Student Name: ___Ally Morrow___ Unit:__West side_Oceans_____ Pt. Initials: _DP_ Date: 4/8/2025___

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: __Cephalaxin, Baspar_____

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

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.)
Propanolol	Beta Blocker	Anxiety	10mg PO 2x daily	Y N		Light headedness, bradycardia	1. Never stop abruptly, as this medication can cause rebound hypertension. 2. Monitor blood pressure while on this medication. 3. This medicine can cause dizziness when moving positions, so move slowly when rising or sitting 4. The apical heart rate will be obtained before administration.
Sertraline	Antidepressant, SSRI	Depressive Disorder	50mg PO 3x daily	Y N		Nausea, Diarrhea/loose stools, and insomnia	1. This medication increases the risk of suicidal thinking and behavior. If these thoughts persist talk to your primary healthcare provider 2. Do not abruptly stop taking this medication so the effectiveness can be ensured. 3. This medicine can cause dizziness when moving positions, so move slowly when rising or sitting 4. This medication can cause insomnia, so avoid taking this medication at night.

Student Name: ___Ally Morrow___ Unit:__West side_Oceans_____ Pt. Initials: _DP_ Date: 4/8/2025___

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: __Cephalaxin, Baspar_____

Gabapentin	GABA Analogs	Withdrawal treatment	300mg PO 3x Daily	Y N		Dizziness, drowsiness, and fatigue	1. Inform your primary care provider if suicidal thoughts occur. 2. Avoid operating machinery, as this medication is a CNS depressant. 3. This medication can cause depression. 4. Take this medication as prescribed.
Hydroxyzine	Antihistamine	anxiety	50mg PO q 6 hr	Y N		Dry mouth, headache, and a rash	1. Avoid driving or operating machinery, as this medication is a CNS depressant. 2. Be sure to sip on liquids throughout, as this medication can cause dry mouth. 3. Report an irritating red rash. 4. Take this medication as prescribed.
				Y N			1. 2. 3. 4.

Student Name: _____ Date: _____

IM6 (Acute Psychiatric) Critical Thinking Worksheet

1. DSM-5 Diagnosis and Brief Pathophysiology (include reference): MDD – Major Depressive Disorder

4. Medical Diagnoses: N/A

2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.);

Relational and substance use

3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References)

1) Depressed Mood most of the day nearly every day.
2) Insomnia
3) Diminished interest in activities that were previously enjoyed
4) Fatigue or loss of energy
5) Feelings of worthlessness

5. Diagnostic Tests Pertinent or Confirming of Diagnosis

Hamilton Depression Rating Scale

6. Lab Values That May Be Affected:

N/A

7. Current Treatment:

Close obs q15
Milieu Therapy
· V/S O2 Sats
· Indl. Support
· Tx Team
· Wt. Monitoring

Meds:
· Propanolol
· Sertraline
· Gabapentin
· Hydroxyzine

Adopted: August 2016, revised October 2018

Student Name: _____ Date: _____

8. Focused Nursing Diagnosis:
Low Self-Esteem

9. Related to (r/t):
Impaired Physical Functioning

10. As evidenced by (aeb):
Withdrawn into social isolation

11. Desired patient outcome:
Client expresses some optimism and hope for the future

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

1. Be accepting of the client & his or her negativism

Evidenced Based Practice: an attitude of acceptance embraces feelings of self worth

2. Spend time with client

Evidenced Based Practice: Convey acceptance & contribute feelings of self-worth

3. ~~Help clients~~ Convey an accepting attitude, & encourage the client to express feelings openly

Evidenced Based Practice: an accepting attitude conveys to the client that you believe he or she is worthwhile

13. Patient Teaching:

1. Avoid alcohol especially while taking antidepressants.
2. Participate in self gratifying activities like sports or finishing a puzzle.
3. Practice breathing techniques when feeling panicked.

14. Discharge Planning/Community Resources:

1. Participate in an AA group to encourage their sobriety journey.
2. Take your medication as prescribed to ensure efficacy in treatment.
3. Be aware that the suicide hotline anytime that you feel is necessary.

NURSING SHIFT ASSESSMENT

DATE: 4/8/2025

SHIFT: ■ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: DP
MR#: _____ D.O.B. 31 yrs

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*** 0 ***Locations*** N/A
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
☐ 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."***		✓
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) _____ *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 _____

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: [14/16]
