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Staff Education to Improve Accuracy and Consistency of Depression Assessment Through Structured Education on the Zung Self-Rating Depression Scale

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Executive Summary: Staff Education Project

Staff Education to Improve Accuracy and Consistency of Depression Assessment Through Structured Education on the Zung Self-Rating Depression Scale

by

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Summary

This Doctor of Nursing Practice project was a staff education initiative to address inconsistent depression screening in an in-person psych unit. Although the Zung Self-Rating Depression Scale (ZSDS) was routinely used, staff showed uneven knowledge of scoring, cut-off interpretation, and clinical application. These gaps risked inaccurate depression identification and weakened standardized screening. Nurses administer and document assessments, so strengthening staff knowledge was essential for patient safety and quality care. The project question was, Does structured staff education on the ZSDS improve nursing knowledge of screening as compared to pre- to post-education?

The purpose of this project was to improve nursing knowledge and consistency in ZSDS scoring and in the interpretation of depression severity through structured education. Evidence was identified and appraised using the Johns Hopkins evidence-based practice model. A database search yielded 42 articles, of which 11 high-quality sources were used to guide project development. Evidence includes systematic reviews, validation studies, and observational research. The project employed a one-group pretest–posttest design with eight nursing staff attending a single, in-person education session. Pretest and post-test scores were analyzed using descriptive statistics, including mean scores and percent differences. Pretest and post-test scores increased from 4.38/8 (54.7%) pretest to 8/8 (100%) post-test, a 45.3% gain. Deliverables included an education module, assessment tools, and evaluation materials. This project supports nursing practice by standardizing depression screening, enhancing clinical decision-making, and promoting early, equitable identification of depression, fostering positive social change.

Background

Depression remains one of the most prevalent and disabling mental health conditions globally and is frequently encountered in primary care settings. Current epidemiological estimates indicate that more than 280 million individuals worldwide experience depressive disorders, with lifetime prevalence rates in adults ranging between 10% and 20% depending on population and setting (World Health Organization [WHO], 2023; Villarreal-Zegarra et al., 2020). In the United States, depression affects approximately one in five adults during their lifetime and is associated with increased healthcare utilization, reduced functional capacity, and higher all-cause mortality (Villarreal-Zegarra et al., 2020; Liu et al., 2024). Despite clear clinical guidelines recommending routine depression screening in primary care, under-recognition remains widespread, particularly when screening tools are inconsistently administered or inaccurately interpreted (Miller et al., 2020; Thombs et al., 2021).

Depression screening tools, which use standardized tests, minimize subjectivity and enhance early detection; however, their success in practice largely depends on staff knowledge and implementation fidelity (O'Connor et al., 2016; Levis et al., 2017). Extensive literature on systematic reviews of depression screening in primary care has shown substantial variability in diagnostic accuracy, with reported sensitivities ranging from 43% to 100% across popular instruments (Levis et al., 2019; Mitchell et al., 2019). This inconsistency is due to both dissimilarity in tool design and inconsistency in administering, scoring, and interpretation by healthcare personnel (Dunstan & Scott, 2019; Miller et al., 2020). In the absence of proper education, screening tools can yield

unreliable data, leading to false negatives, false positives, and improper clinical responses. (Azmi et al.,2022; Mitchell et al., 2019)

One of the most commonly used self-report measures of depressive symptomatology in a clinical and research setting is the Zung Self-Rating Depression Scale (ZSDS). The ZSDS is a 20-item Likert-scale score assigned to both raw and index scores, with predetermined cut-off scores associated with levels of depression severity (Dunstan & Scott, 2019; Zung, 1965). Its applicability has been tested on various populations, including older adults, hospitalized patients, healthcare workers, and community samples (Jokelainen et al., 2019; Liang et al., 2020; Zheng et al., 2025). Validation in the elderly has shown that ZSDS has a sensitivity of approximately 79% and a specificity of 72%, with appropriate scoring procedures and cut-off thresholds (Jokelainen et al., 2019; Miller et al., 2020). These results confirm the psychometric adequacy of the ZSDS and its correct interpretation, highlighting the importance of accurate interpretation (Dunstan & Scott, 2019; Liang et al., 2020).

Wrong application of the ZSDS scoring rules is a documented issue. Dunstan and Scott (2019) were able to show that misclassification of depression severity is substantially caused by confusion between raw scores and index scores and the inconsistent use of cut-off thresholds. They found that minimal differences in their interpretation of scoring altered diagnostic categorization in a proportion significant to patients in a clinically meaningful way. The same issues were also found in comparative studies that compared the ZSDS with other reliable measures, such as the Beck Depression Inventory. Poor scoring in the ZSDS lowered the consensus between

measurements and compromised its clinical use (Jokelainen et al., 2019; Miller et al., 2020).

Further, clinical implications of proper depression screening are illustrated by empirical evidence. In patients with acute cerebral infarction, symptoms of depression were detected in more than 55% of subjects by ZSDS-based screening, and the severity of depression was strongly related to functional impairment, duration of illness, and deficiency of social support (Chen et al., 2023). The results indicate that depression screening can be more than a diagnostic exercise, with effective identification directly affecting care planning and prognosis (Dai & Yu, 2023; Tong et al., 2022). ZSDS among healthcare workers in occupational health settings has been shown to have a prevalence of depression between 17 and 36 percent, depending on work setting and exposure to stress, and it highlights the sensitivity of the scale to psychosocial variables under proper application (Liu et al., 2024; Yao & Zhang, 2024).

Although the evidence in favor of standardized screening is robust, several studies suggest that staff training plays a decisive role in screening performance. When structured education was conducted on depression screening protocols in primary care settings, documentation accuracy and follow-up recommendations improved. Evidence showed that trained personnel were more than twice as likely to complete a screening protocol appropriately as their untrained counterparts (O'Connor et al., 2016; Thombs et al., 2021). On a parallel note, high-volume clinical implementation studies have demonstrated that clinician provision of depression instruments is unreliable when not accompanied by continuous education and supervision, thereby undermining detection rates (Liang et al., 2020; Udedi et al., 2019). Multiple systematic reviews of depression

screening interventions find that education is key to translating tool validity into clinical effectiveness. Thombs et al. (2021) highlighted that the lack of program staff educated in screening does not improve patient outcomes and can lead to increased referrals or missed diagnoses. Conversely, interventions combining training, standardized score direction, and feedback systems are more accurate in detection and enhance continuity of care (Levis et al., 2017; Miller et al., 2020).

The project question was, Does structured staff education in the ZSDS improve nursing knowledge of depression screening as compared to pre- to post-education? The purpose of this Doctor of Nursing Practice project was to address a gap in staff knowledge related to the scoring and interpretation of the Zung Self-Rating Depression Scale. Informal evaluation and feedback from staff at the project location revealed uncertainty about ZSDS scoring, cut-off interpretation, and documentation consistency. These findings align with trends in the literature (Dunstan & Scott, 2019; Jokelainen et al., 2019) and highlight a notable gap in practice. Despite its availability and regular administration, the ZSDS had poor clinical applicability due to inconsistent interpretation. The combination of empirical evidence, observed practice variation, and organizational priorities provided considerable grounds for recommending a specific staff education intervention.

The evidence base for this project was identified using the Johns Hopkins Evidence-Based Practice Model. An initial search yielded 42 articles related to depression screening and ZSDS use. After removing duplicates and excluding non-relevant studies, 19 articles were reviewed in full, and 11 high-quality sources were selected to support the project intervention. The evidence used in this project includes

level 1 systematic reviews, level 11 validation studies, and level 111 observational research (Levis et al., 2017; Liu et al., 2024; O'Connor et al., 2016). This demonstrates strong, coherent support for education-oriented practice change. Level I systematic reviews are the strongest type of evidence and involve the synthesis of results from multiple studies. In contrast, Level 11 validation studies provide evidence of the psychometric reliability and clinical relevance of depression screening instruments. Level 111 observational studies also provide further contextualization of real-world implementation and practice gaps, offering robust and consistent support for education-oriented practice change.

The project design was more focused on clarity, feasibility, and applicability. Educational resources were designed to be reusable and easily updated. Project products included -pre-post-assessment tools. The methodology enabled sustainability, allowing the intervention to be replicated or scaled up in the future without requiring significant additional resources.

Staff Education Project Development

Observed inconsistencies in depression screening documentation and uncertainty about the scoring of the Zung Self-Rating Depression Scale (ZSDS) prompted the development of this staff education project. Although the tool was routinely administered, scoring and cut-off interpretation were applied inconsistently, most commonly resulting in calculation and severity classification errors. These practice gaps directly informed the educational intervention's focus and structure.

The project was implemented in-person in an outpatient psychiatry care unit where routine depression screening is conducted during nursing intake. Eight registered nurses (RNs) participated in the project. All were actively involved in patent intake and routine depression screening as part of their clinical responsibilities. Participation was voluntary, and no identifying information was collected. Each participant was assigned a numeric identifier to support paired pretest and post-test analysis. The project was designed to integrate seamlessly within the existing workflow, rather than disrupt it, and was delivered during a scheduled in-service education session.

Project implementation followed a structured, sequential process. First, the project was designed based on identified practice gaps and a review of current evidence; educational materials were then developed (PowerPoint presentation; see Appendix A). The nursing staff were then notified of the project through verbal communication and the scheduling of a planned in-service, and voluntary participation was confirmed. On the day of the implementation, participants completed a pretest to assess baseline knowledge of the Zung Self-Rating Depression Scale (ZSDS) scoring and interpretation. This was followed by a single, in-person, structured education session. Immediately after the session, participants completed a post-test to evaluate knowledge acquisition, followed by a brief educational evaluation to assess the clarity, relevance, and perceived usefulness of the training.

The project was developed to close the identified gap in the outpatient psychiatric unit. The DNP student held a series of meetings with the stakeholders to harness the project process. Emails and flyers were sent to participants, and 8 RNs volunteered for the project. The project implementation was carried out with adequate arrangements,

ensuring minimal disruption to the work process. Immediately before the in-person education session, participants completed a pretest. (See Appendix B) The pretest measured baseline knowledge related specifically to ZSDS scoring and interpretation. Post-test was issued immediately following the education session to assess participants' knowledge and application of ZSDS scoring and interpretation (See Appendix C). The same instrument was administered immediately following the education session as a post-test. Data collection followed a standardized process. Pretest and posttest scores were recorded in a secure spreadsheet. Scores were reviewed for completeness before analysis. Data were stored on a password-protected device. Each objective was assessed using descriptive statistics, including individual scores, group means, and score ranges. Mean pretest and post-test scores were calculated so that an objective-level comparison was possible. Normalized gain calculations were also used to further measure learning improvement. Normalized gains were calculated by subtracting the average pretest score from the average post-test score and then dividing it by 100. This approach provided a comparative method for evaluating learning improvement across different objectives with varying maximum scores. The gains were computed individually for each objective.

Assessment was not limited to test scores. Respondents underwent a brief post-training assessment to evaluate the clarity, relevance, and perceived usefulness of the training (See Appendix C). This evaluation consisted of Likert-scale items and open-ended questions focused on educational clarity and applicability.

Results

Data analysis of the pretest and post-test scores demonstrated a measurable improvement in staff knowledge following the educational intervention, directly answering the project question. Eight nursing staff members completed both the pretest and the post-test. Pretest scores on the full ZSDS knowledge tool (8 questions) ranged from 3 out of 8, with a mean of 4.375 (54.7%), indicating variability in baseline knowledge. Post-test scores ranged from 8 to 8, with a mean of 8 (100%), representing an absolute gain of 3.625 points (45.3% increase). Pretest scores demonstrated variability in knowledge, confidence, and assessment accuracy

The mean pretest scores for Objective 1, which measured knowledge of ZSDS scoring and interpretation, were 3.75 out of 6. Scores ranged from 2 to 5. Following the educational session, all participants scored 6, resulting in a mean improvement of 2.25 points. This represents a 37.5% increase relative to the maximum score.

For Objective 2, which assessed confidence in selecting appropriate depression screening tools, pretest scores ranged from 1 to 2. The group mean was 1.375 out of 2. Post-test scores were 2 for all participants. This reflected a 0.625-point gain and a 31.25% improvement. All staff reported feeling more confident in determining when to use the ZSDS compared to other tools.

Objective 3 evaluated the overall accuracy and consistency of assessments, including correct scoring and documentation. Pretest scores ranged from 4 to 7 out of 8. The mean score was 5.375. Following education, all participants achieved the maximum score of 8. This improvement of 2.625 points represents a 32.8% increase. Variation among participants was eliminated, indicating standardization of assessment practices.

Normalized gains were calculated for each objective by subtracting the pretest average from the posttest average and dividing by 100. Objective 3 achieved a gain of 0.02625. These figures confirm measurable improvement across all objectives. Additionally, statistics support the impact of the educational session. The posttest mean for total scores across all objectives was 6.67 out of the maximum possible 8. Individual gains ranged from 2.0 to 2.75 points. All participants achieved perfect scores on Objective 3, demonstrating complete mastery of assessment accuracy. The resolution of pretest variability indicates that differences in baseline knowledge among staff were eliminated following the intervention, resulting in a consistent understanding across all participants. Post-training evaluation surveys and informal feedback further confirmed the effectiveness and perceived value of the educational intervention. The evaluation findings supported the project's quantitative results. Evaluation surveys corroborated the quantitative findings. Staff rated clarity, relevance, and usefulness of the training at an average of 4.25 to 4.75 out of 5. Participants indicated that visual examples and practical exercises were critical to understanding scoring procedures. The results demonstrate that the education session improved knowledge, strengthened confidence, and standardized depression screening practices.

Conclusions

This Doctor of Nursing Practice staff education project clearly indicated that a structured, focused education can enhance knowledge of using the Zung Self-Rating Depression Scale (ZSDS). At the organizational level, the project contributed to standardizing depression screening procedures, addressing a documented knowledge gap

in ZSDS scoring and interpretation. Most effective knowledge consistency among nursing staff enhanced documentation patterns and decreased heterogeneity in the interpretation and communication of depression screening outcomes within the practice setting. Further recommendations include adding periodic refresher training to prevent knowledge loss and integrating the ZSDS education module into onboarding and yearly competency training. Regular review of screening records can be discussed to remind of the application of knowledge in the long term.

The implications for nursing practice include the more reliable use of standardized depression screening tools, improved clinical decision support, and increased confidence in communicating screening results to both providers and patients. In terms of positive social changes, standardized depression screening enhances early detection of depressive symptoms and facilitates prompt referral and treatment.

Consistent ZSDS scoring and interpretation knowledge regarding diversity, equity, and inclusion facilitate equitable care, as every patient receives the same standardized assessment regardless of the provider's experience, background, or shift assignment. This helps in the equitable and unbiased diagnosis of depression amongst a wide range of patients.

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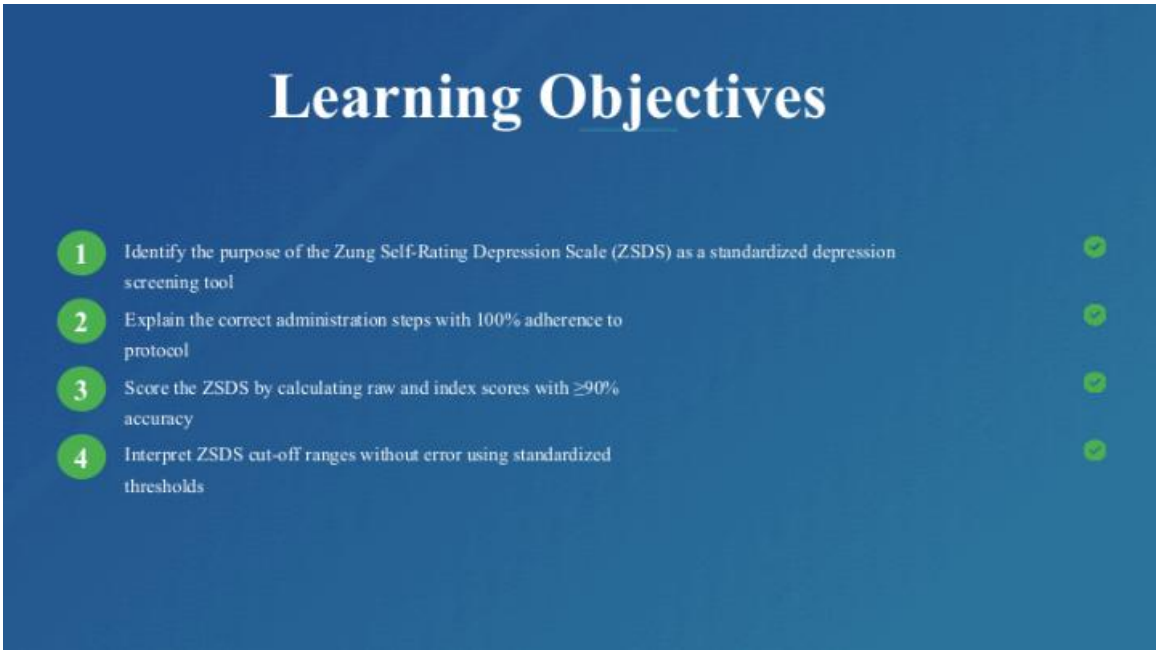
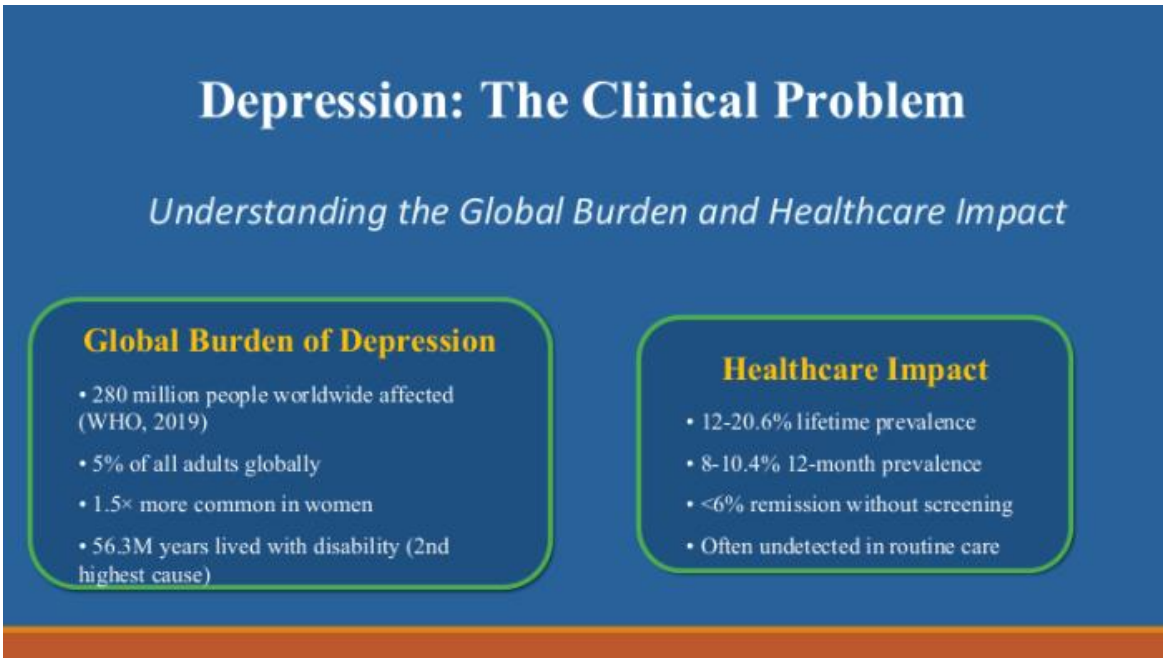
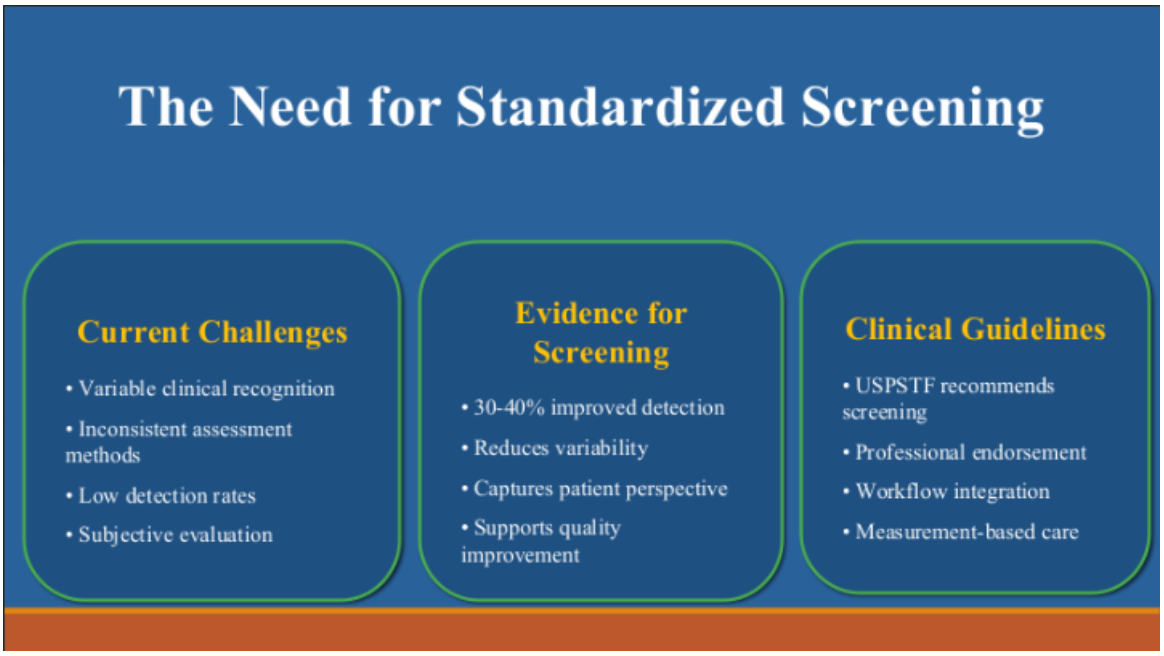
district of Shenzhen: A retrospective study. *Actas Españolas de Psiquiatría*, 53(1), 119–125. https://doi.org/10.62641/aep.v53i1.1699

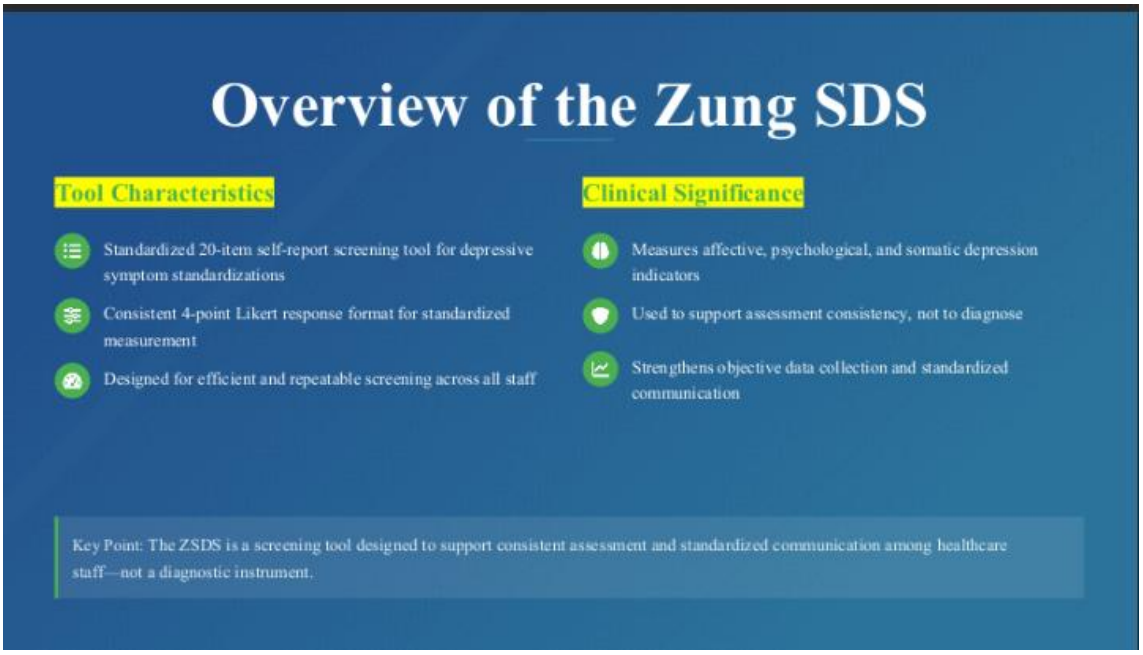
Appendix A: Educational PowerPoint

Enhancing Home Health Nursing Knowledge Through Targeted Education on Polypharmacy in Older Adults





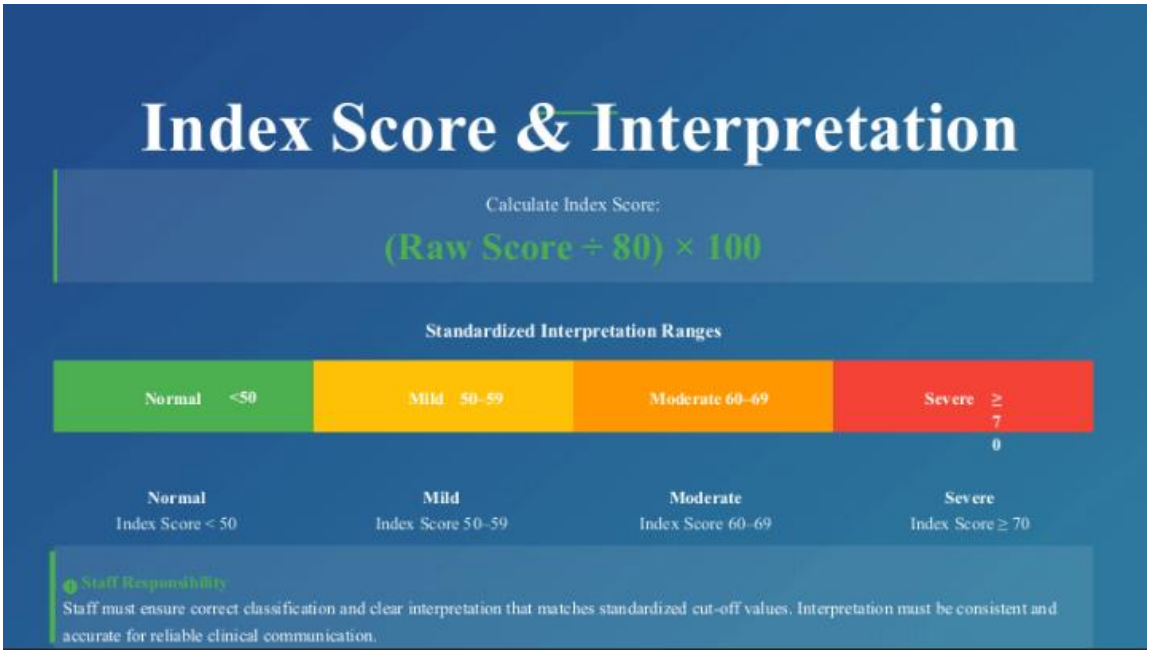

The Need for Standardized Screening
Current Challenges
• Variable clinical recognition
• Inconsistent assessment methods
• Low detection rates
• Subjective evaluation
Evidence for Screening
• 30-40% improved detection
• Reduces variability
• Captures patient perspective
• Supports quality improvement
Clinical Guidelines
• USPSTF recommends screening
• Professional endorsement
• Workflow integration
• Measurement-based care


Overview of the Zung SDS
Tool Characteristics
Standardized 20-item self-report screening tool for depressive symptom standardizations
Consistent 4-point Likert response format for standardized measurement
Designed for efficient and repeatable screening across all staff
Clinical Significance
Measures affective, psychological, and somatic depression indicators
Used to support assessment consistency, not to diagnose
Strengthens objective data collection and standardized communication
Key Point: The ZSDS is a screening tool designed to support consistent assessment and standardized communication among healthcare staff—not a diagnostic instrument.


Development & Validation Evidence
Historical Development
• Developed by Dr. William W.K. Zung (1965)
• Published in Archives of General Psychiatry
• One of first self-report depression tools
• Validated across 50+ countries
Psychometric Properties
• Internal consistency: α = 0.79-0.92
• Test-retest reliability: r = 0.70-0.87
• Sensitivity: 79-92% for major depression
• Specificity: 72-86% for ruling out depression
2,500+
Published Studies
50+
Validated Translations
79-92%
Sensitivity
72-86%
Specificity


Administration Protocol
1
Prepare Environment
Provide the tool in a quiet and private area to minimize distractions and ensure patient comfort
2
Ensure Independence
Instruct staff to allow patients to complete the assessment independently without assistance
3
Maintain Neutrality
Staff must not reword, coach, or influence responses in any way during completion
4
Verify Completion
Verify that all 20 items are completed before proceeding to the scoring stage
5
Ensure Confidentiality
Maintain confidential handling of completed tools according to privacy and security protocols
6
Follow Standards
Follow standardized administration steps consistently for reliability and validity of results
Critical Requirement: Adherence to all six administration steps is essential to preserve the validity and reliability of ZSDS screening results.


Scoring Procedure
Calculation Steps
1 Each item scored 1–4 based on symptom frequency
2 Reverse-score positive items (see list)
3 Total all 20 items for raw score
4 Use reference sheet or calculator for accuracy
5 Confirm totals twice to minimize errors
Raw Score Range
20 to 80
Items Requiring Reverse-Scoring:
2, 5, 6, 11, 12, 14, 16, 17, 18, 20
Verification Protocol: Double-check all calculations before finalizing score. Use standardized reference sheet to ensure consistency and accuracy across all staff members.
Scoring Formula:
Sum of all 20 items (with reverse-scored items adjusted) = Raw Score


Index Score & Interpretation
Calculate Index Score:
(Raw Score ÷ 80) × 100
Standardized Interpretation Ranges
Normal <50
Mild 50–59
Moderate 60–69
Severe ≥ 70
Normal
Index Score < 50
Mild
Index Score 50–59
Moderate
Index Score 60–69
Severe
Index Score ≥ 70
Staff Responsibility
Staff must ensure correct classification and clear interpretation that matches standardized cut-off values. Interpretation must be consistent and accurate for reliable clinical communication.


Staff Competency Expectations
1
Protocol Adherence
Follow standard administration protocol every time without deviation
2
Accurate Scoring
Demonstrate accurate raw and index score calculations consistently
3
Correct Interpretation
Apply correct interpretation using cut-off chart with precision
4
Reference Tools
Use reference materials to maintain consistency and accuracy
5
Competency Refreshers
Participate in periodic training to prevent skill drift
6
Confidential Handling
Maintain professional and confidential handling of all tools
Competency Standard: All six competency areas must be demonstrated and maintained consistently to ensure reliable and valid ZSDS administration across the organization.

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Documentation Requirements
1
Record raw score, index score, and category (normal, mild, moderate, severe)
2
Use standardized terminology for clarity and consistency across all documentation
3
Document in the designated screening section of the patient record
4
Ensure entries are complete, legible, and timely without delays
5
Documentation must match scoring sheet with no discrepancies
6
Maintain confidential handling of all completed assessment tools
Critical Accuracy Standard
All documentation must be accurate, complete, and consistent with the scoring calculations. Any discrepancies between the scoring sheet and patient record must be identified and corrected immediately to maintain data integrity and patient safety.


Key Reinforcement Points
Critical Concepts for Reliable ZSDS Administration
1 ZSDS = Screening Tool → not diagnostic; use to support assessment consistency
2 Independent Completion preserves validity and prevents staff influence on responses
3 Reverse-Scoring is Mandatory for accuracy; items 2, 5, 6, 11, 12, 14, 16, 17, 18, 20
4 Final Index Score drives interpretation and clinical classification
5 Clear, Standardized Documentation is required for all ZSDS results
6 Consistency = Reliability across all staff users and screening encounters
7 Reference Tools & Verification minimize scoring errors and ensure accuracy
8 Competency Refreshers prevent skill drift and maintain organizational standards
Commitment to Excellence
Adherence to these eight key principles ensures reliable, valid, and consistent ZSDS administration that supports quality patient assessment and clinical decision-making across your organization.

Appendix B: Pre-Posttest

PRE TEST – ZUNG SELF-RATING DEPRESSION SCALE (ZSDS)

Instructions: Select the best answer for each question. Answer all items.
Participants Code: _____ Date: _____

All participant information will be treated with the highest level of confidentiality. No names, personal identifiers, or individual responses will be shared or reported in any part of this project

1. A 45-year-old female patient presents with persistent fatigue, loss of appetite, and reduced motivation at work. She denies suicidal thoughts but admits feeling "flat" most days. The nurse decides to administer the Zung Self-Rating Depression Scale (ZSDS) before the provider's review.
What is the main purpose of using this tool in this case?

A. Diagnose major depressive disorder

B. Screen for depressive symptoms and monitor severity over time

C. Measure anxiety symptoms only

D. Replace a formal psychiatric evaluation

2. During a busy clinic day, a 32-year-old male patient begins answering the Zung SDS but pauses to ask the nurse how he "should" respond to certain items. He seems unsure whether to choose the middle option or the highest one. The nurse notices this hesitation. What should the nurse do to ensure valid results?

