

Week 5-4(a-e) Excellent job demonstrating knowledge of frequently prescribed medications utilized in treating mental illness through one-on-one discussion with your instructor during clinical. You administered medications to your patient following all six rights of medication administration. Great discussion of common barriers to maintaining medication compliance in your CDG this week. BL

Week 7 (4a-e) Excellent job with medication administration following all six rights of administration. You demonstrated knowledge and implications for each medication administered, identified classification, significant signs and symptoms, pertinent nursing interventions, and any safety concerns, great job! FB

* End-of-Program Student Learning Outcomes

Objective

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

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
a. Identify the need for the community resources-detox unit available to patients with a mental illness. **(noticing, interpreting)**	na	s	na	na	na	na	~~Na~~ S	na	na	
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	~~Na~~ S	s	na	na	na	na	~~Na~~ S	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	s	na	na	na	na	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	na	na	na	na	na	na	na	
Faculty Initials	MD	HS	CB	BL	BL	CB	FB			

**Alternative Assignment
Comments:
Sandusky Artisans Objective 5B, D-You were able to identify the meeting platform that is utilized at the Sandusky Artisans. You were also able to identify if this is an effective resource for patients with sobriety. You also discussed what learning you experienced during this clinical. MD
Week 2(5a-c)-You discussed the resources that are available to individuals such as therapists and therapy groups. HS

Week 7 (5a,b) These competencies were satisfactory through the development of care for the patient cared for in 1S, great job discussing resources available for the patient upon discharge. FB

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

Comments:
Week 5-6(b) Excellent job documenting on the Nursing Therapy Group this week. BL

Week 7(6a,c) Great job using the electronic health record to gather information on your assigned patient. FB

* End-of-Program Student Learning Outcomes

Objective

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

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

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:
Sandusky Artisans Ojective 7C-You were able to discuss your feelings, attitudes, and response to working with individuals experiencing substance abuse in your CDG. MD
Week 2 (7c)- You briefly reflected within your CDG posting this week. Be sure to answer each question with sufficient information. HS
Week 3(7c,e): Davondre, great job on your hospice reflection paper. RN signature form "Excellent in all areas, expect Satisfactory in establishment in plan of care and manager of care-communication skills." CB

- *5a: I would say that my strength for care delivery on my patient with mental illness would be that I utilized therapeutic techniques, such as active listening, restating what the patient had stated to let them know that I heard what they said, and was somewhat of an outlet to the patients by allowing them the space and freedom to express how they feel as well as being a positive distraction from their internal/external stressors.* Great job, Davondre! BL

Week 5-7I This competency was changed to an "NI" for this week as it relates to responsibility. Your CDGs were not submitted to the appropriate location under "Discussions." Remember, all CDGs are to be posted under the appropriate week on the "Discussions" tab on Edvance360, not your personal dropbox. If you ever need clarification, please reach out to any of the faculty. Remember to address this "U" on your Week 6 clinical tool, including a plan for improvement. BL

- 6e: In the upcoming weeks, I will make sure to submit the remainder of the CDG's to their appropriate location. I will ensure that this is done correctly and in a timely and efficient manner by referring to the handout that was received during the first week to see where the assignments should be submitted. I also will be sure to reach out to classmates or faculty, if I am unsure of where to submit said assignment.

Week 6(7e): Davondre, competency 7e was changed to a "U" due to your clinical tool being submitted after the due date and time. 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. CB

- 7e: I have received a U due to late submission. Moving forward, I will satisfactorily meet this competency by double checking twice, right away when trying to turn it in and before it is due at 2200 on Saturday to ensure it is turned in and prevent this from happening again in the next 2 weeks. It is a great habit to always double check due dates, times, and work submitted. You can also set reminders on your phone so nothing is forgotten. All work was submitted on time this week 7. FB

- 7a: My strength this clinical was participating in all actives, getting patients to participate in actives with me such as coloring, as well has having great conversations with them. This created a trusting relationship with some of the patients as well as gave them a safe space to relax. Great job creating a safe environment for patient to open up and discuss their feelings. It is very important to build the trusting relationship with patients who are at a very vulnerable time in their life. FB

Care Map Evaluation Tool**
Psych

2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
1/16/2024	Suicidal Ideation	S/FB	NA

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

Comments: Satisfactory completion of psychiatric nursing care map. Total score of 41/45. See care map grading rubric for details. FB

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Davondre Harper					
Date or Clinical Week: 7/9/2024 Week 7					

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

	Criteria	3	2	1	0	Points Earned	Comments
Noticing	1.Identify all abnormal assessment findings (subjective and objective); include specific patient data.	(lists at least 7*) *provides explanation if < 7	(lists 5-6)	(lists 5-7 but no specific patient data included)	(lists < 5 or gives no explanation)	3	Great job with identification of all subjective and objective assessment findings, abnormal laboratory data, diagnostic testing, and risk factors.
	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	Nice job distinguishing the appropriate abnormal findings as they relate to the priority problem. Priority problems provided were relevant to your assigned patient. Complications provided and signs and symptoms of each complication were very thorough.
	5. State the goal for the top nursing priority.	Complete			Not complete	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	7. Identify all potential complications for the top nursing priority problem.	(lists at least 3)	(lists 2)		(lists < 2)	3	
	8. Identify signs and symptoms to monitor for each complication.	(lists at least 3)	(lists 2)		(lists < 2)	3	
Respo	9. List all nursing interventions relevant to the top nursing priority.	> 75% complete	50-75% complete	< 50% complete	0% complete	2	Nursing interventions were prioritized, frequencies provided, individualized, and realistic for the patient. Great job with providing rationales for each of the
	10. Interventions are prioritized	> 75% complete	50-75% complete	< 50% complete	0% complete	3	

	Criteria	3	2	1	0	Points Earned	Comments
n d i	11. All interventions include a frequency	> 75% complete	50-75% complete	< 50% complete	0% complete	3	nursing interventions. Additional interventions included should have been regarding education and resources for the patient.
	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
Reflecting	13. An appropriate rationale is included for each intervention	> 75% complete	50-75% complete	< 50% complete	0% complete	3	
	14. List all of the highlighted reassessment findings for the top nursing priority.	>75% complete	50-75% complete	<50% complete	0% complete	3	Evaluation of your priority problem identified was done appropriately. The evaluation should include a statement on whether to continue, modify or terminate the plan of care established. This is determined by the evaluation of your assessment findings.
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	Complete			Not complete	0	

Reference

An in-text citation and reference are required.

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

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

Total Possible Points= 45 points 45-35 points = Satisfactory 34-23 points = Needs Improvement* < 23 points = Unsatisfactory* ***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.** *****Students that are not satisfactory after 2 attempts will be required to meet with course faculty for remediation. ***** **Faculty/Teaching Assistant Comments:** **Satisfactory completion of psychiatric nursing care map. Great job!**	**Total Points:** 41/45 **Faculty/Teaching Assistant Initials:** FB

Geriatric Assessment Rubric
2024

Student Name: ___Davondre Harper_____   Date: ___6/20/2024 6/26/24

Clinical Assessment Rubric

Mental/Physical Health Status Assessment

	Points Possible	Points Received
Physical Assessment	4	3.5 4
Geriatric Depression Scale (short form) Assessment	4	4 4
Short Portable mental status questionnaire	4	2 4
Geriatric Health Questionnaire	2	2 2
Time and change test	4	4 4
Cognitive Assessment (Clock Drawing)	4	4 4
Falls Risk Assessment (Get Up and Go)	4	4 4
Brief Pain inventory (Short form)	2	2 2
Nutrition Assessment (Determine Your Nutritional Health)	4	4 4
Instrumental ADL/ Index of Independence in ADL	4	4 4
Medication Assessment	4	2 2
Points	40	35.5 40

Education Assessment

	Points	Points

	Possible	Received
Learning Needs Identified and Prioritized (3)	10	5 10
Priorities pertinent to learning needs (3)	5	5 5
Nursing interventions related to learning needs (5)	10	7.5 10
Points	25	17.5 25

Education Plan

	Points Possible	Points Received
Education Prioritization and Barriers to Education	5	0 5
Teaching Content and Methods used for Education	10	5 10
Evaluation of Education Plan	10	10 10
Education Resources attached	10	0 10
Points	35	15 35

Total Points 68/100 Unsatisfactory MD
Remediation-100/100 Satisfactory MD

Physical Assessment- Unfortunately you missed addressing the musculoskeletal section leading to 0.5 missed points. MD
Short Portable Mental Status Questionnaire- The score of the patient was not addressed leading to 2 missed points. MD
Medication Assessment- The BEERS list section of the table was not filled in at all. Only half of the medications were also described/addressed leading to 2 missed points. MD
Learning Needs- There were missing "related to" statements with the learning need priorities leading to 5 missing points. MD
Nursing Interventions- There were no timeframes addressed for this section leading to 2.5 missing points. MD
Barriers- This section was not addressed at all leading to 5 missing points. MD
Teaching Content- More details were needed on what specifically you discussed with the patient in an outline form. There should be specific documentation of what your conversation was with your patient leading to 5 missing points. MD
Education Resources- No documents of resources were provided for this project leading to 10 missing points. MD
Evaluation- This was an AMAZING evaluation of your patient! I am so proud of you for catching the lesion and directing the patient to seek further medical care! MD

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	6 Points Identifies 4 or less nursing interventions in priority order including a	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no	0 Points Identifies less than 4 interventions, not prioritized, individual,	

	timeframe. Interventions must be individualized and realistic. Identifies a therapeutic communication goal.	rationale and time frame. Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	rationale or time frame provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	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 weaknesses of therapeutic communication.	10 Points Self-evaluation of communication with patient. Identified 2 strengths and 2 weaknesses of therapeutic	5 Point Self-evaluation of communication with patient. Identified 1 strength and 1 weakness of therapeutic communication.	0 Points No self-evaluation was provided.	

			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	HS	CB	BL	BL	BL	BL	CB	
Remediation: **Date/Evaluation/Initials**	NA	NA	NA	NA	NA	NA	NA	

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

Student Roles: A=Assessment Nurse; M=Medication Nurse
STUDENT NAME(S) AND ROLE(S): 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	Interprets the CIWA Scale score as 4.

• Making Sense of Data:	E	**A**	D	B	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: