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

Student:

Kennedy Baker

Final Grade: <mark>Satisfactory</mark>

Semester: Summer Session

Date of Completion: 7/22/2024

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

Faculty eSignature:

Fran Brennan MSN, RN

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

METHODS OF EVALUATION:

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

ABSENCE (Refer to Attendance Policy)

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

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

* End-of-Program Student Learning Outcomes

PERFORMANCE CODE

SATISFACTORY CLINICAL PERFORMANCE

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

UNSATISFACTORY CLINICAL PERFORMANCE

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

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

OTHER

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

* End-of-Program Student Learning Outcomes

Objective

	1. Apply the principles of psychiatric theory in the care of adolescent to geriatric patients with a mental illness diagnosis. (1, 2, 3, 5, 6, 7, 8)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	Final
Competencies: a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder. **(noticing)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder. **(interpreting)**	S	N/A	S	N/A	S	S	~~N/A~~ S	N/A	N/A	S
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds. **(responding)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care **(noticing)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
e. Recognize social determinants of health and the relationship to mental health. **(reflecting)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
f. Develop and implement an appropriate nursing therapy group activity. **(responding)**	N/A	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
g. Develop a geriatric physical/mental health assessment and education plan. (**Geriatric Assessment**) **(responding)**				N/A				S		S
Faculty Initials	BL	FB	FB	BL	MD	CB	CB	FB	FB	FB
Clinical Location	1 South	N/A	1-South	No Clinical	Detox	Hospice	Artisan's	No Clinical	No Clinical	

Comments:

* End-of-Program Student Learning Outcomes

Week 1-1(a,b,e) Kennedy, 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. Great job! BL

Week 3 (1a,c,d,f) 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! You did a great job leading a nursing therapy group activity with an uno game related to emotions and how to manage emotions in an adaptive manner. FB

Week 5 Detox Objective 1C-D-This week you were able to provide culturally and spiritually competent care and identify appropriate methods that will assist the patient to regain independence in your CDG post for the detox center. Great job! MD

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

Week 8- Satisfactory completion of Geriatric Assessment Assignment, 81/100. Please see attached rubric below. 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)**	S	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
b.	Identify patient's subjective and objective findings including labs, diagnostic tests, and risk factors. **(noticing, recognizing)**	S	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
c.	Demonstrate ability to identify the patient's use of coping/defense mechanisms. **(noticing, interpreting)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
d.	Formulate a prioritized nursing plan of care utilizing clinical judgment skills. **(noticing, interpreting, responding, reflecting)***	S	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
e.	Apply the principles of asepsis and standard precautions. **(responding)**	S	N/A	S	N/A	S	S	N/A	N/A	N/A	S
f.	Practice use of standardized EBP tools that support safety and quality. **(noticing, responding)**	S	N/A	S	N/A	S	S	N/A	N/A	N/A	S
	Faculty Initials	BL	FB	FB	BL	MD	CB	CB	FB	FB	FB

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

Comments:
Week 1-2(a,b,f) Great 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. BL
Week 3 (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
Week 7(2c): You did a good job discussing how individuals with substance abuse problems cope and handle situations they may encounter. CB

* End-of-Program Student Learning Outcomes

Objective

3. Refine basic verbal and nonverbal therapeutic communication skills when interacting with patients, families, and members of the health care team. (1, 2, 3, 5, 7, 8)*

Weeks of Course:	1	2	3	4	5	6	7	8	Make Up	**Final**
a. Illustrate professionally appropriate and therapeutic communication skills in interactions with patients, and families. **(responding)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
b. Demonstrate professional and appropriate communication with the treatment team by using the SBAR format for handoff communication during transition of care. **(responding)**	S	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
c. Identify barriers to effective communication. **(noticing, interpreting)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
d. Develop effective therapeutic responses. **(responding)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
e. Develop a satisfactory patient-nurse therapeutic communication. (**Nursing Process Study**) **(responding, reflecting)**				S̶ NI	S			N/A		S
f. Posts respectfully and appropriately in clinical discussion groups. **(responding, reflecting)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations. **(responding)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
h. Teach patient/family based on readiness to learn and patient needs. **(responding, reflecting)**	S	N/A	S	N/A	S	S	N/A	N/A	N/A	S
Faculty Initials	BL	FB	FB	BL	MD	CB	CB	FB	FB	FB

Comments:
Week 1-3(a,d,f) Kennedy, you did an excellent job therapeutically communicating with all the patients this week. You also did an excellent job with your CDG posts. Keep up all your hard work! BL
Week 3 (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 comprehend adaptive coping skills and behaviors. FB

* End-of-Program Student Learning Outcomes

Week 4-3(e) For the Nursing Process Study assignment, you received 76/100 points which is a "Needs Improvement." Please review the Nursing Process Grading Rubric below for individualized feedback related to the assignment. You are required to revise and resubmit this assignment to your dropbox by 07/01/2024 at 0800. As a reminder, students are allowed one remediation attempt for this assignment in order to become satisfactory. If you have any questions, or need further clarification, please do not hesitate to reach out. BL

Week 5 Objective 3E-You satisfactorily remediated the NPS assignment. MD

Week 5 Detox Objective 3F-You had a wonderful CDG this week! You were able to turn in your CDG on time, have the adequate word count for your post, and meet all of the objectives for the CDG!   MD

Week 6(3f): Great job on your reflection paper for hospice, being very thorough and meeting all the requirements. CB

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

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

Comments:
Week 1-4(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 3 (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)**	S	N/A	S	N/A	S	N/A	N/A ~~~~ S	N/A	N/A	S
b. Discuss recommendations for referrals to appropriate community resources and agencies. **(reflecting)**	S	N/A	S	N/A	S	S	S	N/A	N/A	S
c. Collaborate with the Erie County Health Department Detox Unit while observing the care of a patient with mental illness-substance abuse. **(Community Agency Observation-Detox Unit) **	N/A	N/A	N/A	N/A	S	N/A	N/A	N/A	N/A	S
d. Recognize and describe the need for substance abuse recovery resources. **(Alcoholics/Narcotics Anonymous at the Sandusky Artisans Recovery Center (Observation)**	N/A	N/A	N/A	N/A	N/A	N/A	S	N/A	N/A	S
Faculty Initials	BL	FB	FB	BL	MD	CB	CB	FB	FB	FB

**Alternative Assignment
Comments:
Week 3 (5a,b)- Great job realizing the need for community resources and the importance for patients to follow up with resources when discharged from the acute care facility. FB
Week 5 Detox Objective 5A-C-In your CDG posting for this week you were able to identify community resource needs, appropriate referral options, and discuss your observations at the Detox center. MD
Week 7(5a,b,d): Great job attending the Sandusky Artisan's and participating in a meeting with individuals facing substance abuse challenges. CB

* 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)**	S	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
b. Demonstrate satisfactory documentation of psychiatric assessments and nursing notes utilizing the electronic health record. **(responding)**	~~S~~ NA	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
c. Demonstrate the use of technology to identify mental health resources. **(responding)**	S	N/A	S	N/A	S	S	N/A	N/A	N/A	S
Faculty Initials	BL	FB	FB	BL	MD	CB	CB	FB	FB	FB

Comments:
Week 1-6(a,b) Great job navigating the electronic health record to research information on your patient. Going forward, you will have an opportunity to document in the electronic health record more in your other 1 South clinicals. BL
Week 3(6a-c) Great job using the electronic health record to gather information on your assigned patient. You also did a great job demonstrating the appropriate documentation on all individuals regarding the attendance to nursing group therapy activity. 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)	S	N/A	S	N/A	N/A	N/A	N/A	N/A	N/A	S
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care. (responding)	S	N/A	S	N/A	S	S	S	N/A	N/A	S
c. Illustrate active engagement in self-reflection and debriefing. (reflecting)	S	N/A	S	N/A	S	S	N/A	N/A	N/A	S
d. Incorporate the core values of caring, diversity, excellence, integrity, and "ACE" – attitude, commitment, and enthusiasm during all clinical interactions. (responding)	S	N/A	S	N/A	S	S	S	N/A	N/A	S
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect. (responding)	S	N/A	S	N/A	S	S	S	N/A	N/A	S
f. Comply with the standards outlined in the FRMCSN policy, "Student Conduct While Providing Nursing Care." (responding)	S	N/A	S	N/A	S	S	S	N/A	N/A	S
Faculty Initials	BL	FB	FB	BL	MD	CB	CB	FB	FB	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: My strength this week was listening, this is because these patients had big feelings and it made them feel a little better if they felt as if someone was listening to them. Great job! BL

Week 1-7(b) Excellent discussion related to factors that create a culture of safety while in the psychiatric unit in your CDG this week. BL

Week 3 7a My strength this week was my therapy group because I feel like I did well on it despite being nervous and not good at talking to people. Great job with nursing therapy group activity related to emotions with the use of uno cards.

Week 3 (7c,e) Excellent job engaging with patients during this clinical experience. You presented yourself in a professional manner, were respectful, and displayed a non-judgmental attitude toward patients in a vulnerable situation. FB

Week 5 Detox Objective 7C-In your discussion post, you provided great information on a reflection of your time at the Detox center. Great job! MD

Week 6(7c,e): Kennedy, great job on your hospice reflection paper. RN signature form "Excellent in all areas." RN comment: "Will be a great nurse." CB

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

Care Map
Evaluation Tool**
Psych 2024

Date	Nursing Priority Problem	Evaluation & Instructor Initials	Remediation & Instructor Initials
6/11/2024	Risk for suicidal behavior	S/FB	NA/FB

**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 42/45. See care map grading rubric for details. FB

Firelands Regional Medical Center School of Nursing
Nursing Care Map Rubric

Student Name: Kennedy Baker	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: 6/11/2024 Week 3		

	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. Possible complications were appropriate with signs and symptoms provided.
	5. State the goal for the top nursing priority.	**Complete**			**Not complete**	3	
	6. Highlight all of the related/relevant data from the Noticing boxes that support the top priority nursing problem.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	
	7. Identify all potential complications for the top nursing priority problem.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
	8. Identify signs and symptoms to monitor for each complication.	**(lists at least 3)**	**(lists 2)**		**(lists < 2)**	3	
Responding	9. List all nursing interventions relevant to the top nursing priority.	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	3	Nursing interventions were not prioritized, listening attentively and encouraging verbalization should have been one of the top interventions. Not all interventions were provided with time frame or frequency, and several did not have rationale. In the future make sure to follow the care map guidelines provided.
	10. Interventions are prioritized	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	
	11. All interventions include a frequency	**> 75% complete**	**50-75% complete**	**< 50% complete**	**0% complete**	2	
	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	2	
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.**	**Total Points: 42/45 points** **Faculty/Teaching Assistant Initials:** Fran Brennan MSN, RN/ FB

Student Name: Kennedy Baker__   Date: _7/15/2024__

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	2
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	34/40

Education Assessment

	Points Possible	Points Received
Learning Needs Identified and Prioritized (3)	10	10
Priorities pertinent to learning needs (3)	5	5
Nursing interventions related to learning needs (5)	10	7

Points	25	22/25

Education Plan

	Points Possible	Points Received
Education Prioritization and Barriers to Education	5	5
Teaching Content and Methods used for Education	10	5
Evaluation of Education Plan	10	10
Education Resources attached	10	5
Points	35	25/35

Total Points __81/100_____

Satisfactory completion of the Geriatric Assessment Assignment. Overall good job! Points were deducted for scoring deficits on the assessments. There were also timeframes missing on the nursing interventions. Additional points were deducted for no outline form and no attachments were provided. Printed material are good for a reference at a later date. FB

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.	5
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 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.	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	0/18
Criterion #7 Process Recording	10 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 10 interchanges between patient and student.	6 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 7 interchanges between patient and student.	4 Points Communication has a natural beginning and ending; the conversation flows from sentence to sentence and has a logical conclusion. There are at least 5 interchanges between patient and student.	0 Points There was less than 5 interchanges between patient and student provided.	10
Criterion #8 Evaluation	15 Points Self-evaluation of communication with patient. Identify at least 3 strengths and 3 weaknesses of therapeutic communication.	10 Points Self-evaluation of communication with patient. Identified 2 strengths and 2 weaknesses of therapeutic communication.	5 Point Self-evaluation of communication with patient. Identified 1 strength and 1 weakness of therapeutic communication.	0 Points No self-evaluation was provided.	15
Criterion #9 Evaluation	10 Points Identify at least 3 barriers to 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	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	0 Points Identify at least 1 barrier to communication did not include interventions or communication that could have been done differently. Did not	8

		determinants of health.	social determinants of health.	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: Kennedy, Overall Good job with your Nursing Process Study! Criterion 2- You did not provide a descriptive paragraph related to the patient's admission to the inpatient psychiatric unit. Therefore, there was a deduction for this criterion. Criterion 6- You did not provide a <u>complete</u> 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 <u>all</u> interchanges. For reference, there is an example of a sample process recording on pg. 120 in your textbook (Table 5-5) that demonstrates how to correctly complete this section. The analysis of the interaction for interchanges was completed for the resubmission of the Nursing Process Study assignment. 18 points were given because it was completed after feedback received. FB 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. Satisfactory completion of Nursing Process Study Assignment, 94/100 points.				**Total Points:**	**76/100 94/100** **Needs Improvement** **Satisfactory completion**
				Faculty Initials: FB	

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	S
Faculty Initials	FB	FB	BL	BL	MD	MD	CB	FB
Remediation: **Date/Evaluation/Initials**	NA	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): Kennedy Baker (M), Anthony Drivas (A), Tylie Dauch (M), Lindsey Steele (A)
GROUP #: 1
SCENARIO: Alcohol Substance Use Simulation
OBSERVATION DATE/TIME(S): 06/26/2024 0800-0915

CLINICAL JUDGMENT COMPONENTS					<u>OBSERVATION NOTES</u>
NOTICING: (1,2,5)*					Notices the patient's blood pressure is elevated.
• Focused Observation:	E	**A**	D	B	Notices the patient appears anxious.
• Recognizing Deviations from Expected Patterns:	E	**A**	D	B	Seeks out information related to patient's substance use history.
• Information Seeking:	**E**	A	D	B	Recognizes the patient does not need Lorazepam based on the CIWA Scale score.
					Notices the patient is complaining of visual hallucinations.
					Notices the patient is complaining of itching.
					Seeks out information related to the patient's support system and substance use.
					Recognizes the patient needs Lorazepam based on the CIWA Scale score.
INTERPRETING: (2,4)*					Prioritizes performing the CAGE Questionnaire and CIWA Scale.
• Prioritizing Data:	**E**	A	D	B	Interprets the CAGE Questionnaire as negative.
• Making Sense of Data:	E	**A**	D	B	Interprets the CIWA Scale score as 5.
					Interprets the CIWA Scale score as 12.
					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	Obtains vital signs (T-98.6, BP-150/90, SpO2-99%, HR-84, RR-12).
• Clear Communication:	**E**	A	D	B	Asks the patient questions related to reason for admission.

• Well-Planned Intervention/ Flexibility:		E	**A**	D	B
• Being Skillful:	E	**A**	D	B	

Performs the CAGE Questionnaire.

Performs the CIWA Scale.

Utilizes therapeutic communication with the patient.

Medication nurse educates the patient on medications to be administered.

Medication nurse does not identify or scan patient.

Medication nurse administers ordered daily medications.

Introduces self and identifies patient.

Performs CIWA Scale.

Obtains vital signs.

Medication nurse verifies patient and scans.

Administers Lorazepam 4 mg PO (per protocol).

Attempts to utilize therapeutic communication with the patient.

Provides education related to withdrawal symptoms and substitution therapy.

No education provided related to community resources or support groups.

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: 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 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

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:

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:

Kennedy Baker