A. Read each question aloud and guide the patient's answers

B. Encourage the patient to complete the scale independently and honestly, without staff influence

C. Wait until the provider interprets the results before assisting

D. Have the patient redo the scale later if time allows

3. A nurse educator reviews completed Zung SDS forms during a training session. Each question has four fixed choices ranging from "None or a little of the time" to "Most or all of the time." A new staff member asks what kind of response structure this represents. What is the correct answer?

A. Yes/No question format

B. 0–10 numeric rating scale

C. Four-point Likert scale measuring frequency of feelings or behaviors

D. Open-ended response format

4. A staff nurse totals the 20 Zung SDS items for a patient who recently began antidepressant therapy. The raw total adds up to 72. She wants to confirm whether this score falls within the expected scoring range of the instrument.
What is the correct raw score range for the Zung SDS?

A. 10–50

B. 25–100

C. 20–80

D. 0–100

5.After scoring a patient's Zung SDS, the nurse calculates an **Index Score of 63**. The patient reports difficulty sleeping, frequent crying, and loss of energy.
How should the nurse interpret this finding?

A. Mild depression

B. Normal mood pattern

C. Moderate to severe depression requiring further clinical evaluation and follow-up

D. Anxiety symptoms only

6.While scoring several completed Zung SDS forms, a nurse realizes that certain items—such as "I feel hopeful about the future"—are phrased positively. She recalls that positive statements require special handling before calculating totals.
What action must the nurse take to ensure accurate scoring?

A. Reverse-score the positively worded items before computing the total

B. Double the highest item score for emphasis

C. Ask the patient to rescore those items

D. Add a fixed value to balance the results

7.A nurse calculates and interprets a Zung SDS Index Score of 68 for a patient being followed for chronic illness and emotional distress. After completing the scoring and reviewing accuracy, the nurse must determine the correct next step.
What should be done next?

A. Document both the score and a brief interpretation in the patient's chart, noting whether follow-up is needed

B. Store the paper form in the patient file without notes

C. Compare the result to other patients' scores

D. Disregard results unless the patient appears visibly distressed

8.During monthly data review, the nurse educator compares scores from multiple staff screenings. She wants to verify proper interpretation across staff.
Which classification reflects a normal Zung SDS result?

A. Index below 50 = normal range (no clinical depression)

B. Index 50–59 = no depression

C. Index 60–69 = mild depression

D. Index 20–40 = severe depression

Appendix C: Educational Evaluation Form

ZSDS Staff Education Evaluation Form
Purpose: This evaluation is designed to gather feedback on the Zung Self-Rating Depression Scale (ZSDS) education session. Your input will help improve future training. Responses are anonymous.
Participant ID: _____
Date: _____

Section 1: Learning Objectives

1. Were the learning objectives clearly met during the session?
   ☐ Yes, completely
   ☐ Yes, mostly
   ☐ Somewhat
   ☐ No
2. How confident do you feel about administering and interpreting the ZSDS after the training?
   ☐ Very confident
   ☐ Confident
   ☐ Neutral
   ☐ Unconfident
   ☐ Very unconfident

Section 2: Knowledge and Skill Acquisition

3. Rate your improvement in understanding ZSDS scoring and cut-off interpretation.
   ☐ Significant improvement
   ☐ Moderate improvement
   ☐ Slight improvement
   ☐ No improvement
4. How effective were the pre- and post-tests in measuring your understanding?
   ☐ Very effective
   ☐ Mostly effective
   ☐ Somewhat effective
   ☐ Not effective
5. How useful were the case examples and practical exercises?
   ☐ Very useful
   ☐ Mostly useful
   ☐ Somewhat useful
   ☐ Not useful

Section 3: Session Content and Delivery

6. How clear and easy to follow was the PowerPoint presentation?
   - ☐ Very clear
   - ☐ Clear
   - ☐ Neutral
   - ☐ Somewhat unclear
   - ☐ Very unclear
7. Was the amount of content appropriate for the session duration?
   - ☐ Too much
   - ☐ Just right
   - ☐ Too little
8. How relevant was the content to your daily clinical practice?
   - ☐ Highly relevant
   - ☐ Relevant
   - ☐ Neutral
   - ☐ Slightly relevant
   - ☐ Not relevant

Section 4: Overall Assessment

9. How likely are you to apply the knowledge gained in your work?
   - ☐ Very likely
   - ☐ Likely
   - ☐ Neutral
   - ☐ Unlikely
   - ☐ Very unlikely
10. How would you rate the overall quality of this training session?
    - ☐ Excellent
    - ☐ Good
    - ☐ Fair
    - ☐ Poor

Section 5: Open-Ended Feedback

11. What aspect of this training was most helpful?

12. What improvements would you suggest for future sessions?

13. Additional comments or feedback:

Instructions for Submission: Please submit this form to the project coordinator or designated collection point by 13th Dec. Your responses are confidential and will be used to enhance future staff education sessions.