NURSING SHIFT ASSESSMENT

DATE: 2/18/25

SHIFT: ☐ Day(7A-7P) ☐ Night(7P-7A)

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

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☐ Withdrawn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

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
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes (No) ***Pain scale score*** _____ ***Locations*** _____
Is pain causing any physical impairment in functioning today ☑ No ☐ If yes explain _____

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

☐ ***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	
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? YES	MOD	
4) Have you had these thoughts and had some intention of acting on them? NO 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." preparation	HIGH	
6) Have you done anything, started to do anything, or prepared to do anything to end your life? gun 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. YES	HIGH	

☐ Low Risk ☐ Moderate Risk ☑ High Risk

Nurse Signature(s) _____ Date: _____ 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 _____

Student Name: Lindsay McCormack Date: 2/18/25

IM6 (Acute Psychiatric) Critical Thinking Worksheet

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)
~~Anxiety~~ PTSD:	- environmental: pt stated noises she hears, or some people she see's causes her to become anxious / stressed	• Recurrent distressing dreams in which content and/or affect of dream is related to a traumatic stress event • Dissociative reactions (flashbacks)
4. Medical Diagnoses: X		
5. Diagnostic Tests Pertinent or Confirming of Diagnosis (Assessment) - PCL Assessment	6. Lab Values That May Be Affected: X	7. Current Treatment: - Psych medication - Psych therapy

Adopted: August 2016, revised October 2018

Student Name: Lindsey McCormack Date: 2/18/25

8. Focused Nursing Diagnosis:
~~Major Depressive Disorder (MDD)~~
Suicide Ideation

9. Related to (r/t):
Major Depressive Disorder

10. As evidenced by (aeb):
- Sad, dull affect
- Preoccupation with own thoughts
- expression of feeling alone

11. Desired patient outcome:
- Optimism and hope for the futer
- Sets goals for herself
- Identify triggers / stressors for PTSD

12. Nursing Interventions related to the Nursing Diagnosis in #7:
1. Cognitive Therapy

Evidenced Based Practice:
Help the patient recognize her triggers, and change harmful thinking patterns

2. Relaxation Techniques

Evidenced Based Practice:
Deep breathing, painting, coloring, listening to music to calm the patient down

3. IPT Therapy

Evidenced Based Practice:
improves relationships with people and relieve symptoms

13. Patient Teaching:
1. Relaxation techniques: deep breathing, coloring, exercising

2. Set realistic goals

3. Maintain a healthy diet

14. Discharge Planning/Community Resources:
1. Take medications as persicribed, do not stop abruptly

2. Therapy; gradual exposure to avoiding/stressful situations

3. Regular follow up appointments with HCP

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: Dana

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?				✓	
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					✓
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?	✓				
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?			✓		
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					✓
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?	✓				
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					✓
8.	Trouble *remembering important parts* of a stressful experience from the past?	✓				
9.	Loss of *interest in things that you used to enjoy?*					✓
10.	Feeling *distant* or *cut* off from other people?				✓	
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?			✓		
12.	Feeling as if your *future* will somehow be *cut short*?			✓		
13.	Trouble *falling* or *staying asleep*?		✓			✓
14.	Feeling *irritable* or having *angry outbursts*?				✓	
15.	Having *difficulty concentrating*?					✓
16.	Being *"super alert"* or watchful on guard?			✓		
17.	Feeling *jumpy* or easily startled?			✓		

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

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

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.

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.
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: [9]

NURSING SHIFT ASSESSMENT

DATE: 2/19/25

SHIFT: ☐ Day(7A-7P) ☐ Night(7P-7A)

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

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
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☐ Guarded
☐ Improved
☐ Blunted

ADL
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☐ Partial Assist
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☐ Psychomotor retardation
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☐ Posturing
☐ Repetitive acts
☐ Pacing

Mood
☑ Irritable
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☑ Agitated
☐ Labile
☐ Euphoric

Behavior
☐ Withdrawn ☐ Aggressive
☐ Suspicious ☐ Manipulative
☐ Tearful ☐ Complacent
☐ Paranoid ☐ Sexually acting out
☐ Isolative ☑ Cooperative
☐ Preoccupied ☐ Guarded
☐ Demanding ☐ 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
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: ***Yes*** (No) ***Pain scale score*** _____ ***Locations*** _____
Is pain causing any physical impairment in functioning today ☑ No ☐ If yes explain _____

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

☐ ***Low Risk*** ☐ ***Moderate Risk*** ■ ***High Risk***

Nurse Signatures) _____ *Date:* _____ *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* _____