

EVALUATION OF CLINICAL PERFORMANCE TOOL
Psychiatric Nursing- 2021
Firelands Regional Medical Center School of Nursing
Sandusky, Ohio

Student:

Victoria Glaze

Final Grade: Satisfactory/Unsatisfactory

Semester: Summer Session

Date of Completion:

**Faculty: Brian Seitz MSN, RN, Kelly Ammanniti MSN, RN,
 Liz Woodyard MSN, RN, Brittany Lombardi MSN, RN
 Teaching Assistants: Nick Simonovich BSN, RN, Devon Cutnaw BSN, 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 on the comment section by the faculty member with the rationale for the evaluation. All competencies must be rated a "S, NI, or U". 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, the following week it must be addressed with a comment as to why it is no longer a "U". If the student does not state why the "U" is corrected, then it will be another "U" until the student addresses it. All clinical competencies are critical to meeting the objectives of the course. If the final performance code is unsatisfactory in any one of the competencies, a grade of unsatisfactory is given. If a pattern of unsatisfactory performance occurs after performing the competency satisfactorily, this also constitutes a grade of unsatisfactory. An unsatisfactory as a final score in any single competency results in a clinical course grade of unsatisfactory; this is a failure of the course. The terms Satisfactory and Unsatisfactory will be used in evaluating the final grade or clinical course performance.

METHODS OF EVALUATION:

- al Patient Profile
- Meditech Documentation
- Evaluation of Clinical Performance Tool
- Onsite Clinical Debriefing
- Clinical Discussion Rubric
- Nursing Process Recording Rubric
- Geriatric Assessment Rubric Lasater Clinical Judgment Rubric
- Virtual Simulation scenarios
- ABCDEF Bundle Grading Rubric
- Pathophysiology Grading Rubric
- Participation in adjunctive therapies (N.A./A.A.; Erie County Health Department Detox Unit, Hospice inpatient/outpatient care
- EBP Presentations Rubric
- Hospice Reflection Journal
- Virtual Simulation Scenarios
- Lasater Clinical Judgment Rubric
- Observation of Clinical Performance
- Clinical Nursing Therapy Group Rubric

ABSENCE (Refer to Attendance Policy)

Date	Number of Hours	Comments	Make Up (Date/Time)
Initials	Faculty Name		
BS	Brian Seitz MSN, RN		
KA	Kelly Ammanniti MSN, RN		
BL	Brittany Lombardi MSN, RN		
LW	Liz Woodyard MSN, RN		
NS	Nick Simonovich BSN, RN		
DC	Devon Cutnaw BSN, 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.

Objective											
1. Apply the principles of psychiatric theory in the care of diverse populations, 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	9	Make Up	Final
Competencies:		S	S	N/A	N/A	S					
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder.		S	S	N/A	N/A	S					
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder.		S	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.		S	N/A	N/A	N/A	S					
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care		S	S	N/A	N/A	S					
e. Recognize normal versus non-normal behavior patterns in terms of developmental milestones. (Erickson).		S	S	N/A	N/A	S					
f. Develop and implement an appropriate nursing therapy group activity.		S	N/A	N/A	N/A	S NA					
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment)					S						
Faculty Initials		EW	NS	DC	KA	BL					
Clinical Location		hospice	DETOX			1 SOUTH					

* End-of-Program Student Learning Outcomes

Comments:

Week 5 – 1g – You satisfactorily completed your geriatric assessment. Please see your rubric for further comments. KA

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	9	Make Up	Final
Competencies:		S	S	N/A	N/A	S					
a. Assemble a health history which includes past and current history of mental and medical health issues and chief reason for hospitalization. (noticing)		S	S	N/A	N/A	S					
b. Identify the individual patient’s symptoms related to the psychiatric diagnosis. (interpreting)		S	S	N/A	N/A	S					
c. Demonstrate ability to identify the patient’s use of coping/defense mechanisms. (noticing, interpreting)		S	S	N/A	N/A	S					
d. Formulate a prioritized nursing care plan utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting)		S	N/A	N/A	N/A	S					
e. Apply the principles of asepsis and standard precautions.		S	S	N/A	N/A	S					
f. Practice use of standardized EBP tools that support safety and quality. (noticing, responding)		S	S	N/A	N/A	S					
Faculty Initials		EW	NS	DC	KA	BL					

Comments:

Week 6-2(d) Excellent job formulating a prioritized nursing care plan for your patient utilizing clinical judgment skills. Please see the Care Plan Grading Rubric at the end of this document for my feedback. 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	9	Make Up	Final
a. Illustrate professionally appropriate and therapeutic communication skills in interactions with patients, and families.		S	N/A	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.		S	N/A	N/A	N/A	S					
c. Identify barriers to effective communication. (noticing, interpreting)		S	S	N/A	N/A	S					
d. Construct effective therapeutic responses.		S	N/A	N/A	N/A	S					
e. Construct a satisfactory patient-nurse therapeutic communication. (Nursing Process Study)					N/A						
f. Posts respectfully and appropriately in clinical discussion groups.		S	S	N/A	N/A S	S					
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations.		S	S	N/A	N/A	S					
h. Teach patient/family based on readiness to learn and patient needs. (responding, reflecting)		S	N/A	N/A	N/A	S					
Faculty Initials		EW	NS	DC	KA	BL					

