

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

Student:

Christina Lopez

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:		na	s	s	s	na	na				
a. Demonstrate an understanding of the relationship between mental health, physical health, and environment for those patients diagnosed with a mental disorder.		na	s	s	s	na	na				
b. Correlate prescribed therapies, psychotherapy, and alternative therapies in relation to the patient's mental disorder.		na	s	s	na	na	na				
c. Provide culturally and spiritually competent care within the scope of nursing that meets the needs of assigned patients from diverse cultural, racial and ethnic backgrounds.		na	s	s	Na S	na	s				
d. Identify appropriate methods that will assist the patient to regain independence and achieve self-care		na	s	s	Na S	na	na				
e. Recognize normal versus non-normal behavior patterns in terms of developmental milestones. (Erickson).		na	s	s	s	na	s				
f. Develop and implement an appropriate nursing therapy group activity.		na	s	na	na	na	na				
g. Develop a geriatric physical/mental health assessment and education plan. (Geriatric Assessment)					na						
Faculty Initials		BL	BL	BL	BL	DC	BL				
Clinical Location		na	1 south	1 south	Detox center AA/NA		Stein Hospice				

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Comments:

Week 3-1(f) Christina, you did an excellent job facilitating nursing therapy group for the patients. Your activity was engaging and a great way for patients to identify ways to cope with stress. 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	9	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	na	na				
b. Identify the individual patient's symptoms related to the psychiatric diagnosis. (interpreting)		na	s	s	na	na	na				
c. Demonstrate ability to identify the patient's use of coping/defense mechanisms. (noticing, interpreting)		na	s	s	na	na	s				
d. Formulate a prioritized nursing care plan utilizing clinical judgment skills. (noticing, interpreting, responding, reflecting)		na	s	S NA	na	na	na				
e. Apply the principles of asepsis and standard precautions.		na	s	s	na	na	s				
f. Practice use of standardized EBP tools that support safety and quality. (noticing, responding)		na	s	s	na	na	s				
Faculty Initials		BL	BL	BL	BL	DC	BL				

Comments:

Week 3-2(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

Week 3-2(f) Great job with discussion of your EBP article titled "Reducing Falls after Electroconvulsive Therapy" during debriefing. BL

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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.		na	s	s	na	na	s				
b. Demonstrate professional and appropriate communication with the treatment team by using the SBAR format for handoff communication during transition of care.		na	s	s	na	na	s				
c. Identify barriers to effective communication. (noticing, interpreting)		na	s	s	na	na	s				
d. Construct effective therapeutic responses.		na	s	s	na	na	s				
e. Construct a satisfactory patient-nurse therapeutic communication. (Nursing Process Study)					S U S						
f. Posts respectfully and appropriately in clinical discussion groups.		na	S NI	s	S U	na	Ni S				
g. Respect the privacy of patient health and medical information as required by federal HIPAA regulations.		na	s	s	s	na	s				
h. Teach patient/family based on readiness to learn and patient needs. (responding, reflecting)		na	s	s	na	na	s				
Faculty Initials		BL	BL	BL	BL	DC	BL				

Comments:

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

Week 3-3(f) Christina, overall you did a nice job with your CDG for this week. However, you did not submit your CDG in the appropriate location. Your CDG should be posted under discussions, not submitted to your personal dropbox. Additionally, for Clinical Day 1, there was some information missing for question 3. Specifically, you did not provide any defining characteristics for the second nursing diagnosis you chose (Ineffective Coping). For Clinical Day 2, your care plan

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is very well done. Please see the Care Plan Grading Rubric at the end of this document for my feedback. Lastly, you did not provide an in-text citation in your post at all. You provided two references, but no in-text citation. Remember, for every reference that you have, there should be an in-text citation within the posting as well. Both an in-text citation and a reference are required in all CDG postings for a satisfactory grade. If you have any questions, please do not hesitate to reach out. BL

Week 4-3(f) Excellent job with your CDG this week. BL

Week 5-3(e) You have been graded as unsatisfactory for your Nursing Process Study with a score of 72/100. Please review the Nursing Process Study Rubric for the appropriate areas that need to be corrected in order to become satisfactory for this assignment. If you have any questions, please do not hesitate to ask. Please remember to address this “U” on your clinical tool next week. BL

Week 5-3(f)-Christina, overall you did a very nice job with your CDG postings for your Detox and Sandusky Artisans clinical experiences. Unfortunately, you did not include an in-text citation or a reference for your Detox CDG. Per the CDG grading rubric, if a student omits both an in-text citation and reference from their CDG posting, they are automatically graded as unsatisfactory. Please be sure to include both an in-text citation and a reference in all CDG postings. If you have any questions, or need assistance, I would be happy to help you. Remember to address this “U” on your clinical tool next week with a plan for improvement. BL

For week 5-3 I will make sure to prepare and understand the instructions for my clinical tools due every week. I will double check my assignments before turning them into be sure everything is included in my work.

Week 7-3(f) Christina, you did an excellent job with your Hospice Reflection Journal. I’m glad you learned a lot during this experience and enjoyed your time spent there. Thank you so much for sharing your thoughts and feelings about the experience. BL

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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.		na	s	s	na	na	S NA				
b. Demonstrate ability to discuss the uses and implication of psychotropic medications		na	s	s	na	na	S NA				
c. Identify the major classification of psychotropic medications.		na	s	s	na	na	S NA				
d. Identify common barriers to maintaining medication compliance.		na	s	s	na	na	S NA				
e. Explain the effects, adverse effects, nursing interventions and safety issues, related to the use of psychotropic medications.		na	s	s	na	na	S NA				
Faculty Initials		BL	BL	BL	BL	DC	BL				

Comments:

Week 3-4(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

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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.		na	na	na	s	na	na				
b. Discuss recommendations for referrals to appropriate community resources and agencies.		na	na	na	s	na	na				
c. Attend Erie County Health Department Detox Unit observing the care of a patient with mental illness-substance abuse. (Community Agency Observation-Detox Unit)		na	na	na	s	na	na				
d. Attend Narcotics/Alcoholics Anonymous meeting. (Alcoholics/Narcotics Anonymous at the Artisans of Sandusky Observation)		na	na	na	s	na	na				
Faculty Initials		BL	BL	BL	BL	DC	BL				

Comments:

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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:		na	s	s	na	na	na				
a. Demonstrate competence in navigating the electronic health record.		na	s	s	na	na	na				
b. Demonstrate satisfactory documentation of physical and psychiatric assessments and nursing notes utilizing the electronic health record.		na	s	s	na	na	na				
Faculty Initials		BL	BL	BL	BL	DC	BL				

Comments:

Week 4-6(a) Excellent job taking the time to navigate the electronic health record in order to research information about your patient. BL

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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		na	s	s	na	na	na				
b. Demonstrates effective use of strategies to reduce risk of harm to self or others. Create a safe environment for patient care.		na	s	s	na	na	s				
c. Illustrate active engagement in self-reflection and debriefing.		na	s	s	na	na	na				
d. Incorporate the core values of caring, diversity, excellence, integrity, and “ACE” – attitude, commitment, and enthusiasm during all clinical interactions.		na	s	s	s	na	s				
e. Exhibit professional behavior i.e. appearance, responsibility, integrity, and respect.		Na NI	s	s	s	na	s				
f. Follow the standards outlined in the FRMCSN policy, “Student Conduct While Providing Nursing Care.”		na	s	s	Na S	na	s				
Faculty Initials		BL	BL	BL	BL	DC	BL				

Comments:

Week 2-7(e) This competency has been changed to an “NI” for this week because your clinical tool was not submitted on time. Going forward, please be sure to submit your clinical tool by the appropriate due date and time. If you have any questions, please do not hesitate to reach out. BL

Nursing Care Plan Grading Tool
Psychiatric Nursing
2021

Student Name: **Christina Lopez**

Clinical Date: **6/15-6/16/2021**

Objective # 6: Develop patient-centered plans of care utilizing the nursing process. (3,4,5,6,7)*	Low self-esteem
**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)-0 Defining Characteristics (1)-1	Total Points: 2 Comments: Nursing diagnosis is appropriate for patient, however, you did not include an etiology. For example, Low self-esteem R/T lack of approval. You must always include an etiology statement. Defining characteristics are well done. BL
Goal and Outcome (6 points total) Goal Statement (1 point)-0 Outcome: Specific (1)-1 Measurable (1)-1 Attainable (1)-1 Realistic (1)-1 Time Frame (1)-1	Total Points: 5 Comments: Remember to include an overall goal statement. For example, "Patient will have high self-esteem" and then AEB your outcome statements. Great job with outcome statements, they 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 your 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 = 20/22 Comments: Satisfactory care plan. Great 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)
	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
Evaluation	S	S	S	S	S	
Faculty Initials	BL	BL	BL	DC	DC	
Remediation: Date/Evaluation/Initials	NA	NA	NA	NA	NA	

* Course Objectives

Lasater Clinical Judgment Rubric Scoring Sheet

STUDENT NAME: **Maura Brown, Audra Howes, Christina Lopez, Katie McCoy** OBSERVATION DATE/TIME: **7/8/21** SCENARIO #: **Substance Use Disorder**

CLINICAL JUDGMENT	OBSERVATION NOTES
<p>COMPONENTS NOTICING:</p> <p>1. Focused Observation: E A D B</p> <p>2. Recognizing Deviations from Expected Patterns: E A D B</p> <p>a. Information Seeking: E A D B</p>	<p>Focused observation on vital signs when entering the room. Noticed abrasion to the forehead. Noticed potential problem with substances based on CAGE-AID questionnaire. Did not seek further information related to substance use. Noticed anxiety, restlessness and agitation. Prioritized vital signs when entering the room for the second time. Noticed enhanced symptoms of hallucinations and agitation. Sought further information related to withdrawal symptoms. Sought further information related to substance use.</p>
<p>INTERPRETING:</p> <p>3. Prioritizing Data: E A D B</p> <p>b. Making Sense of Data: E A D B</p>	<p>Prioritized focused neuro assessment related to abrasion on the patient's head.</p> <p>Prioritized full head to toe assessment rather than focusing on mental health evaluation initially.</p> <p>Prioritized CAGE-AID questionnaire. Identified potential problem with substance use.</p> <p>Prioritized brief mental health evaluation to determine baseline.</p> <p>Did not make sense of withdrawal symptoms to prioritize the CIWA assessment.</p> <p>Prioritized drug and alcohol history assessment.</p> <p>Eventually prioritized CIWA assessment to determine potential need for substitution therapy.</p> <p>Interpreted CIWA score as 8 (high for the first group). Prioritized re-assessment of vital signs prior to administering lorazepam. Made sense of CNS depressant effects on vital signs.</p> <p>Prioritized mental health evaluation and CIWA assessment based on new symptoms and behaviors. Prioritizing this assessment can help to prevent worsening symptoms related to withdrawal.</p>
<p>RESPONDING:</p>	<p>Calm communication with the patient when performing assessments.</p>

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<p>4. Calm, Confident Manner: E A D B</p> <p>5. Clear Communication: E A D B</p> <p>c. Well-Planned Intervention/ Flexibility: E A D B</p> <p>d. Being Skillful: E A D B</p>	<p>Consider explaining to the patient the rationale behind performing assessments such as the CAGE-AID, mental health evaluation, CIWA, etc. It is important to build a trusting relationship by keeping the patient informed on why you are performing interventions.</p> <p>Good teamwork with assessments.</p> <p>Consider exploring patient's feelings based on responses to sensitive questions related to substance use and loss rather than reading one question after another. Therapeutic responses and offering self are important.</p> <p>Calm demeanor during assessment allowing the patient to feel comfortable and safe.</p> <p>Consider explaining the purpose of the CIWA assessment. CIWA performed appropriately.</p> <p>Appropriate dose of lorazepam administered based on CIWA protocol.</p> <p>Educated the patient on each medication. Important interventions ensure and promote trust with the patient.</p> <p>Good communication with the patient related to roles. Explained to the patient what the nurse was doing when leaving the room. Nice job building trust. Asked the patient If she had any questions or concerns. Good therapeutic communication.</p> <p>Good education to the patient on withdrawal symptoms and need for substitution therapy. Great job keeping the patient informed.</p> <p>Nice job with therapeutic and empathetic communication. Offered self and allowed the patient to open up about feelings.</p> <p>Educated on community resources. Consider timing of the education, is the patient in the right mindset to receive education at this time? Good education was provided.</p>
<p>REFLECTING:</p> <p>6. Evaluation/Self-Analysis: E A D B</p> <p>e. Commitment to Improvement: E A D B</p>	<p>Reflected on and discussed the use of effective therapeutic communication for a patient with an acute mental health crisis. Identified areas for improvement when utilizing the CIWA scale.</p> <p>Reflected on appropriate education and timing related to community support and resources. All members of the team evaluated personal performance, identifying areas of strength and areas for improvement. Decision points were identified and alternatives considered. All members of the group discussed a commitment for improvement in the future.</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>A= Accomplished</p> <p>D= Developing</p> <p>B= Beginning</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 observed and monitored a variety of data pertinent to the scenario, including both subjective and objective information. Most useful information was noticed. The team recognized most obvious patterns and deviations in data and used the information provided in the scenario to continually assess the patient. The group actively sought subjective information about the patient and her situation to support planning of interventions and pursued important leads.</p> <p>Interpreting: The group made an effort to prioritize and focus on most important data, but did not always pursue priority leads. In most situations, the group interpreted patient data patterns and compared to known patterns in order to develop an intervention plan with appropriate rationale; exceptions were rare or in most complicated situations.</p> <p>Responding: The group displayed leadership and confidence and was able to calm and control the situation. Some stress was shown during complex situations. Communicated well with team members and the patient. Explained some aspects to the patient while others were not explained clearly at times. Developed interventions on the basis of most obvious data; monitored progress regularly; unable to make some adjustments as indicated by the patient’s responses at times. Displayed proficiency in the use of most nursing skills.</p> <p>Reflecting: Evaluated and analyzed clinical performance individually and as a team, noted decision making points, elaborated on decisions, and evaluated alternatives. Committed to ongoing improvement, reflected on experience, accurately identified strengths and weaknesses and developed a plan for improvement in the future.</p> <p>Satisfactory Completion of Psychiatric Nursing Simulation Scenario on Substance Use.</p>
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EVALUATION OF CLINICAL PERFORMANCE TOOL

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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: