LOS ANGELES HARBOR COLLEGE
WEEKLY CLINICAL EVALUATION for NURSING 343

Student:	Clinical Instructor:	Agency:	Semester:

Evaluation Criteria

Satisfactory: Clinical performance demonstrates continued growth towards course competencies. Behaviors are consistent, safe, and performed at expected learner level described in the student competency behavior descriptors for satisfactory performance.

Needs Improvement: Behaviors manifested have potential for causing harm. Student requires excessive prompting and direction to perform safely and at expected learner level.

- **Unsatisfactory:** Behaviors performed or omitted are unsafe. Student behaviors lack knowledge base and skill competencies expected (see unsatisfactory behavior descriptors).

(*)-Represents Critical Competency Behaviors: Competency Behaviors must be met in order to pass the clinical component of this course. "Unsatisfactory" daily ratings will be given for the following behaviors:

- An "Unsatisfactory" rating in any critical behavior (delineated by an "*").
- Three or more "Needs Improvement" ratings in any area on one day of clinic or 1 "Unsatisfactory" rating in a non critical behavior and 1 "Needs Improvement" in 1 clinic day

The Student must demonstrate a "Satisfactory" level of **performance for 75% of the clinical rotation** in order to pass the course. Two "Unsatisfactory" clinical weeks will result in a clinic failure.

COMPETENCIES/PERFORMANCE CRITERIA

I. APPLY THE NURSING PROCESS USING THE ROY ADAPTATION MODEL IN CARING FOR INDIVIDUALS AND GROUPS ACROSS THE LIFESPAN AND DEVELOPMENTAL STAGES.

1. Collects comprehensive assessment data that includes the patient's values, preferences, expressed needs, and developmental, emotional, cultural, religious, and spiritual influences.*
2. Creates a nursing history and assessment that categorizes ineffective behaviors that affect adaptation in the four modes: physiological, self-concept, role function, and interdependence.*
3. Evaluates ineffective behaviors and links these behaviors to one or more stimuli.
4. Analyzes assessment data to determine actual or potential nursing diagnoses in each mode.
5. Proposes a rationale for the priority nursing diagnosis identified from the practice care plans.
6. Formulates expected outcomes based on ineffective behaviors and patient values, preferences, and expressed needs for each nursing diagnosis.
7. Collaborates with the patient and interprofessional team to prescribe nursing interventions for each stimuli identified to achieve expected outcomes.
8. Evaluates patient responses to therapeutic nursing and medical interventions, treatments, medications, teaching, reports and modifies plan as needed.

WEEK/DATE	1	2		3		4		5		6	
Evaluator		Stud.	Inst.	Stud.	Inst.	Stud.	Inst.	Stud.	Inst.	Stud.	Inst.
SAT.	ORIENT										
N.I.											
UNSAT.											
N/A											

II. PRACTICE PROFESSIONAL BEHAVIOR STANDARDS OF NURSING PRACTICE.

1. Internalizes one's role as a nurse in ways that reflect integrity, responsibility, ethical practices, and an evolving identity as a nurse committed to evidence based practice, caring, advocacy, and safe, quality care for diverse patients within a family and community context.
2. Integrates the Code of Ethics, Standards of Practice, and policies and procedures of Los Angeles Harbor College, nursing program, and clinical agencies into practice.*
3. Exhibits appropriate behaviors, e.g. prompt and timely arrival to class and clinic; adherence to uniform standards; attendance, honesty; and attitude.*
4. Accepts accountability and responsibility for own actions.*
5. Advocates for patients and families in ways that promote their self-determination, integrity, and ongoing growth as human beings.
6. Evaluates own performance correctly and thoughtfully.
7. Establishes and maintains nurse-patient boundaries including appropriate use of self-disclosure.*

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III. DEMONSTRATE CLINICAL DECISION MAKING THAT IS ACCURATE AND SAFE.

1. Formulates and develops critical thinking in making clinical decisions (e.g. mental status assessment, medical history and psychiatric history taking, assessment, diagnostic tests, laboratory values, and medications) to develop an individualized plan of care for the patient.*
2. Integrates and validates stimuli of effective and ineffective behaviors.
3. Considers all relevant information/inconsistencies and appropriate resources for clinical decision-making.
4. Recognizes manipulative and testing behaviors.
5. Maintain the safety and integrity of the locked status of the units.*
6. Immediately report any observed self-harm or suicidal behavior to the charge nurse or clinical instructor.*

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N.I.											
UNSAT.											
N/A											

IV. PROVIDE SAFE, PATIENT-CENTERED CARE.

1. Relates knowledge of pathophysiology and pharmacotherapy for patients.
2. Assesses learning needs, develop teaching plans, implement teaching and evaluate effectiveness.
3. Respects and encourages individual expression of patient values, preferences, and expressed needs.
4. Provides and integrates patient-centered care with sensitivity and respect for developmental stage, values, customs, religion, ethnicity, and culture.
5. Assesses and treats pain (physical or psychological) and suffering in light of patient values, preferences, and expressed needs.
6. Performs nursing skills competently and safely according to college or agency policy and procedure guidelines.*
7. Adheres to current Behavioral Health National Patient Safety Goals (including suicidal ideation assessment) and Patients Rights under the Lanterman-Petris-Short Act.*
8. Implements strategies to prevent and reduce harm.

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N/A											

V. FUNCTION EFFECTIVELY WITHIN NURSING AND INTERPROFESSIONAL TEAMS UTILIZING EFFECTIVE COMMUNICAITON STRATEGIES.

1. Functions competently within scope of practice as a member of the interdisciplinary team and describe the scopes of practice and roles of health care team members (psychiatrist, psychiatric nurse, nurse manager, clinical social worker, psychiatric technician, recreation therapist, music therapist, court advocates, spiritual practitioner, unit secretary, etc.) to achieve patient outcomes.
2. Consistently develops therapeutic communication skills to assist the patient, family, and significant others to enhance coping and assist in problem solving. *
3. Correctly self-evaluates therapeutic communication interactions in the form of process recordings.
4. Interacts effectively with multidisciplinary team members and instructor.
5. Actively participates in clinical conferences.
6. Researches and facilitates a therapeutic group experience for peers or patients as assigned.
7. Formulates communication practices that minimize risks associated with handoffs among providers across transitions of care (SBAR).
8. Reports ineffective behaviors, accurate, pertinent information, and patient concerns in a timely manner to staff and/or instructor. *

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VI. INCORPORATE EVIDENCE-BASED PRACTICES THAT SUPPORT CLINICAL REASONING.

1. Demonstrate evidence-based practice to include the components of research evidence (etiology, pathophysiology, medication management, stress management techniques), clinical expertise, and patient/family values.
2. Apply efficient search strategies to locate reliable sources of evidence that will provide the ability to make judgments in practice, substantiated with evidence, that integrate nursing science in the provision of safe, quality care and promote health of patients within a family and community context.
3. Authenticate the evidence that underlies clinical nursing practice to challenge the status quo, question underlying assumptions, and other new insights to improve the quality of care for patients, families, and communities.

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N/A											

VII. IDENTIFY AREAS FOR IMPROVEMENT IN QUALITY AND SAFETY OF HEALTHCARE SYSTEMS.

1. Examine a variety of sources of information to review outcomes of care and identify potential areas for improvement. (e.g. increased dignity and satisfaction for the patient, decreased restraint rates, decreased fall rates).
2. Compare and contrast the roles of nursing and other health professions as parts of systems of care that affect outcomes for patients, families, and communities.
3. Completes care safely, cost effectively, organized and timely to improve the quality of care.
4. Verify measurable outcomes on care plans to evaluate care.
5. Appraises and evaluates personal biases and stereotypes toward people with mental health challenges.
6. Utilizes quality and safety measures in place at the clinical agency (Morse Fall Scale, Rapid Response, suicide assessment, etc.).*
7. Relates clinical safety concerns for group discussion and resolution in clinical conference.

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N/A											

VIII. UTILIZE TECHNOLOGY TO RESEARCH PATIENT INFORMATION AND COMMUNICATE WITH INTERPROFESSIONAL TEAMS, MANAGE KNOWLEDGE, MITIGATE ERROR, AND SUPPORT DECISION MAKING.

1. Demonstrate successful navigation and documentation within the electronic health record in the clinical setting.*
2. Examine appropriate resources, collected electronically or other means to communicate with the interprofessional teams and solve patient problems.
3. Maintains patient confidentiality and security of all health records.*
4. Researches and provides appropriate community–based support resources, computer-based support, or apps that can enhance patient well-being.

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STUDENT REFLECTIONS: IDENTIFY THE AREA OF QSEN THAT YOU ARE GOING TO REFLECT UPON FROM THE PREVIOUS PAGES/TABLES. Write about feelings, opinions and concerns regarding patient care activities that went well and not so well, transfer of theoretical knowledge and nursing interventions that promoted effective adaptation of your client. Write comments related to resolution of performance, lessons learned, procedures performed.

REFLECTION COMMENTS: USE BACK OF PAGE AS NEEDED
Week 1
Week 2
Week 3
Week 4
Week 5
Week 6

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Instructor' Weekly Feedback regarding student clinical performance: State positive performance and suggestions for improvement. Circle weekly performance level rating.	Student Initial
Week 1 ___ punctual ___ dressed appropriately ___ wore name tag ___ brought all materials _____ completed Prep/pathophysiology _____ participated in clinical conference Weekly Rating: Sat. NI Unsat	
Week 2 Weekly Rating: Sat. NI Unsat	
Week 3 Weekly Rating: Sat. NI Unsat	
Week 4 Weekly Rating: Sat. NI Unsat	
Week 5 Weekly Rating: Sat. NI Unsat	
Week 6 (Summary) Weekly Rating: Sat. NI Unsat	

Care Plan #1 _____/___30___ = _____% Care Plan #2 _____/___30___ = _____%

Total Points _____/_____ =_____% Theory Grade_____ Clinic Grade _____

Date:_____

Student Signature_____ Clinic Instructor Signature_____

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Competency	Satisfactory (Moving toward independent level. Performing as Expected for this level)	Unsatisfactory (Dependent level, significant concerns for safety)
I. APPLY THE NURSING PROCESS USING THE ROY ADAPTAON MODEL IN CARING FOR INDIVIDUALS AND GROUPS ACROSS THE LIFESPAN AND DEVELOPMENTAL STAGES.	Utilizing appropriate guidelines, resources, & assessment techniques, demonstrates steps of the nursing process. Identifies adaptive & ineffective behaviors in all four modes. Includes subjective & objective data. Identifies stimuli for ineffective behaviors, includes patient values, preferences, expressed-needs, growth & developmental stage, culture, spiritual, adaption levels, & economic factors, as they relate to the patient. H&A forms contain 95% of pertinent data (e.g. lab, diagnostic tests, mode assessment data, BMI, general assessment - < 2 areas needing minor corrections or additions). Identifies ≥ 3 prime Nursing diagnoses (ND). Identifies ≥ 3 pertinent manipulatable stimuli for each ND. Main care plans reflect priority nursing diagnosis. Goal stated are appropriate for patient. Has ≥ 3 outcomes measurable & with realistic critical times. Identifies 95% of therapeutic nursing interventions (NI) related to stated outcomes. Gives rationale for each NI. Evaluates progress towards outcomes & revises NI PRN. Receives ≥ 22.5 out of 30 points awarded on each CP.	Does not utilize appropriate guidelines or resources. Submits work late. Does not utilize appropriate assessment techniques. History and Assessment contains less than 75% of pertinent data. Does not relate patient values, preferences, expressed-needs, growth & developmental stage, culture, spiritual, adaption levels, & economic factors when indicated. Inaccurate data obtained. Failure to identify all significant related subjective and objective data for selected nursing diagnosis. Fails to demonstrate understanding of the link between stimuli and supporting behaviors. Cannot verbalize stimuli for patient behaviors with major cues. Care plan not individualized. Fails to demonstrate the ability to prioritize nursing diagnoses. Outcomes are not measurable or lack of realistic critical time for 3 or more outcomes. Nursing interventions do not have related rationales. Missing 3 or more key interventions on plan of care. Does not evaluate outcomes or revise nursing interventions as indicated. Score < 20 on care plan.
II. DISPLAY PROFESSIONAL BEHAVIOR FOR NURSING PRACTICE.	Presents to the clinical setting in a punctual manner, dressed appropriately, with name badge (and hospital required ID if indicated), and all prep/paperwork completed. Participates in clinical conference. Researches and adheres to agency guidelines and school policies. Conducts self in an honest and ethical manner within the legal limits and scope of practice of a student nurse. Treats staff, patients, instructors, and peers respectfully and with dignity. Engages in self-reflection to accurately identify performance areas for personal and professional growth. Recognizes and discusses transference/countertransference experience in the clinical conference and maintains safe boundaries. Self-disclosure is patient-centered and general.	Any tardiness or absence without notification of instructor or unit. Arriving late to groups or when leading a group. Does not comply with instructor's request/instructions. Does not correct behaviors after being discussed by instructor. Is dishonest, disrespectful or argumentative with patient, staff, or instructor. Leaves unit without reporting to primary nurse or instructor. Assignments submitted > 1 day late, or < 2 weekly assignments submitted late. Consistent use of unapproved abbreviations. Removes chart from nursing station without proper notification of staff > 2 times. Non-compliance with the college dress code for mental health nursing. Does not correctly evaluate self for second week during the rotation. Does not reflect on how to correct or improve upon major weakness. Unable to recognize transference/ countertransference in the nurse/patient relationship. Uses self-disclosure in an excessive or harmful manner.
III. DEMONSTRATE CLINICAL DECISION MAKING THAT IS ACCURATE AND SAFE.	Completes Mental Status Examination (MSE) with less than 3 items needing correction. Presents patient case study with pertinent needs and proposed nursing diagnoses identified. Recognizes and discusses manipulative and testing behaviors in the clinical conference and records on MSE. Records pertinent laboratory values on medication administration record sheet.	Consistent missing or inaccurate assessment data on the MSE form, multiple blanks. Unable to present patient case study in clinical conference with pertinent data nor propose nursing diagnoses. Does not recognize behavior outside social norms, testing or manipulative behavior. Does not recognize or report adverse medication side effects.

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Competency	Satisfactory (Moving toward independent level. Performing as Expected for this level)	Unsatisfactory (Dependent level, significant concerns for safety).
IV. PROVIDES SAFE, PATIENT-CENTERED CARE.	Identifies and complies with National Behavioral Health Patient Safety Guidelines. Immediately reports and patient behavior that is unsafe to the charge nurse or clinical supervisor. Seeks assistance or mentorship when needed. Able to relate knowledge of the mechanism of action, indication, dosage range, therapeutic effect, laboratory values, side effects and nursing actions related to all medications. Keeps custody of assigned unit key at all times. Follows hospital policy for unit codes, fall precautions and behavioral crises). Develops a plan for patient, family and group teaching and evaluates whether learning has occurred. Assesses developmental stage, values, customs, religion, ethnicity and culture in all care given.	Fails to adhere to National Behavioral Health Patient Safety Guidelines. Cannot answer instructor's questions regarding significant patient information, medication and plan of care. Needs major prompt or instructor intervening to safely perform interventions. Does not ask questions when unsure of patient status or appropriate interventions. Does not follow standard precautions or hospital policies concerning patient safety (fall precautions, restraints, unit codes, behavioral crises, unit keys). Does recognize need to know results of diagnostic reports/lab values. No use of hand washing or universal precautions when necessary. Does not notify instructor of errors. No use of patient identifier when providing care. Commit actions that cause or have the potential to cause significant harm to a patient.
V. FUNCTION EFFECTIVELY WITHIN NURSING AND INTERPROFESSIONAL TEAMS UTILIZING EFFECTIVE COMMUNICAITON STRATEGIES.	Able to relate knowledge of the different roles of the members of the health care team and communicate with appropriate member to meet patient needs. Completes process recordings with less than 2 errors per recording. Consistently recognizes blocking techniques and provides therapeutic alternates each occurrence. Demonstrates a non-judgmental acceptance of views differing from own. Assess and reports clinical condition, suicidal ideation and pain consistently throughout shift. Able to demonstrate SBAR communication in association with patient handoffs.	Does not utilize communication channels with members of the healthcare team as indicated by patient needs. Consistently unable to identify therapeutic or blocking techniques on the process recording form as evidenced by greater than 4 mistakes per assignment beyond week 3. Displays a judgmental attitude toward patients or other members of the health care team. Does not assess or report detrimental change in condition, pain or suicidal ideation to instructor or assigned nurse. Unable to relate pertinent information in SBAR format.
VI. INCORPORATE EVIDENCE-BASED PRACTICES TO SUPPORT CLINICAL REASONING.	Demonstrates ability to research appropriate evidence-base practices through accurate completion of prep/pathophysiology care sheet assignments with omission of less than two main areas of importance. Identifies evidence-based stress management techniques for use in practice. Able to verbalize and incorporate reliable evidence-based data when planning and providing patient care.	Cannot locate resources for obtaining evidence-based data to provide for patient care. Missing greater than 3 areas of evidence-based data that drive appropriate clinical reasoning for care given to patients on the pathophysiology sheet. Cannot describe evidence-based guidelines for care given in the clinical setting.
VII. IDENTIFY AREAS FOR IMPROVEMENT IN QUALITY AND SAFETY OF HEALTHCARE SYSTEMS.	Able to identify individual measures that move the system to improved quality and safety. Addresses personal biases and stereotypes in clinical conference. Evaluates instances of behavioral crises in clinical conference for potential system failures. Utilizes quality and safety measures in place at the clinical agency.	Unable to verbalize or demonstrate system based thinking. Cannot verbalize potential quality or safety issues in the clinical setting. Does not recognize personal biases or stigma in the mentally ill population. Does not follow protocols of safety and quality at the clinical agency.
VIII. UTILIZE TECHNOLOGY TO RESEARCH PATIENT INFORMATION AND COMMUNICATE WITH INTERPROFESSIONAL TEAMS, MANAGE KNOWLEDGE, MITIGATE ERROR, AND SUPPORT DECISION MAKING.	Completes all hospital-required training for access to electronic medical records (EMR). Maintains integrity of personal passwords. Demonstrates the ability to navigate and document in the EMR per agency protocol. Able to utilize EMR based resources to promote communication, manage knowledge, mitigate error and support decision-making. Strictly maintains patient confidentiality and reports any breach observed. Researches and analyzes community-based support resources, computer-based support or evidence-based apps that enhance patient well-being.	Unable to navigate or document within the EMR after the second week without major prompting from clinical instructor. Shares personal passwords to electronic medical record system with others. Unaware of mechanisms within the EMR that promote communication, manage knowledge, mitigate error and support decision-making. Breach of patient confidentiality in oral, written or social media form. Fails to researches and analyzes community-based support resources, computer-based support or evidence-based apps that enhance patient well-being.