Student Name: Vanette Martinez-Gonzalez Date: 09/03/24

IM6 (Acute Psychiatric) Critical Thinking Worksheet

Last of 2018

1. DSM-5 Diagnosis and Brief Pathophysiology (include reference):	2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.);	3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References)
SI w/o plan PPD, MDD and GAD "she needed all the anxiety to stop"	PDD After birth she "wanted for the feeling to go away". She felt thight chest and has an 11 week old baby. She's in recovery. The baby is the biggest priority right now.	3. Significant weight loss when not dieting a weight Gain. 4. Insomnia or hypersomnia 5. fatigue or loss of energy nearly every day
4. Medical Diagnoses:		
PPD, MDD and GAD SI w/o plan (main one PDD)		
5. Diagnostic Tests Pertinent or Confirming of Diagnosis	**6. Lab Values That May Be Affected:**	**7. Current Treatment:**
Anxiety 8 at of 10 Tests: Depression/Anxiety "She wanted the feeling to go away"	TSH: one time (major depressive disorder) T4 free one time (major depressive disorder) CMP: one time Hbg A1C one time Lipid panel one time	15min Observation Eduction Groups per schedule Suicide / Self Harm precautions meds: Risperidone Test: Depression Escitalopram Anxiety propranolol Hydroxyzine

Adopted: August 2016, revised October 2018

Diet: Regular

Student Name: Vonette Martinez-Gonzalez Date: 04/3/24

8. Focused Nursing Diagnosis:

Risk for suicide

(SI)

9. Related to (r/t):

States desire to die
Threats of killing self

10. As evidenced by (aeb):

N/A

11. Desired patient outcome:

for the patient to finish recovery to be able to go home to her baby since she's in (PPD).

12. Nursing Interventions related to the Nursing Diagnosis in #7: PDD

1. Create a safe environment for the client

Evidenced Based Practice: Client safety is a nursing priority

2. formulate a short-term verbal & written contract with the client that he or she will not harm self.

Evidenced Based Practice:

Discussion of suicidal feelings with a trusted individual provides some relief to the client.

3. Secure promise from a client that he or she will seek out of a staff member if thoughts of suicide emerge

Evidenced Based Practice:

Suicidal clients are often very ambivalent about their feeling.

13. Patient Teaching:

1. Relaxation techniques (such as painting, coloring)

2. Teach Deep breathing techniques (3in, 3out)

Call 911 if (SI)

3. find Hobbies to keep you busy

14. Discharge Planning/Community Resources:

1. Call Hotline # if Suicidal thoughts.

2. Try to find psychotherapy to help the pt cope w/ Anxiety

3. find talk Groups to help the the patient express her feelings.

Adopted: August 2016, revised October 2018

Vanette Mariner Gonzalez
9/13/24

Hamilton Depression Rating Scale (HDRS)

Reference: Hamilton M. A rating scale for depression. J Neurol Neurosurg Psychiatry 1960; 23:56–62

Rating Clinician-rated

Administration time 20–30 minutes

Main purpose To assess severity of, and change in, depressive symptoms

Population Adults

Commentary

The HDRS (also known as the Ham-D) is the most widely used clinician-administered depression assessment scale. The original version contains 17 items ($HDRS_{17}$) pertaining to symptoms of depression experienced over the past week. Although the scale was designed for completion after an unstructured clinical interview, there are now semi-structured interview guides available. The HDRS was originally developed for hospital inpatients, thus the emphasis on melancholic and physical symptoms of depression. A later 21-item version ($HDRS_{21}$) included 4 items intended to subtype the depression, but which are sometimes, incorrectly, used to rate severity. A limitation of the HDRS is that atypical symptoms of depression (e.g., hypersomnia, hyperphagia) are not assessed (see SIGH-SAD, page 55).

Scoring

Method for scoring varies by version. For the $HDRS_{17}$, a score of 0–7 is generally accepted to be within the normal range (or in clinical remission), while a score of 20 or higher (indicating at least moderate severity) is usually required for entry into a clinical trial.

Versions

The scale has been translated into a number of languages including French, German, Italian, Thai, and Turkish. As well, there is an Interactive Voice Response version (IVR), a Seasonal Affective Disorder version (SIGH-SAD, see page 55), and a Structured Interview Version (HDS-SIV). Numerous versions with varying lengths include the HDRS17, HDRS21, HDRS29, HDRS8, HDRS6, HDRS24, and HDRS7 (see page 30).

Additional references

Hamilton M. Development of a rating scale for primary depressive illness. Br J Soc Clin Psychol 1967; 6(4):278–96.

Williams JB. A structured interview guide for the Hamilton Depression Rating Scale. Arch Gen Psychiatry 1988; 45(8):742–7.

Address for correspondence

The HDRS is in the public domain.

Hamilton Depression Rating Scale (HDRS)

PLEASE COMPLETE THE SCALE BASED ON A STRUCTURED INTERVIEW

Instructions: for each item select the one "cue" which best characterizes the patient. Be sure to record the answers in the appropriate spaces (positions 0 through 4).

1 DEPRESSED MOOD *(sadness, hopeless, helpless, worthless)*

- 0 [✓] Absent.
- 1 [ ] These feeling states indicated only on questioning.
- 2 [ ] These feeling states spontaneously reported verbally.
- 3 [ ] Communicates feeling states non-verbally, i.e. through facial expression, posture, voice and tendency to weep.
- 4 [ ] Patient reports virtually only these feeling states in his/her spontaneous verbal and non-verbal communication.

2 FEELINGS OF GUILT

- 0 [ ] Absent.
- 1 [ ] Self reproach, feels he/she has let people down.
- 2 [ ] Ideas of guilt or rumination over past errors or sinful deeds.
- 3 [✓] Present illness is a punishment. Delusions of guilt.
- 4 [ ] Hears accusatory or denunciatory voices and/or experiences threatening visual hallucinations.

Vonetie Montez 9/3/24

3 SUICIDE
- 0 [✓] Absent.
- 1 [ ] Feels life is not worth living.
- 2 [ ] Wishes he/she were dead or any thoughts of possible death to self.
- 3 [ ] Ideas or gestures of suicide.
- 4 [ ] Attempts at suicide (any serious attempt rate 4).

4 INSOMNIA: EARLY IN THE NIGHT
- 0 [✓] No difficulty falling asleep.
- 1 [ ] Complains of occasional difficulty falling asleep, i.e. more than ½ hour.
- 2 [ ] Complains of nightly difficulty falling asleep.

5 INSOMNIA: MIDDLE OF THE NIGHT
- 0 [✓] No difficulty.
- 1 [ ] Patient complains of being restless and disturbed during the night.
- 2 [ ] Waking during the night – any getting out of bed rates 2 (except for purposes of voiding).

6 INSOMNIA: EARLY HOURS OF THE MORNING
- 0 [✓] No difficulty.
- 1 [ ] Waking in early hours of the morning but goes back to sleep.
- 2 [ ] Unable to fall asleep again if he/she gets out of bed.

7 WORK AND ACTIVITIES
- 0 [✓] No difficulty.
- 1 [ ] Thoughts and feelings of incapacity, fatigue or weakness related to activities, work or hobbies.
- 2 [ ] Loss of interest in activity, hobbies or work – either directly reported by the patient or indirect in listlessness, indecision and vacillation (feels he/she has to push self to work or activities).
- 3 [ ] Decrease in actual time spent in activities or decrease in productivity. Rate 3 if the patient does not spend at least three hours a day in activities (job or hobbies) excluding routine chores.
- 4 [ ] Stopped working because of present illness. Rate 4 if patient engages in no activities except routine chores, or if patient fails to perform routine chores unassisted.

8 RETARDATION (slowness of thought and speech, impaired ability to concentrate, decreased motor activity)
- 0 [✓] Normal speech and thought.
- 1 [ ] Slight retardation during the interview.
- 2 [ ] Obvious retardation during the interview.
- 3 [ ] Interview difficult.
- 4 [ ] Complete stupor.

9 AGITATION
- 0 [✓] None.
- 1 [ ] Fidgetiness.
- 2 [ ] Playing with hands, hair, etc.
- 3 [ ] Moving about, can't sit still.
- 4 [ ] Hand wringing, nail biting, hair-pulling, biting of lips.

10 ANXIETY PSYCHIC
- 0 [✓] No difficulty.
- 1 [ ] Subjective tension and irritability.
- 2 [ ] Worrying about minor matters.
- 3 [ ] Apprehensive attitude apparent in face or speech.
- 4 [ ] Fears expressed without questioning.

11 ANXIETY SOMATIC (physiological concomitants of anxiety) such as:
gastro-intestinal – dry mouth, wind, indigestion, diarrhea, cramps, belching
cardio-vascular – palpitations, headaches
respiratory – hyperventilation, sighing
urinary frequency
sweating
- 0 [✓] Absent.
- 1 [ ] Mild.
- 2 [ ] Moderate.
- 3 [ ] Severe.
- 4 [ ] Incapacitating.

12 SOMATIC SYMPTOMS GASTRO-INTESTINAL
- 0 [✓] None.
- 1 [ ] Loss of appetite but eating without staff encouragement. Heavy feelings in abdomen.
- 2 [ ] Difficulty eating without staff urging. Requests or requires laxatives or medication for bowels or medication for gastro-intestinal symptoms.

13 GENERAL SOMATIC SYMPTOMS
- 0 [✓] None.
- 1 [ ] Heaviness in limbs, back or head. Backaches, headaches, muscle aches. Loss of energy and fatigability.
- 2 [ ] Any clear-cut symptom rates 2.

14 GENITAL SYMPTOMS (symptoms such as loss of libido, menstrual disturbances)
- 0 [ ] Absent.
- 1 [✓] Mild.
- 2 [ ] Severe.

15 HYPOCHONDRIASIS
- 0 [✓] Not present.
- 1 [ ] Self-absorption (bodily).
- 2 [ ] Preoccupation with health.
- 3 [ ] Frequent complaints, requests for help, etc.
- 4 [ ] Hypochondriacal delusions.

16 LOSS OF WEIGHT ***(RATE EITHER a OR b)***

a) According to the patient:	b) According to weekly measurements:
0 [ ] No weight loss.	0 [ ] Less than 1 lb weight loss in week.
1 [ ] Probable weight loss associated with present illness.	1 [ ] Greater than 1 lb weight loss in week.
2 [ ] Definite (according to patient) weight loss.	2 [✓] Greater than 2 lb weight loss in week. 2015
3 [ ] Not assessed.	3 [ ] Not assessed.

17 INSIGHT
- 0 [✓] Acknowledges being depressed and ill.
- 1 [ ] Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
- 2 [ ] Denies being ill at all.

Total score: [16]

Vonette Martinez Gonzalez
9/13/24

Hamilton Anxiety Rating Scale (HAM-A)

Reference: Hamilton M. The assessment of anxiety states by rating. Br J Med Psychol 1959; 32:50–55.

Rating Clinician-rated

Administration time 10–15 minutes

Main purpose To assess the severity of symptoms of anxiety

Population Adults, adolescents and children

Commentary

The HAM-A was one of the first rating scales developed to measure the severity of anxiety symptoms, and is still widely used today in both clinical and research settings. The scale consists of 14 items, each defined by a series of symptoms, and measures both psychic anxiety (mental agitation and psychological distress) and somatic anxiety (physical complaints related to anxiety). Although the HAM-A remains widely used as an outcome measure in clinical trials, it has been criticized for its sometimes poor ability to discriminate between anxiolytic and antidepressant effects, and somatic anxiety versus somatic side effects. The HAM-A does not provide any standardized probe questions. Despite this, the reported levels of inter-rater reliability for the scale appear to be acceptable.

Scoring

Each item is scored on a scale of 0 (not present) to 4 (severe), with a total score range of 0–56, where <17 indicates mild severity, 18–24 mild to moderate severity and 25–30 moderate to severe.

Versions

The scale has been translated into: Cantonese for China, French and Spanish. An IVR version of the scale is available from Healthcare Technology Systems.

Additional references

Maier W, Buller R, Philipp M, Heuser I. The Hamilton Anxiety Scale: reliability, validity and sensitivity to change in anxiety and depressive disorders. J Affect Disord 1988;14(1):61–8.

Borkovec T and Costello E. Efficacy of applied relaxation and cognitive behavioral therapy in the treatment of generalized anxiety disorder. J Clin Consult Psychol 1993; 61(4):611–19

Address for correspondence

The HAM-A is in the public domain.

S
B
A
→ Recommend

Vanette Martinez-Gonzalez
9/3/24

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

1 Anxious mood [0] [1] [2] [3] [4]

Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension [0] [1] [2] [3] [4]

Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears [0] [1] [2] [3] [4]

Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia [0] [1] [2] [3] [4]

Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual [0] [1] [2] [3] [4]

Difficulty in concentration, poor memory.

6 Depressed mood [0] [1] [2] [3] [4]

Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular) [0] [1] [2] [3] [4]

Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone. (Back pain)

8 Somatic (sensory) [0] [1] [2] [3] [4]

Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms [0] [1] [2] [3] [4]

Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms [0] [1] [2] [3] [4]

Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms [0] [1] [2] [3] [4]

Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms [0] [1] [2] [3] [4] (irregular PPD)

Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms [0] [1] [2] [3] [4]

Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview [0] [1] [2] [3] [4]

Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

(3)

Vanette Martinez-Gonzalez 9/3/24 (Reflection)

Step 1 Description

I Attended Oceans @ 6:30 a.m on Tuesday and Wednesday. The psych Clinicction wasn't what I expected. The patients are actully nice and they have good manners. I was assigned to a pt each day and had to perform assesments based on why they were admitted.

Step 2 Feelings

At the beginning I was nervous but it turned out to be better. The clinical made me feel sad because most of the patients have to be w/o phones and the only entertainment they have are the group therapies or Activities. I felt better towards the end because they are here to better themselves

Step 3 Evaluation

The difficult part was waking up early because the day were cloudy and it makes it hard. The experience was really good and I didn't expect for the psych patients to have manners and be super nice. We shouldn't judge a book by it's cover.

Step 4 Analysis

The patients I was Assigned to were (5) Q15 and we just had the lecture about suicide which it's definetly different hearing about it and actually being treated for it. Suicide ideas is a very hard topic but the fact that is a real thing is what makes it hard. The patients had differences but the one's assigned for me were (Q15)

Step 5 Conclusion

The psych clinical experience wasn't bad for me. I would just choose learns at noon because there is not much things we are assigned to do. the 1st day went by fast and the second went by slow. But Overall the experience was great

Step 6 Action plan

I will use this experience to continue to be compassionate regardless of the patient hx because we are all humans and I do not know what everyone is going through. My experience was Great! So far the best clinical experience.

Student Name: Vonette Mathez-Gonzalez **Unit:** psych **Pt. Initials:** _____ **Date:** 09/03/24

Allergies: Latex

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
N/A	Isotonic/ Hypotonic/ Hypertonic	N/A	N/A	N/A

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List solution to dilute and rate to push. IVPB – List mL/hr and time to give	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Risperidone	Atypical antipsychot	mood changes	0.5mg Bed Time PO	(Y) N	N/A	Dizzy Confused Diabetes HA	1. Get up slowly from bed 2. Walk in quiet puzzles if Confusion 3. Eat a BRAT Diet 4. Turn the light off if a HA
Escitalopram Oxalate	(SSRI) (Lexapro)	Anxiety w/ Depression	10mg QD PO	(Y) N		Diarrhea Nausea Fatigue HA	1. Black Box - Suicide 2. Call if ret help if thoughts of Suicide 3. Eat a BRAT Diet 4. Turn light off if Dizzy.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

Observation Q15

1

Vanette Martinez-Gonzalez

NURSING SHIFT ASSESSMENT

DATE: 9/3/24 **SHIFT:** ☑ Day(7A-7P) ☐ Night(7P-7A)

OCEANS

Label
Name: _____
MR#: _____ D.O.B. _____

(protective custody)

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
☐ Appropriate
☐ Inappropriate
☐ Flat
☐ Guarded
☐ Improved
☐ Blunted

ADL
☑ Independent
☐ Assist
☐ Partial Assist
☐ Total Assist

Motor Activity
☑ Normal
☐ Psychomotor retardation
☐ Psychomotor agitation
☐ Posturing
☐ Repetitive acts
☐ Pacing

Mood
☐ Irritable
☐ Depressed
☑ Anxious
☐ Dysphoric
☐ Agitated
☐ Labile
☐ Euphoric

Behavior
☐ Withdrawn
☐ Suspicious
☐ Tearful
☐ Paranoid
☐ Isolative
☐ Preoccupied
Demanding
☐ Aggressive
☐ Manipulative
☐ Complacent
☐ Sexually acting out
☑ Cooperative
☐ Guarded
☐ Intrusive

wants to Go home to Gdy

Thought Processes
☑ Goal Directed ☐ Tangential ☐ Blocking
☐ Flight of Ideas ☐ Loose association ☐ Indecisive
☐ Illogical Delusions:) (type)_____

Thought Content
☐ Obsessions ☐ Compulsions ☐ Suicidal thoughts
☐ Hallucinations:☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical N/A
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes No ***Pain scale score*** _____ ***Locations*** _____
Is pain causing any physical impairment in functioning today No If yes exp ain _____

Nursing Interventions:
☑ Close Obs. q15 ☐ Ind. Support ☐ Reality Orientation ☐ Toilet Q2 w/awake ☐ 1 to 1 Observation _____ reason (specify)
☐ Milieu Therapy ☐ Monitor Intake ☐ Encourage Disclosure ☐ Neuro Checks ☐ Rounds Q2
☐ V/S ☐ O2 sat. ☐ Tx Team ☐ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☐ Nursing group/session (list topic): (Boundaries)
☐ ADLs assist ☐ I&O ☐ PRN Med per order _____

☐ ***DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES*** *(violence, suicide, elope, fall, physical health)* ***DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted***	***Since Last Contact***	
Ask Question 2*	***YES***	***NO***
2) ***Have you actually had thoughts about killing yourself?***	***LOW***	X
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) ***Have you been thinking about how you might do this?***	***MOD***	
4) ***Have you had these thoughts and had some intention of acting on them?*** ***E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."***	***HIGH***	
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** ***As opposed to "I have the thoughts, but I definitely will not do anything about them."***	***HIGH***	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** ***Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.***	***HIGH***	X

☑ ***Low Risk*** ☐ ***Moderate Risk*** ☐ ***High Risk***

Nurse Signatures) _____ *Date:* 9/3/24 *Time:* Not sure

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☑ WNL ☐ Elevated B/P ☐ ↓ B/P
☐ Chest Pain
☐ Edema: ☐ upper ☐ lower

Respiratory/Breath sounds:
☑ Clear ☐ Rales ☐ Crackles ☐ Wheezing
☐ Cough ☐ S.O. B Other: _____
☐ O2 @____ l/min ☐ Cont. ☐ PRN
Via ☐ nasal cannula face mask

Neurological / L.O.C.:
☑ Unimpaired ☐ Lethargic ☐ Sedated
☐ Dizziness ☐ Headache ☐ Seizures
☐ Tremors ☐ Other _____

Musculoskeletal/Safety:
☑ Ambulatory ☐ MAE ☐ Full ROM
☐ Walker ☐ W/C ☐ Immobile
☐ Pressure ulcer ☐ Unsteady gait
☐ Risk for pressure ulcer
☐ Reddened area(s)

Nutrition/Fluid:
☐ Adequate ☐ Inadequate ☐ Dehydrated
☐ Supplement ☐ Prompting ☐ Other _____
new onset of choking risks assessed

Skin:
☑ Bruises ☐ Tear ☐ No new skin issues
☐ Wound(s) (see Wound Care Packet)
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
☑ Continent ☐ Incontinent ☐ Catheter
☐ Diarrhea ☐ OTHER _____

Hours of Sleep: ____ Day Night

At Risk for Falls: ☐ Yes ☐ No

At Risk for FALL Precautions:
☐ Arm Band ☐ Nonskid footwear
☐ BR light ☐ ambulate with assist
☐ Call bell ☐ Clear path
☐ Edu to call for assist ☐ Bed alarm
☐ Chair alarm ☐ 1:1 observation level
☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____

Vanette Martinez-Gonzalez

NURSING SHIFT ASSESSMENT

DATE: 9/4/24 **SHIFT:** ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: _____
MR#: _____ D.O.B. _____

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
☐ Appropriate
☐ Inappropriate
☑ Flat
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☐ Preoccupied
☐ Demanding
☐ Aggressive
☐ Manipulative
☐ Complacent
☐ Sexually acting out
☑ Cooperative
☐ Guarded
☐ Intrusive

Thought Processes
☑ Goal Directed ☐ Tangential ☐ Blocking
☐ Flight of Ideas ☐ Loose association ☐ Indecisive
☐ Illogical Delusions:) (type)_____

Thought Content
☐ Obsessions ☐ Compulsions ☐ Suicidal thoughts
☐ Hallucinations: ☐ Auditory ☐ Visual ☐ Olfactory ☐ Tactile ☐ Gustatory
☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical N/A
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes No ***Pain scale score*** _____ ***Locations*** _____
Is pain causing any physical impairment in functioning today No If yes exp ain _____

Nursing Interventions:
☑ Close Obs. q15 ☐ Ind. Support ☐ Reality Orientation ☐ Toilet Q2 w/awake ☐ 1 to 1 Observation _____ reason (specify)
☐ Milieu Therapy ☐ Monitor Intake ☐ Encourage Disclosure ☐ Neuro Checks ☐ Rounds Q2
☐ V/S ☐ O2 sat. ☐ Tx Team ☐ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☑ Nursing group/session (list topic): Gratitude
☐ ADLs assist ☐ I&O ☐ PRN Med per order _____

☐ ***DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES*** *(violence, suicide, elope, fall, physical health)* ***DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted***	***Since Last Contact***	
Ask Question 2*	***YES***	***NO***
2) ***Have you actually had thoughts about killing yourself?***	***LOW***	X
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
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4) ***Have you had these thoughts and had some intention of acting on them?*** ***E.g., "I thought about taking an overdose, but I never made a specific plan as to when where or how I would actually do it....and I would never go through with it."***	***HIGH***	
5) ***Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*** ***As opposed to "I have the thoughts, but I definitely will not do anything about them."***	***HIGH***	
6) ***Have you done anything, started to do anything, or prepared to do anything to end your life?*** ***Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc.***	***HIGH*** C	X

☑ ***Low Risk*** ☐ ***Moderate Risk*** ***High Risk***

Nurse Signatures) _____ ***Date:*** 9/4/24 ***Time:*** _____

REVIEW OF SYSTEMS

Cardio/Pulmonary:
☐ *WNL* ☐ *Elevated B/P* ☐ *↓ B/P*
☐ *Chest Pain*
☐ *Edema:* ☐ *upper* ☐ *lower*

Respiratory/Breath sounds:
☐ *Clear* ☐ *Rales* ☐ *Crackles* ☐ *Wheezing*
☐ *Cough* ☐ *S.O. B* *Other:* _____
☐ *O2 @* ____ *l/min* ☐ *Cont.* ☐ *PRN*
Via ☐ *nasal cannula face mask*

Neurological / L.O.C.:
☐ *Unimpaired* ☐ *Lethargic* ☐ *Sedated*
☐ *Dizziness* ☐ *Headache* ☐ *Seizures*
☐ *Tremors* ☐ *Other* _____

Musculoskeletal/Safety:
☐ *Ambulatory* ☐ *MAE* ☐ *Full ROM*
☐ *Walker* ☐ *W/C* ☐ *Immobile*
☐ *Pressure ulcer* ☐ *Unsteady gait*
☐ *Risk for pressure ulcer*
☐ *Reddened area(s)*

Nutrition/Fluid:
☐ *Adequate* ☐ *Inadequate* ☐ *Dehydrated*
☐ *Supplement* ☐ *Prompting* ☐ *Other* _____
new onset of choking risks assessed

Skin:
☐ *Bruises* ☐ *Tear* ☐ *No new skin issues*
☐ *Wound(s)* (See Wound Care Packet)
☐ *Abrasion* ☐ *Integumentary Assess*
☐ *Other:* _____

Elimination:
☐ *Continent* ☐ *Incontinent* ☐ *Catheter*
☐ *Diarrhea* ☐ *OTHER* _____

Hours of Sleep: ____ ***Day*** ***Night***

At Risk for Falls: ☐ ***Yes*** ☐ ***No***

At Risk for FALL Precautions:
☐ *Arm Band* ☐ *Nonskid footwear*
☐ *BR light* ☐ *ambulate with assist*
☐ *Call bell* ☐ *Clear path*
☐ *Edu to call for assist* ☐ *Bed alarm*
☐ *Chair alarm* ☐ *1:1 observation level*
☐ *Assist with ADLs* ☐ *Geri Chair*
☐ *Ensure assistive devices near*
☐ *Other* _____