Comments:

Week 3 3(f) – Nice work with your CDG responses based on your Detox unit clinical experience. You provided good insight related to your experience and even provided some suggestions that you noticed could be utilized for improving the mental health of the clients. All criteria met for a satisfactory evaluation. See my response on your initial post for further comments. Great job! NS

* End-of-Program Student Learning Outcomes

Week 5 – 3f – You did a nice responding to the CDG questions with thorough and thoughtful comments. You did a great job sharing your thoughts on AA and substance abuse. KA

Week 6-3(a, d) Tori, you did an excellent job therapeutically communicating with all the patients this week. Keep up your excellent work! BL

Week 6-3(f) Excellent job with your CDG posting this week. You also did a great job with your care plan as well. BL

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	9	Make Up	Final
a. Discuss the safe administration of medication while observing the six rights of medication administration.		N/A	N/A	N/A	N/A	S					
b. Demonstrate ability to discuss the uses and implication of psychotropic medications		N/A	N/A	N/A	N/A	S					
c. Identify the major classification of psychotropic medications.		N/A	N/A	N/A	N/A	S					
d. Identify common barriers to maintaining medication compliance.		N/A	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.		N/A	N/A	N/A	N/A	S					
Faculty Initials		EW	NS	DC	KA	BL					

Comments:

Week 6-4(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. Keep up the great work! BL

* End-of-Program Student Learning Outcomes

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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	9	Make Up	Final
a. Identify the need for the community resources-detox unit available to patients with a mental illness.		N/A	S	N/A	N/A	N/A					
b. Discuss recommendations for referrals to appropriate community resources and agencies.		S	S	N/A	N/A	S					
c. Attend Erie County Health Department Detox Unit observing the care of a patient with mental illness-substance abuse. (Community Agency Observation-Detox Unit)		N/A	S	N/A	N/A	N/A					
d. Attend Narcotics/Alcoholics Anonymous meeting. (Alcoholics/Narcotics Anonymous at the Artisans of Sandusky Observation)		N/A	N/A	N/A	S	N/A					
Faculty Initials		EW	NS	DC	KA	BL					

Comments:

Week 3 5(a,b,c) – Nice job responding to the reflection questions based on your experience at the Detox center. Good detail and insight were provided in each response. Hopefully it yielded some good learning opportunities. Great job! NS

* End-of-Program Student Learning Outcomes

* 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	9	Make Up	Final
Competencies:		N/A	N/A	N/A	N/A	S					
a. Demonstrate competence in navigating the electronic health record.		N/A	N/A	N/A	N/A	S					
b. Demonstrate satisfactory documentation of physical and psychiatric assessments and nursing notes utilizing the electronic health record.		N/A	N/A	N/A	N/A	S NA					
Faculty Initials		EW	NS	DC	KA	BL					

Comments:

* 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	9	Make Up	Final
a. Identify your strengths for care delivery of the patient with mental illness		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.		S	N/A	N/A	N/A	S					
c. Illustrate active engagement in self-reflection and debriefing.		N/A	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.		S	S	N/A	S	S					
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect.		S	S	N/A	S	S					
f. Follow the standards outlined in the FRMCSN policy, “Student Conduct While Providing Nursing Care.”		S	S	N/A	S	S					
Faculty Initials		EW	NS	DC	KA	BL					

Comments:

Nursing Care Plan Grading Tool
Psychiatric Nursing
2021

Student Name: **Victoria Glaze**

Clinical Date: **7/8/2021-7/9/2021**

Objective # 6: Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*	Risk for suicide r/t hopelessness
**Nursing care plan not appropriate to patient situation = 0 and automatic unsatisfactory rating	Total Points Comments
Nursing Diagnosis: (3 points) Problem Statement (1)-1 Etiology (1)-1 Defining Characteristics (1)-1	Total Points: 3 Comments: Excellent job! Nursing diagnosis is appropriate for your patient, and defining characteristics are specific. BL
Goal and Outcome (6 points total) Goal Statement (1 point)-1 Outcome: Specific (1)-1 Measurable (1)-1 Attainable (1)-1 Realistic (1)-1 Time Frame (1)-1	Total Points: 6 Comments: Great job! Goal statement is correctly written and all outcome statements are SMART. BL
Nursing Interventions: (8 points total) Prioritized (1)-1 What (1)-1 How Often (1)-1 When (1)-1 Individualized (1)-1 Realistic (1)-1 Rationale (1)-1 All pertinent interventions listed (1)-1	Total Points: 8 Comments: Excellent job with all nursing interventions. BL
Evaluation: (5 points total) Date (1)-1 Goal Met/partially/unmet (1)-1 Defining characteristics (1)-1 Plan to continue//modify/terminate (1)-1 Signature (1)-1	Total Points: 5 Comments: Great job! BL
Total possible points = 22 18-22 = Satisfactory care plan 17-14 = Needs improvement care plan <13 = Unsatisfactory care plan	Total Points for entire Care plan = 22/22 Comments: Satisfactory care plan. Excellent job! BL

Firelands Regional Medical Center School of Nursing
 Psychiatric Nursing 2021
 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)	Sandra Littlefield (Borderline Personality Disorder Scenario) (*1,2,3,4,5)	Adult Live-Simulation (*1,2,3,4,5,7/7)	George Palo (Alzheimer's Disorder) (*1,2,3,4,5)	Randy Adams (PTSD Scenario) (*1,2,3,4,5)
	Date: 6/11/2021	Date: 6/25/2021	Date: 7/2/2021	Date: 7/7/2021 7/8/2021	Date: 7/9/2021	Date: 7/23/2021
	S	S	S	S	S	
Evaluation	S	S	S	S	S	
Faculty Initials	EW	DC	KA	BL	BL	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	

* Course Objectives

Firelands Regional Medical Center School of Nursing
Psychiatric Nursing 2021

Lasater Clinical Judgment Rubric Scoring Sheet

STUDENT NAME: **V. Glaze (Group 2)** OBSERVATION DATE/TIME: **7/7/2021 0920-1035** SCENARIO #: **1**

CLINICAL JUDGMENT	OBSERVATION NOTES
<p>COMPONENTS NOTICING:</p> <ul style="list-style-type: none"> • Focused Observation: E A D B • Recognizing Deviations from Expected Patterns: E A D B • Information Seeking: E A D B 	<p>Notices abrasion on patient's eye.</p> <p>Notices patient history of alcohol use and recent loss.</p> <p>Notices patient's restlessness.</p> <p>Notices patient's stress with job.</p> <p>Notices patient is feeling anxious.</p> <p>Notices patient is feeling itchy and numb.</p> <p>Notices patient is hallucinating (seeing spiders).</p>
<p>INTERPRETING:</p> <ul style="list-style-type: none"> • Prioritizing Data: E A D B • Making Sense of Data: E A D B 	<p>Interprets patient's behavior as restless and anxious.</p> <p>Interprets patient's feelings of loneliness and recent loss as risk factors for depression.</p> <p>Interprets correct use of medications for patient.</p> <p>Interprets CIWA score as 8.</p> <p>Interprets patient's signs and symptoms as alcohol withdrawal symptoms.</p> <p>Interprets CIWA score as 15.</p> <p>Interprets correct use of Lorazepam.</p>
<p>RESPONDING:</p> <ul style="list-style-type: none"> • Calm, Confident Manner: E A D B • Clear Communication: E A D B • Well-Planned Intervention/ Flexibility: E A D B 	<p>Introduces self to patient.</p> <p>Remains calm with patient.</p> <p>Medication nurse identifies patient and introduces herself.</p> <p>Obtains vital signs.</p> <p>Performs head to toe assessment.</p>

<ul style="list-style-type: none"> Being Skillful: E A D B 	<p>Asks about history of alcohol use and current alcohol use.</p> <p>Attempts to utilize therapeutic communication to assess patient's alcohol use and history.</p> <p>Performs CIWA and educates patient on reasoning for use.</p> <p>Excellent therapeutic communication with patient about recent loss, feelings of unhappiness, and coping mechanisms.</p> <p>Provides education to patient about medication.</p> <p>Administers 2mg of Lorazepam for CIWA score of 8.</p> <p>Performs Brief Mental Status Evaluation. Uses open-ended questions and therapeutic communication to obtain further information.</p> <p>Asks about coping mechanisms.</p> <p>Gives thorough SBAR report.</p> <p>Introduces self to patient.</p> <p>Remains calm with patient.</p> <p>Obtains vital signs.</p> <p>Asks about patient's signs and symptoms of anxiety.</p> <p>Performs CIWA assessment.</p> <p>Medication nurse introduces self and identifies patient.</p> <p>Administers 4 mg Lorazepam for CIWA score 15.</p>
<p>REFLECTING:</p> <ul style="list-style-type: none"> Evaluation/Self-Analysis: E A D B Commitment to Improvement: E A D B 	<p>Identified strengths and areas of improvement for performance.</p> <p>Reflected on the importance of providing education to the patient about substance abuse and community resources available.</p> <p>Reflected on the importance of providing education when it is appropriate.</p> <p>Reflected on the importance of therapeutic communication.</p> <p>Identified risk factors patient had related to substance abuse.</p>
<p>SUMMARY COMMENTS:</p> <p>Satisfactory completion of the simulation scenario is a score of "Developing" or higher in all areas of the rubric.</p> <p>E= Exemplary</p>	<p><i>Lasater Clinical Judgement Rubric: Information provided relates to the Clinical Judgement Rubric based on comments listed above from student performance. Refer to Lasater's Clinical Judgement Rubric for more detailed information.</i></p> <p>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. Identifies obvious patterns</p>

<p>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</p>	<p>and deviations, missing some important information; unsure how to continue 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>
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E = exemplary, A = accomplished, D = developing, B = Beginning
Based off of Lasater's Clinical Judgment Rubric

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: