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

Student: Dylan Wilson

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)
6/4/2024	2	EBP article assignment	6/5/2024 1400
6/15/2024	1	1 south clinical survey	6/18/2024

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

* End-of-Program Student Learning Outcomes

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

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

OTHER

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

* End-of-Program Student Learning Outcomes

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

Comments:

* End-of-Program Student Learning Outcomes

Week 2(1a,b,e,f): Dylan, 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 an preparing an appropriate nursing therapy group activity for the patients of the milieu. 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) I changed this competency to NA because you did not conduct a nursing therapy group this week. HS

Week 4 (1g) Dylan, You did not hand in the Geriatric Assessment Assignment therefore, this competency was changed to a "NA". Make sure you are self-rating on the appropriate competencies. FB

Week 5 (1a,b,d)- 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 and the assistance of group therapy to assist patients in regaining independence as they start their life of sobriety. FB

Week 6-1(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 7-1(c,d) Great job identifying and discussing potential barriers to culturally and spiritually competent care at the Erie County Health Center Detoxification Unit in your CDG. You also identified and discussed several appropriate methods that will assist this patient population in regaining independence and achieving self-care. BL

Objective

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

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

*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 research and talk about an EBP article titled "Treatment patterns and sequences of pharmacotherapy for patients diagnosed with depression in the United States." related to mental health during clinical debriefing. I changed competency 2d to "S", although you did not create care map, you are always formulating a plan of care on your patients. 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

* End-of-Program Student Learning Outcomes

(2d)- I changed this to a NI because you did not include an intext citation, and received an overall evaluation of needs improvement based on the total rubric score for the nursing care map. Please refer to the comments within the nursing care map rubric for suggestions on how to correct the missing information prior to resubmitting the nursing care map with the necessary revisions. HS

Week 5 (2c)- Identification of coping strategies and defense mechanisms were provided as you interpreted the objectives and effect of the SARCC meeting. FB
Week 6-2(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

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

Comments:

Week 2(3a,c,d,f): Dylan, 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. You did not meet the requirements for the day 3 CDG resulting in a needs improvement evaluation. The day 4 CDG you met the requirements for the posting however, your in-text citation and the reference is not in APA format,

* End-of-Program Student Learning Outcomes

please refer to Purdue Owl for tips and or in Edvance under clinical resources, APA formatting. You can also reach out to faculty or seek assistance from Libby Kyle in the library. HS

Week 3- I will spend more time using Purdue owl to practice for future in text citations, or reach out to staff members to help.

Week 4 (a,c,d,e) These competencies were changed based on the results of your Nursing Process Study. Please see rubric below! **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. FB**

Week 5-3(e) Satisfactory completion of the Nursing Process Study assignment after revisions were made. You received 90/100 points, which is satisfactory. Great job! HS

Week 6-3(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(f) Satisfactory completion of your Hospice Reflection Journal. You provided a thoughtful reflection related to your experience and shared new knowledge related to hospice services when caring for the end-of-life patient. Great job! BL

Week 7-3(f) Satisfactory completion of your CDG this week. Excellent job! BL

* 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	S	S	NA	~~S~~ NA	S	S	NA		
b. Demonstrate ability to discuss the uses and implication of psychotropic medications. **(responding, reflecting)**	NA	S	S	NA	NA	NA	S	NA		
c. Identify the major classification of psychotropic medications. **(interpreting)**	NA	S	S	NA	NA	NA	S	NA		
d. Identify common barriers to maintaining medication compliance. **(reflecting)**	NA	S	S	NA	NA	NA	S	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	NA		
Faculty Initials	HS	CB	HS	FB	FB	BL	BL			

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 each prescribed medication for your patient, the indication for use, side effects, classification, related interventions and safety issues to monitor for. HS**

Week 5 (4a)- This competency was changed because you did not administer or observe medication administration during your clinical experience this week. Make sure you are self-rating on competencies actual performed during the clinical experience for the corresponding week. 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	S	NA	S	NA	S	NA		
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	NA	~~NA~~ S	S	NA	S	NA	S	NA		
c. Collaborate with the Erie County Health Department Detox Unit while observing the care of a patient with mental illness-substance abuse. **(Community Agency Observation-Detox Unit) ****	NA	NA	S	NA	NA	NA	S	NA		
d. Recognize and describe the need for substance abuse recovery resources. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**	NA	NA	S	NA	S	NA	NA	NA		
Faculty Initials	HS	CB	HS	FB	FB	BL	BL			

****Alternative Assignment**

Comments:

Week 2(5b): You were able to discuss and observe discussion related to resources in the community to help patients with mental health disorders, therefore competency 5b was changed to a "S". CB

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

Week 5 (5b,d)- 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

* End-of-Program Student Learning Outcomes

Week 7-5(a-c) Excellent job attending your Erie County Health Center Detoxification Unit clinical experience in which you were able to learn more about the community resources they provide, and how to care for this patient population during the detoxification process. BL

* 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	S	S	NA	~~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	~~S~~ NA	NA	NA	NA		
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	NA	S	S	NA	~~S~~ NA	NA	NA	NA		
Faculty Initials	HS	CB	HS	FB	FB	BL	BL			

Comments:

Week 2(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 group therapy. CB

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

Week 5 (6a-c) These competencies were changed because you did not complete during the clinical experience you had this week. Again, make sure you are self-rating on competencies that you actually completed during the clinical experience the corresponding week. FB . I had originally put "S" related to the live simulation.

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

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

Comments:

Week 2- My strength this week was getting comfortable around the patients in 1S. Being a new environment and having to learn what you can and cannot do/say was a struggle during day 1, but by day 2 I felt more understanding about what 1S was about. At first I wasn't sure if we could even sit next to the patients, but by the end of the day all the students were confidently playing games and talking to the patients.

Week 2(7a,b,e): 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. 7E was changed to an "U" because you did not have your EBP article presentation prepared on the correct day. Please make sure you address this "U". "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- Day 2 of week 2 I presented by article in full during debriefing proving it to be satisfactory. I will continue to double check all needed information before going to my next clinicals by using my calendar. HS

Week 3 Strength- My strength this week on 1S was using better communication techniques appropriately. I felt more knowledgeable knowing how to address the patient concerns or problems with a more therapeutic technique such as, exploring ideas, active listening, and using SOLER. You did a nice job effectively communicating with several of the patients this week in clinical. HS

Week 5- My strength this week was during simulation when I provided resources for the patient with a drinking problem related to AA and using therapeutic communication to establish trust and rapport. You only need to identify a strength for 1 south clinical experience. Read highlighted sentence above. FB
Week 4 (7c,d,e) Great job Dylan, for being actively engaged, having a great attitude, committing to learn and behaving in a professional manner. FB

Week 6- My strength this week was participating in feeding a patient for 1 hour while the other nurses were busy. This allowed for the hospice nurses to have more time for other patients with high levels of acuity. The patient in end of life care was slow to eat which was expected and took about an hour to eat their food. Great job, Dylan. BL

Week 6-7(c) Dylan, your Hospice Reflection Journal was very well done and provided a great reflection related to your experience. It is unfortunate you did not have a positive experience, but I hope you were still able to learn something from this in the end. Keep up all your hard work! BL

Week 7-7(c) Excellent job reflecting on your clinical experience at the Erie County Health Center Detoxification Unit in your CDG. You did a great job discussing your feelings and attitude about patients that this agency provides services for. BL

Care Map Evaluation Tool**
Psych
2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/15/2024	Ineffective Coping	NI/HS	S/HS

**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: You did not include an in-text citation on the care map which is a requirement. You also did not meet a total score of 35 to be considered satisfactory on the rubric for the total points, and therefore revisions must be completed prior to resubmission. Please add an in-text citation and read the comments within the rubric to make additional corrections to become satisfactory for the care map assignment. Please reach out for any questions or concerns regarding this assignment. HS

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Dylan Wilson				**Course Objective:**			
Date or Clinical Week: 6/15/2024							
	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)**	3/3	Nice job! You included a thorough list of abnormal assessment findings, abnormal lab findings, and risk factors. HS No changes. 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	
	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)**	3/3	
Interpreting	4. List all nursing priorities and highlight the top priority problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2/2	You listed 4 appropriate nursing priorities however, since the patient had a history of schizo-affective disorder and was homeless there are other nursing priorities that could also apply to the patient. You set an appropriate goal. You identified 3 potential complications and included signs and symptoms to monitor the patient for. HS No changes within the interpreting section. HS
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3/3	
	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**	3/3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3/3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3/3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2/2	The list of nursing interventions is not thorough. Remember to assess, do, and educate in the interventions. Think specifically about the patient and how you plan to assist in meeting the goal. Were there any medications ordered to assist with his abnormal assessment findings, that may impact his mood and ultimately assist with his ability to cope. You stated he had insomnia could lack of sleep
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2/2	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3/3	
	12. All interventions are individualized and realistic	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2/2	

							impact coping could there be an intervention to assist with that?

	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**	0/1	The rationale does not state why you plan to perform each specific intervention or why that intervention is imperative to the plan of care. For example, why are you going to determine the use of defense mechanisms for this patient? You would state something such as: to determine if the patient is using maladaptive coping mechanisms which can negatively impact decision making. You added a couple interventions and included an appropriate rationale with them. You did not correct the ones that were previously in the care map. HS
Reflecting	14. List all of the highlighted reassessment findings for the top nursing priority.	**>75% complete**	**50-75% complete**	**<50% complete**	**0% complete**	1/1	You did not reassess the abnormal findings from the noticing/recognizing portion of the care map, if they are unchanged you put the unchanged information in the evaluation if there is new or different information you would put that there as well. You did not state if the care plan should be continued, modified, or terminated. You continued the plan of care. HS
	15. Evaluation includes one of the following statements: • Continue plan of care • Modify plan of care • Terminate plan of care	**Complete**			**Not complete**	0/3	

