

Shamari M
2/19/25

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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

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).

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 (HDRS₁₇) 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 (HDRS₂₁) 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).

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.

Scoring

Method for scoring varies by version. For the HDRS₁₇, a score of 0-7 is generally accepted to be within the normal

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.

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 1/2 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 *nausea*
- 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 <input type="checkbox"/> No weight loss. | 0 <input type="checkbox"/> Less than 1 lb weight loss in week. |
| 1 <input checked="" type="checkbox"/> Probable weight loss associated with present illness. | 1 <input type="checkbox"/> Greater than 1 lb weight loss in week. |
| 2 <input type="checkbox"/> Definite (according to patient) weight loss. | 2 <input type="checkbox"/> Greater than 2 lb weight loss in week. |
| 3 <input type="checkbox"/> Not assessed. | 3 <input type="checkbox"/> 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: **15**

NURSING SHIFT ASSESSMENT

SHIFT:

Day(7A-7P)

Night(7P-7A)

DATE: 2/19/25

Shamari Mims

Orientation	Affect	ADL	Motor Activity	Mood	Behavior
<input checked="" type="checkbox"/> Person	<input checked="" type="checkbox"/> Appropriate	<input checked="" type="checkbox"/> Independent	<input checked="" type="checkbox"/> Normal	<input type="checkbox"/> Irritable	<input type="checkbox"/> Withdrawn
<input checked="" type="checkbox"/> Place	<input type="checkbox"/> Inappropriate	<input type="checkbox"/> Assist	<input type="checkbox"/> Psychomotor agitation	<input checked="" type="checkbox"/> Depressed	<input type="checkbox"/> Suspicious
<input checked="" type="checkbox"/> Time	<input type="checkbox"/> Flat	<input type="checkbox"/> Partial Assist	<input type="checkbox"/> Posturing	<input type="checkbox"/> Anxious	<input checked="" type="checkbox"/> Tearful
<input checked="" type="checkbox"/> Situation	<input type="checkbox"/> Guarded	<input type="checkbox"/> Total Assist	<input type="checkbox"/> Repetitive acts	<input type="checkbox"/> Dysphoric	<input type="checkbox"/> Paranoid
	<input type="checkbox"/> Improved		<input type="checkbox"/> Pacing	<input type="checkbox"/> Agitated	<input type="checkbox"/> Isolative
	<input type="checkbox"/> Blunted			<input type="checkbox"/> Labile	<input type="checkbox"/> Preoccupied
				<input type="checkbox"/> Euphoric	<input type="checkbox"/> Demanding
					<input type="checkbox"/> Aggressive
					<input type="checkbox"/> Manipulative
					<input type="checkbox"/> Complacent
					<input type="checkbox"/> Sexually acting out
					<input checked="" type="checkbox"/> Cooperative
					<input type="checkbox"/> Guarded
					<input type="checkbox"/> Intrusive

Thought Processes

Goal Directed Tangential Blocking

Flight of Ideas Loose association Indecisive

Illogical Delusions: (type) _____

Pain: Yes No **Pain scale score** 4 **Locations** Sciatica, hip

Is pain causing any physical impairment in functioning today No If yes explain _____

Nursing Interventions:

Close Obs. q15 Ind. Support

Milieu Therapy Monitor Intake

V/S O2 sat Tx Team

Nursing group/session (list topic): _____

ADLs assist I&O PRN Med per order _____

DOCUMENT ABNORMAL OCCURRENCES IN MULTIDISCIPLINARY NOTES (Violence, suicide, elope, fall, physical health) **DAILY SUICIDE RISK ASSESSMENT*** Note - for frequent assessment purposes, Question 1 has been omitted

Ask Question: 2*

1) Have you actually had thoughts about killing yourself?	YES	NO
2) Have you been thinking about how you might do this?	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?

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."

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."

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.

Low Risk Moderate Risk High Risk

Nurse Signatures) [Signature] Date: 2/19/25 Time: 0905

Name: _____ Label: _____

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

REVIEW OF SYSTEMS

Cardio/Pulmonary:

MNL 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 Seizure

Tremors Other _____

Musculoskeletal/Safety:

Ambulatory MAE Full ROM

Walker GM/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 h

Wound(s) (see Wound Care Pa

Abrasion Integumentary Asses

Other _____

Elimination:

Continent Incontinent Cat

Diarrhea OTHER _____

Hours of Sleep: _____ Day Night

At Risk for Falls: Yes No

At Risk for FALL Precautions:

Arm Band Non-skid footwear

Bed light ambulate with assist

Call bell Clear path Bed alarm

Bedu to call for assist Bed alarm

Chair alarm 1:1 observation

Assist with ADLs Geri Chair

Ensure assistive devices near

Other _____

NURSING SHIFT ASSESSMENT

DATE: 2/18/25

Shamari Mims

SHIFT: Day(7A-7P)

Night(7P-7A)

Rosemary

Name: _____ Label _____
 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): _____
- 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

Ask Question 2*

2) Have you actually had thoughts about killing yourself?

Since Last Contact	
YES	NO
LOW	<input checked="" type="checkbox"/>

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."

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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.

Low Risk Moderate Risk High Risk

Nurse Signatures) [Signature]

Date: 2/18/25 Time: 0930

REVIEW OF SYSTEMS

Cardio/Pulmonary:

- WNL Elevated B/P B/P
- Chest Pain
- Edema: upper lower

Respiratory/Breath sounds:

- Clear Rales Crackles Whe
- Cough S.O.B Other: _____
- O2 @ _____ /min Cont. PRN
- Via nasal cannula face mask

Neurological / L.O.C.:

- Unimpaired Lethargic Sedat
- Dizziness Headache Seizur
- 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 Dehydr
- Supplement Prompting Other _____
- new onset of choking risks assess

Skin:

- Bruises Tear No new skin l
- Wound(s) (see Wound Care Pa
- Abrasion Integumentary Asses
- Other: _____

Elimination:

- Continent Incontinent Cat
- Diarrhea OTHER _____

Hours of Sleep: _____ Day Nite

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 alar
- Chair alarm 1:1 observation le
- Assist with ADLs Geri Chair
- Ensure assistive devices near
- Other _____

Student Name: Shamari Mims

Date: _____

IM6 (Acute Psychiatric) Critical Thinking Worksheet

<p>1. DSM-5 Diagnosis and Brief Pathophysiology (include reference): (GAD) Generalized Anxiety Disorder</p>	<p>2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.): Environmental - Those around her when she is home without her son</p>	<p>3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References) Excessive anxiety and worry (Apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance) The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning</p>
<p>4. Medical Diagnoses: N/A</p>	<p>6. Lab Values That May Be Affected: N/A</p>	<p>7. Current Treatment: Treating paranoia with risperidol and medical needs</p>
<p>5. Diagnostic Tests Pertinent or Confirming of Diagnosis DSM-5 for generalized anxiety disorder</p>		

Student Name: Shamari Mims

Date: _____

8. Focused Nursing Diagnosis:

Fear

9. Related to (r/t):

Phobic Stimulus

[Being in place or situation from which escape might be difficult]

10. As evidenced by (aeb):

Identifies object of fear

-Symptoms of apprehension or sympathetic stimulation in presence of phobic object or situation

11. Desired patient outcome:

Short-term goal

-Client will discuss the phobic object or situation with the healthcare provider within (time specified)

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

1. Reassure client of her safety and security.

Evidenced Based Practice: At panic level of anxiety, client may fear for own life

2. Explore the client's perception of threat to physical integrity or threat to self-concept

Evidenced Based Practice: It is important to understand the client's perception of the phobic object or situation in order to assist with the desensitization process

3. Discuss reality of the situation with client in order to recognize aspects that can be changed and those that cannot

Evidenced Based Practice: Client must accept the reality of the situation (aspect that cannot change) before the work of reducing the fear can progress.**13. Patient Teaching:**

1. Letting the patient know, when she is starting to feel anxious to take slow deep breaths, smelling flowers and blowing out the candles.

2. Teaching her how to fill out her coping sheet. Making what it was asking simple for understanding.

3. Engaging in things that she used to love doing. Music therapy made her happy.

14. Discharge Planning/Community Resources:

1. Discharging to a facility where she can talk to others during the day.

2. Joining support groups. She did well in group therapy.

3. Following up with doctor to help stay on track with treatment plan.

Shamari Mims

Quick Screening for Psychotic Symptoms (QSPS)

Ask:	Yes	No	Unsure/Did not answer
1 Have you had any strange or odd experiences lately that you cannot explain?		✓	
2 Do you ever feel like people are bothering you or trying to harm you?		✓	
3 Has it ever seemed like people were talking about you or taking special notice of you?	✓		
4 Are you afraid of anything or anyone?			✓
5 Do you ever have visions or see things that other people cannot see?		✓	
6 Do you ever hear things that other people cannot hear, such as noises, or the voices of other people that are whispering or talking? If yes, ask:		✓	
If you hear voices, can you understand what the voices are saying? If yes, ask:			
Are the voices telling you to do anything that could harm yourself or someone else? If yes, ask:			
What are the voices telling you to do? (Record response here):			

Answering "yes" to any of these questions indicates the need for a more detailed assessment and follow-up questions.