

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

Student: Karli Schnellinger

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)
6/8/2024	1H	Missed SARCC Survey	6/10/2024/0800
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	NA	NA	S	NA	S	NA	NA	
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	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	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	S	S	S	NA	S	NA	NA	
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care (noticing)	NA	NA	NA	NA	S	NA	S	NA	NA	
e. Recognize social determinants of health and the relationship to mental health. (reflecting)	NA	S	S	NA	S	NA	S	NA	NA	
f. Develop and implement an appropriate nursing therapy group activity. (responding)	NA	NA	NA	NA	S	NA	S NA	NA	NA	
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment) (responding)				S				NA		
Faculty Initials	HS	FB	MD	FB	CB	BL	FB			
Clinical Location	No Clinical	Sandusky Artisans	Hospice	Detox	1 South	No Clinical	1 South	No Clinical	No Clinical	

Comments:

* End-of-Program Student Learning Outcomes

Week 2 (1a,b,c,e)- Great job with understanding the relationship between substance abuse and how this effects mental health of an individual. You provided the correlation of mental illness the assistance of group therapy and how the needs of diverse cultures are met through this therapy. You also recognized the effect social determinants of health can have on the use of addictive substances and how individuals recover or cope from addiction. FB

Week 4 (1g) Satisfactory completion of Geriatric Assessment Assignment. Please grading rubric below. FB

Week 5(1a,b,e,f): Karli, 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 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! (1f) You did not implement or run a therapy group during this clinical rotation, therefore this competency was changed to a "NA". FB

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:	NA	NA	NA	NA	S	NA	S	NA	NA	
a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. (noticing)	NA	NA	NA	NA	S	NA	S	NA	NA	
b. Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. (noticing, recognizing)	NA	NA	S	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	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	S	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	HS	FB	MD	FB	CB	BL	FB			

* End-of-Program Student Learning Outcomes

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

Comments:

Week 2 (2c)- Identification of coping strategies and defense mechanisms were provided as you interpreted the objectives and effect of the SARCC meeting. FB

Week 5(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 "The power of support from companion animals for people living with mental health problems: a systemic review and narrative synthesis of the evidence." related to mental health during clinical debriefing. Competency 2d was changed to an "S" because plans of care are constantly being formulated when caring for patients. CB

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

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

Comments:

Week 2 (3a,c,d)- Great job with communication skills during the SARCC meeting. You identified many barriers that can occur including culture, individual personality, and the milieu present at the meeting. You participated responding in a therapeutic manner as you participated in the meeting. Great job! (3f) CDG was posted on time and followed all expectations from CDG rubric. FB

* End-of-Program Student Learning Outcomes

Week 4 (3f,g) Great job being respectful on individuals as they are starting the road to sobriety. Clinical discussion was posted in a timely manner following all expectations of the grading rubric. Keep up the great work. FB

Week 5(3a,c,d,f): Karli, you did a great job with therapeutic communication this week. You completed day 1 and 2 cdgs Satisfactorily, meeting all requirements. CB

Week 7 (3c,f,h) Great job with the identification of barriers for your assigned patient that may hamper their communication skills. You did a great job with CDG post, following all expectations of CDG rubric. Great job with assessing your patient for the readiness to learn and comprehension of adaptive coping skills and behaviors. FB

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	S	S 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	S	S	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	HS	FB	MD	FB	CB	BL	FB			

Comments:

Week 4 (4a) This competency was changed because you were on Detox unit at the Erie County Health department which is an observation clinical experience. No medication administration is an objective of this clinical. (4d) Great job identifying barriers for the patient that you assessed for your Geriatric Assessment Assignment. FB

Week 5(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 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	NA	NA	NA	S	NA	S	NA	NA	
b. Discuss recommendations for referrals to appropriate community resources and agencies. (reflecting)	NA	NA	NA	NA	S	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	NA	NA	S	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))	NA	S	NA	NA	NA	NA	NA	NA	NA	
Faculty Initials	HS	FB	MD	FB	CB	BL	FB			

****Alternative Assignment**

Comments:

Week 2 (5d)- Great job discussing the need and benefits for referrals to the SARCC community resource. You also recognize the need for this type of resource in the community and the great asset it is to have available. FB

Week 4 (5c) Great job with discussion regarding the services and process of the Erie County Detox unit. You also recognized the importance and need of this resource for many individuals. The collaboration of the different health care professionals was also explained. Keep up the great work. FB

Week 5(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

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

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	NA	NA	NA	S	NA	S	NA	NA	
a. Demonstrate competence in navigating the electronic health record. (responding)										
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. (responding)	NA	NA	NA	NA	S	NA	S	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	HS	FB	MD	FB	CB	BL	FB			

Comments:

Week 5(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 7(6a-c) Great job using the electronic health record to gather information on your assigned patient. FB

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	S	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	S	S	S	NA	S	NA	NA	
c. Illustrate active engagement in self-reflection and debriefing. (reflecting)	NA	NA S	S	S	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	S	S	S	S	NA	S	NA	NA	
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (responding)	NA	S	S	S	S	NA	S	NA	NA	
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." (responding)	NA	S	S	S	S	NA	S	NA	NA	
Faculty Initials	HS	FB	MD	FB	CB	BL	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:

Week 2 7a: I really enjoyed going to the dual-diagnosis meeting at the Sandusky Artisans. I think it allowed me to see the other side of recovery, whereas in the hospital you might only see the start of the recovery process. A strength for this week would be my active listening skills and participating during the meeting. At the end, when we were all getting our things together to leave, one of the participants came up and thanked me for coming and sharing my thoughts, and how much she really appreciated us. This showed how much it can really mean to someone when you just sit and listen to them as they express how they are feeling, and everything they have been through. **Exactly, we all can make a difference by practicing kindness and listening! Great job this week. FB**

Week 2 (7c-f)-You demonstrated active engagement and participation with an ACE attitude, professional behavior, and excellent student code of conduct. **FB**

Week 3 7a: A strength for this week's clinical experience at hospice would be when I sat down and held hands with one of the patients when they were super nervous and anxious feeling. When the nurse and I went in to give this patient her medications, she grabbed my hand, and did not want to let go, and when we tried to leave the room, you could tell she felt scared, so I stayed awhile until she was ready for me to leave and she felt okay. This was definitely something different that I have to do that I have never

done at a clinical experience, and it made me very grateful to be in the position I am to help people on their worst days. **This is wonderful! I am so glad you were able to have this experience! MD**

Week 3 Hospice Objective 7C-You had a wonderful reflection journal this week! You were able to turn in your reflection journal on time, have the adequate word count, and meet all of the objectives! It really was evident that you had an eye-opening experience with this type of nursing. I appreciated reading your reflection journal and all you were able to learn about this clinical setting. MD

Week 3 Hospice Objective 7E-This week in hospice clinical you were rated excellent in all areas by your nurse you were working with. Great job! MD

Week 4 7a: A strength this week at detox would be sitting in during a meeting with one of the case managers and a patient during my time there, and learning as much as I could within the time I had. Since I have never worked in a hospital before, I have never seen what case managers do especially in a detox unit setting. It was interesting to listen in on the types of questions he was asking the patient as well as having different comforting conversations with her throughout. **There are many health care disciplines that work together that contribute to the best outcomes for patients in all settings. Great job staying engaged in this clinical experience and learning something that you did not know, this a great learning experience. FB**

Week 4 (7c,d,e) Great job Karli for being actively engaged, having a great attitude, committing to learn and behaving in a professional manner. FB

Week 5 7a: I think a strength I had for this week at clinical would be going and interacting with the patients. I did not really know what to expect walking into 1 South so I was nervous to interact with the patients because it was not like a normal clinical setting in the hospital that I was used to. I was proud of myself for getting over my nervousness and being able to make connections with some of the individuals, as well as have fun with them by playing games such as UNO.

Week 5(7a,b): Karli, you did a great job in clinical this week! I would agree that interacting and therapeutic communication was a strength of yours, as well as active listening. You did a great job creating a culture of safety, as well as discussing them in your cdg. CB

Week 7 7a: A strength for this week at clinical would be my patience. There were several patients that would come up and talk to you and it could be hard to get away to go do the things you needed to do. However, I was able to remain calm and patient and let them talk until they were finished because I did not want to make them upset by walking away. Patience is not something that I always have, so I was proud of myself when I was able to stay and listen and not worry about getting things done in a hurry. **Great job Karli, it can be very hard to be patient with an individual that might present with anxiety, flight of ideas, and generalized mental illness. You will want to practice some relaxation techniques to assist with patience. There are many times you will need all the patience you can muster up to care for difficult patients. FB**

Care Map Evaluation Tool**
Psych
2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
1/16/2024	Risk for Suicide	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 43/45. See care map grading rubric for details. FB

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Karli Schellinger				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)*			
Date or Clinical Week: 7/9/2024 Week 7							
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	2	Nice job distinguishing the appropriate abnormal findings as they relate to the priority problem. Priority problems provided were relevant to your assigned patient. All of the provided risk factors can be related to or relevant to the priority problem, therefore I would have highlighted all. There was a deduction of a point because you did not highlight your priority problem.
	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	2	
	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	Nursing interventions were prioritized, frequencies provided, individualized, and realistic for the patient. Great job with providing rationales for each of the nursing interventions.
	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	Evaluation of your priority problem identified was done appropriately, great job!
	15. Evaluation includes one of the following statements: - Continue plan of care - Modify plan of care - Terminate plan of care	Complete			Not complete	3	

Reference

An in-text citation and reference are required.

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

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

Total Possible Points= 45 points

45-35 points = Satisfactory

34-23 points = Needs Improvement*

< 23 points = Unsatisfactory*

***Total points adding up to less than or equal to 34 points require revision and resubmission until Satisfactory. Refer to the course specific requirements for resubmission deadlines.**

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

Faculty/Teaching Assistant Comments:

Satisfactory completion of psychiatric nursing care map. Great job!

Total Points: 43/45

Faculty/Teaching Assistant Initials: FB

Geriatric Assessment Rubric
2024

Student Name: Karli Schnellinger

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	2
Cognitive Assessment (Clock Drawing)	4	2
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	36

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 96/100

Satisfactory completion of the Geriatric Assessment. Excellent job, Karli! Two points were deducted for the "Time and Change Test" and "Cognitive Assessment" because there were no scores/results identified. 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	6 Points Identifies 4 or less nursing interventions in priority order including a rationale and time frame.	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale,	

	individualized and realistic. Identifies a therapeutic communication goal.	Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	no time frame. No therapeutic communication goal.	
Criterion #5 Process Recording	15 Points Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.	10 Points Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 7 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	5 Point Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 5 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	0 Points Direct quotes are not provided. Nonverbal and Verbal behavior is not described for less than half of the interactions. Student thoughts and feelings for less than half of the interactions provided.	
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 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					Total Points:
Faculty comments:					Faculty Initials:

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	FB	MD	FB	FB	CB	CB	BL	
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): Karli Schnellinger (A), Essence Byrd (M), Melisa Fahey (A), Presley Stand (M)

GROUP #: 5

SCENARIO: Alcohol Substance Use Simulation

OBSERVATION DATE/TIME(S): 06/27/2024 0800-0915

CLINICAL JUDGMENT COMPONENTS	<u>OBSERVATION NOTES</u>
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. 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 the patient's substance use and fall. Seeks out information related to patient's support system and use of coping skills.
INTERPRETING: (2,4)* • Prioritizing Data: E A D B • Making Sense of Data: E A D B	Prioritizes performing CIWA Scale. Interprets CIWA Scale score as 3. Interprets CIWA Scale score as 36. 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 • Well-Planned Intervention/ Flexibility: E A D B • Being Skillful: E A D B	Obtains vital signs (T-98.6, HR-84, BP-154/90, SpO2-98%, RR-18). Performs CIWA Scale. Performs the Brief Mental Status Evaluation. Medication nurse reviews medication with the patient and administers them, after asked by patient about all morning medications. Medication nurse verifies patient, DOB, allergies and scans. Attempts to utilize therapeutic communication with the patient. Provides education related to community resources and self-help groups. Identifies self and patient. Obtains vital signs (HR-82, BP-145/89, RR-20, SpO2-98%). Assesses patient's pain level (0/10). Assesses patient's anxiety level (6/10). Performs parts of CAGE Questionnaire. Performs CIWA Scale. Be aware of aggressive behavior towards your patient (touching), when the patient informs you to "stop". Medication nurse verifies patient, DOB, allergies and scans. Medication nurse administers Lorazepam 4 mg PO (per protocol).
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	Lasater Clinical Judgement Rubric Comments: Noticing: Regularly observes and monitors a variety of data, including both subjective and objective; most useful information is noticed; may miss the most subtle signs. Recognizes subtle patterns and deviations from expected patterns in data and uses these to guide the assessment. Actively seeks subjective information about the patient's situation from the patient and family to support planning interventions; occasionally does not pursue important leads.

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