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:

You did a nice job in the noticing/recognizing cues, and interpreting sections of the care map. You need to review the responding and

Total Points:33/45 Needs Improvement
37/45 Satisfactory

Faculty/Teaching Assistant Initials: HS /HS

reflecting section of the care map. Please refer to the care map guidelines and utilize skyscape and the Psychiatric Nursing Pocket Guide to assist you in completing those areas. You did not include an intext citation within the care map, this is a requirement you must add that within the care map as well. Please let me know if you have questions or concerns on how to correct the care map. HS Upon remediation of your care map you are now satisfactory. You made some of the suggested changes within the care map. You added the in-text citation as required however, in future care maps you should consider adding the citation within the nursing intervention section	

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 communication goal.	6 Points Identifies 4 or less nursing interventions in priority order including a rationale and time frame. Interventions are not individualized and/or realistic. Identifies a therapeutic communication goal.	4 Point Identifies 4 or less nursing interventions but not prioritized and/or no rationale or time frame provided. Interventions are not individualized and /or realistic. Identifies a therapeutic communication goal.	0 Points Identifies less than 4 interventions, not prioritized, individual, realistic, no rationale, no time frame. No therapeutic communication goal.	10
Criterion #5	15 Points	10 Points	5 Point	0 Points	~~10~~

Process Recording	Provides direct quotes for all interchanges. Nonverbal and Verbal behavior is described for all interactions. Students thoughts and feelings concerning each interaction is provided.	Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 7 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	Direct quotes are not provided. Nonverbal and Verbal behavior is described for at least 5 interactions. Student thoughts and feelings concerning at least 5 interactions are provided.	Direct quotes are not provided. Nonverbal and Verbal behavior is not described for less than half of the interactions. Student thoughts and feelings for less than half of the interactions provided.	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.	5
Criterion #9 Evaluation	10 Points Identify at least 3 barriers to communication including interventions or communication that could have been done differently. Identify all pertinent social determinants of health.	6 Points Identify at least 2 barriers to communication including interventions or communication that could have been done differently. Identify all	4 Point Identify at least 2 barriers to communication did not include interventions or communication that could have been done differently. Did not	0 Points Identify at least 1 barrier to communication did not include interventions or communication that could have been done	10

		pertinent social determinants of health.	identify any pertinent social determinants of health.	differently. Did not identify any pertinent social determinants of health.	

Total Possible Points= 100 points
77-100 points= Satisfactory completion.
76-53 points= Needs Improvement
< 53 points= Unsatisfactory

Total Points: ~~65~~ 90

Faculty comments: Dylan, overall your Nursing Process Study assignment is well done. Unfortunately, you received 65/100 points which is a needs improvement. Points were deducted from criterion #5 because you did not provide direct quotes (quotation marks) for any of your interchanges. Points were deducted from criterion #6 because you did not provide a complete analysis of the interaction for any of your interchanges. In order for the analysis to be complete, 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 all 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. Points were deducted from criterion #8 (self-evaluation of communication with patient) because you did not identify and explain 3 weaknesses of therapeutic communication based on the conversation that you had with the patient. 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.

Dylan, you are now satisfactory on your Nursing Process Study assignment. You have added the quotes within the conversation portion of the assignment. You also provided an analysis of the interaction including identifying if it was therapeutic or nontherapeutic and the technique with an explanation of the interaction. You did not receive any additional points in the evaluation section because you did not identify weaknesses related to your conversation with the patient. Nice job on your revisions! HS

Faculty Initials: HS

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

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

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

Scenario Objectives: • **Demonstrate effective therapeutic communication while interacting with patient admitted for an acute mental health crisis. (1, 2, 3)*** • **Utilize the CIWA scale to assess a patient with a history of substance abuse. (1, 2)*** • **Determine appropriate medication administration steps utilizing the CIWA scale. (4)*** • **Provide patient with appropriate education on community support and resources. (5)***	experienced nurse. Responding: Generally displays leadership and confidence and is able to control or calm most situations; may show stress in particularly difficult or complex situations. Communicates effectively; explains interventions; calms and reassures patients and families; directs and involves team members, explaining and giving directions; checks for understanding. Develops interventions on the basis of relevant patient data; monitors progress regularly but does not expect to have to change treatments. Displays proficiency in the use of most nursing skills; could improve speed or accuracy. Reflecting: Independently evaluates and analyzes personal clinical performance, noting decision points, elaborating alternatives, and accurately evaluating choices against alternatives. Demonstrates commitment to ongoing improvement; reflects on and critically evaluates nursing experiences; accurately identifies strengths and weaknesses and develops specific plans to eliminate weaknesses. Satisfactory completion of the simulation scenario. Great job! CB

EVALUATION OF CLINICAL PERFORMANCE TOOL
Psychiatric Nursing

Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

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

Student eSignature & Date: