

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?		
What are the voices telling you to do? (Record response here):			
"They tell me to do bad things to women"			

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

NURSING SHIFT ASSESSMENT

DATE: _____

- 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- Withdrawn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
 - Intrusive

- Aggressive
- Manipulative
- Compliant
- Sexually acting out
- Cooperative
- Guarded

Night(7P-7A)

SHIFT:  Day(7A-7P)

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

Pain: Yes No Pain scale score _____

Is pain causing any physical impairment in functioning today? No 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
 - Reality Orientation
 - Encourage Disclosure
 - Wt. Monitoring

- Locations**
- PRN Med per order
 - Toilet Q2 w/awake
 - Neuro Checks
 - Elevate HOB
 - 1 to 1 Observation
 - Rounds Q2
 - MD notified

- Thought Content**
- Obsessions
 - Hallucinations: Auditory Visual Olfactory Tactile Gustatory
 - Worthless
 - Somatic
 - Assaulative Ideas
 - Homocidal thoughts
 - Hopeless
 - Helpless
 - Logical

Ask Question 2 - _____

2) Have you actually had thoughts about killing yourself? _____

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? _____

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? _____

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: _____

Name: Zavi Label _____

MR#: _____ D.O.B. _____

REVIEW OF SYSTEMS

Cardio/Pulmonary:

- MWNL Elevated B/P D1 B/P
- Chest Pain
- Edema: upper lower
- Respiratory/Breath sounds:
- Clear Rales Crackles Wheezir
- Cough S.O. B Other: _____
- O2 @ _____ /min Cont. PRN
- Via nasal cannula face mask

Neurological/L.O.C.:

- Unimpaired Lethargic
- Dizziness Headache Seizures
- Tremors Other: _____

Musculoskeletal/Safety:

- Ambulatory MAE Full ROM
- Walker DW/C Immobility
- Pressure ulcer Unsteady gait
- Risk for pressure ulcer
- Reddened area(s) _____

Nutrition/Fluid:

- Adequate Inadequate Dehydrat
- Supplement Prompting Other
- New onset of choking risks assessec

Skin:

- Bruises Tear No new skin lssr
- Wound(s) (see Wound Care Pack
- Abrasion Integumentary Assess
- Other: _____

Elimination:

- Continent Incontinent Cathe
- Diarrhea OTHER _____

Hours of Sleep: _____ Day Night

At Risk for Falls: Yes No

At Risk for FALL Precautions:

Arm Band Non-skid footwear

DBR light ambulate with assist

CCall bell Clear path

Dedu to call for assist Bed alarm

Chair alarm 1:1 observation lev

Assist with ADLs Geri Chair

Ensure assistive devices near

Other _____

NURSING SHIFT ASSESSMENT

DATE: _____

SHIFT: Day(7A-7P) Night(7P-7A)



Night(7P-7A)

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

REVIEW OF SYSTEMS

Cardio/Pulmonary: DWNL Elevated B/P B/P

Chest Pain upper lower

Edema: upper lower

Respiratory/Breath sounds: Crackles Wheezii

Clear Rales O.S. B. Other: _____

Cough S.O. B. Other: _____

O2 @ _____ U/min Cont. PRN

Via nasal cannula face mask

Neurological / L.O.C.: Sedated

Unimpaired Lethargic Seizures

Dizziness Headache Tremors Other: _____

Musculoskeletal/Safety: MAE Full ROM

Ambulatory DW/C Immobile

Walker DW/C Unsteady gait

Pressure ulcer Unsteady gait

Risk for pressure ulcer

Reddened area(s)

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Supplement Prompting Other: _____

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Call bell Clear path

Bed alarm 1:1 observation leve

Assist with ADLs Geni Chair

Ensure assistive devices near

Other _____

Orientation

- Person
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- ## Affect
- Appropriate
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- ## ADL
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- ## Thought Processes
- Goal Directed
 - Tangential
 - Blocking
 - Flight of Ideas
 - Loose association
 - Illogical
 - Delusions: (type) **paranoia**

Pain: Yes No Pain scale score _____

Is pain causing any physical impairment in functioning today? No Yes explain _____

Locations _____

Nursing Interventions:

- Close Obs. q15
- Milieu Therapy
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- Nursing group/session (list topic): _____
- ADLs assist I&O

- Ind. Support
- Monitor Intake
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- Reality Orientation
- Encourage Disclosure
- Wt. Monitoring
- Toilet Q2 w/awake
- Neuro Checks
- Elevate HOB
- PRN Med per order _____

- 1 to 1 Observation _____
- Rounds Q2
- MD notified _____
- reason (specify) _____

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?

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 Signature(s) _____ Date: _____ Time: _____

Since Last Contact	YES	NO
2) Have you actually had thoughts about killing yourself?	YES	NO
3) Have you been thinking about how you might do this?	MOD	X
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."	X	X
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."	X	X
6) Have you done anything, started to do anything, or prepared to do anything to end your life?	X	X

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): "commit suicide" "find a gun"			

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

Student Name: _____

Unit: _____

Pt. Initials: _____

Date: _____

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: _____

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.)
Clozapine	Antipsychotic	Lower suicide risk	100mg PO Q12hrs	Y N	IVPB – List ml/hr and time to give	Dizziness, lightheadedness, seizures, drop in blood pressure, agranulocytosis	<ol style="list-style-type: none"> 1. May cause dizziness, so don't operate machinery. 2. Due to lightheadedness get up slowly in bed, let your feet dangle before standing 3. Do not stop taking abruptly, can cause withdrawal symptoms. 4. This medication can cause agranulocytosis regular blood tests need to be conducted
Risperidone	Antipsychotic	Schizophrenia	3mg PO Q24hrs	Y N		Abnormal heart rhythms, tinnitus, dyskinesia, sedation, sexual dysfunction	<ol style="list-style-type: none"> 1. do not stop taking abruptly can't cause withdrawal symptoms. 2. do not operate heavy machinery, until know how this medication affects you. 3. Monitor renal function as this medication can cause toxicity 4. avoid alcohol while taking this medication it can make the side effects worse.
Carbamazepine	Anticonvulsant	Bipolar depression	400mg PO Q12hrs	Y N		Dizziness, drowsiness, unsteadiness, dry mouth, constipation, skin rashes, suicidal	<ol style="list-style-type: none"> 1. Report any rashes, bruising, or blistering these can be signs of a serious allergic reaction 2. Avoid heavy machinery and so you know how this medication affects you. 3. stop abruptly as this can cause withdrawal symptoms. 4. drink plenty of fluid while taking this medication to avoid constipation.

Aspire, AA and Oceans Reflection (300 word minimum)

<p>Safety & Quality</p> <p>Describe anything you accomplished to maintain a safe, quality environment</p>	<p>We listened to each client tell us their story while encouraging them to disclose any information they were comfortable with.</p>
<p>Clinical Judgment</p> <p>As you listened during group, how were you able to integrate classroom knowledge with what the patient/therapist were discussing:</p> <ul style="list-style-type: none"> • What can you apply to this situation from your previous knowledge? • Can you apply these learnings to other events? How can you use this to further improve your practice in the future? • What have you learned from clinical? 	<p>In the two group sessions I attended they discussed coping mechanisms and setting boundaries. Many of the clients participated and gave their input into the discussion. Nursing care and patient advocacy are subjects we've learned about previously that I felt like I used while visiting Oceans.</p>
<p>Patient Centered Care</p> <p>Identify one client in the group, what concerns, recommendations/interventions would you suggest?</p>	<p>I had a client, Melissa who suffered from auditory and visual hallucinations that told her to commit suicide. She really enjoys reading her Bible so I recommend she continues her meds and maybe joins a Bible study group. I also saw in her chart that she suffered from severe childhood trauma, so I also think continuing seeing a therapist would be very beneficial.</p>
<p>Professionalism</p> <p>How did you maintain professionalism? You can review your clinical evaluation for ideas (What has this taught you about professional practice? About yourself?)</p>	<p>As we listened to each client tell their story we were sure to encourage them to disclose information and made sure they were always comfortable while doing so. We also validated the client by telling them we believe everything they told us they were experiencing.</p>
<p>Communication & Collaboration</p> <p>Describe how you utilized therapeutic communication/collaboration</p>	<p>I made sure that both of the clients I interviewed got my full attention and I refrained from making any comments until the client was done talking. When making comments, I made sure that the client was comfortable and felt validated.</p>

<p style="text-align: center;">Feelings</p> <ul style="list-style-type: none"> • How were you feeling at the beginning? • What were you thinking at the time? • How did the event make you feel? • What did the words or actions of others make you think? • How did this make you feel? • How did you feel about the outcome? • What is the most important emotion or feeling you had? 	<p>At the beginning of this clinical experience, I was a little nervous. I feel like movies portrayed places such as Oceans as this place where chaos is constantly happening. After talking to several of the clients and hearing their stories, I was quickly reminded that these clients are regular people that are just struggling with serious mental disorders. Hearing them participate in group discussions showed that they are trying to improve their lives, and I was so thankful to get to experience their journey's.</p>
<p style="text-align: center;">Evaluation</p> <p>What stood out the most about Aspire, AA, or Oceans</p>	<p>The staff in group sessions were amazing. Every client had a different unique story and I enjoyed getting to hear each of them. Oceans is a place that I could see myself possibly working at in the future.</p>

Student Name: _____

Date: _____

IM6 (Acute Psychiatric) Critical Thinking Worksheet

<p>1. DSM-5 Diagnosis and Brief Pathophysiology (Include reference):</p> <p>Schizophrenia - neurohorm. Imbalance (Dopamine overactivity, hypodopaminergic activity) (pos. neg. sym.)</p>	<p>2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.):</p> <p>Childhood trauma (sexual abuse) Social isolation</p>	<p>3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References)</p> <p>A. 2 2+ of the following:</p> <ol style="list-style-type: none">1. Delu2. Hallu3. Disorg. Speech4. grossly disorganized5. Neg. sym.
<p>4. Medical Diagnoses:</p> <p>N/A</p>	<p>6. Lab Values That May Be Affected:</p> <p>N/A</p>	<p>B. Level of functioning in major areas (work, relation, self-care) dec.</p> <p>C. Persist for at least 1m, with atleast 1m of symptoms.</p>
<p>5. Diagnostic Tests Pertinent or Confirming of Diagnosis</p> <p>Suicide - Suicide QUESTIONNAIRE</p> <p>- ASSESSMENT</p> <p>- Meds</p>		<p>D. Schizoaffective: bipolar ruled out.</p> <p>E. Not attributable to a substance.</p> <p>F. If history of autism disorder, schizo made only if prominent hallucinations.</p>

Student Name: _____

Date: _____

<p>8. Focused Nursing Diagnosis:</p> <p>Risk for self-directed or other-directed violence</p>	<p>12. Nursing Interventions related to the Nursing Diagnosis in #7:</p> <p>1. Redirect violent behavior w/ physical outlets.</p>	<p>13. Patient Teaching:</p> <p>1. Understand illness (teach pos. ? neg. symptoms, ? emphasize its a long-term condition)</p> <p>2. Importance of meds! (consistency, DO NOT stop abruptly)</p> <p>3. Lifestyle ? Support (healthy routines, coping, boundaries)</p>
<p>9. Related to (r/t):</p> <ul style="list-style-type: none"> lack of trust delusional thinking Command hallucinations 	<p>Evidenced Based Practice: exercise - safe way to release pent-up tension.</p> <p>2. Staff is calm towards client.</p> <p>Evidenced Based Practice: anxiety is contagious</p>	<p>14. Discharge Planning/Community Resources:</p> <p>1. Med. management ? Med. access</p> <p>2. Therapy planning ? Support Systems</p>
<p>10. As evidenced by (aeb):</p> <p>N/A</p>	<p>3. Remove all dangerous objects from client.</p> <p>Evidenced Based Practice: when agitated, she won't use them to harm self or others.</p>	<p>3. Housing ? Daily living needs / Financial Support</p>
<p>11. Desired patient outcome:</p> <p>Client will not harm self or others</p>		