

Cayce Dutton

NURSING SHIFT ASSESSMENT

ATE: 8/19



SHIFT: Day(7A-7P)

Night(7P-7A)

Name	Label
MRN	D.O.B.

Orientation <input checked="" type="checkbox"/> Person <input checked="" type="checkbox"/> Place <input checked="" type="checkbox"/> Time <input checked="" type="checkbox"/> Situation	Affect <input checked="" type="checkbox"/> Appropriate <input type="checkbox"/> Inappropriate <input type="checkbox"/> Flat <input type="checkbox"/> Guarded <input type="checkbox"/> Improved <input type="checkbox"/> Blunted	ADL <input checked="" type="checkbox"/> Independent <input type="checkbox"/> Assist <input type="checkbox"/> Partial Assist <input type="checkbox"/> Total Assist	Motor Activity <input checked="" type="checkbox"/> Normal <input type="checkbox"/> Psychomotor retardation <input type="checkbox"/> Psychomotor agitation <input type="checkbox"/> Posturing <input type="checkbox"/> Repetitive acts <input type="checkbox"/> Pacing	Mood <input type="checkbox"/> Irritable <input type="checkbox"/> Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Dysphoric <input type="checkbox"/> Agitated <input type="checkbox"/> Labile <input checked="" type="checkbox"/> Euphoric	Behavior <input type="checkbox"/> Withdrawn <input type="checkbox"/> Suspicious <input type="checkbox"/> Tearful <input type="checkbox"/> Paranoid <input type="checkbox"/> Isolate <input type="checkbox"/> Preoccupied <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
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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 _____
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 _____

REVIEW OF SYSTEMS

Cardio/Pulmonary:
 JVD
 Elevated B/P
 B/P
 Chest Pain
 Edema: upper lower

Respiratory/Breath sounds:
 Clear
 Rates
 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
 Dehydrate
 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
 Non-skid footwear
 R light
 ambulate with assist
 Call bell
 Clear path
 Edu to call for assist
 Bed alarm
 Chair alarm
 1:1 observation level
 Assist with ADLs
 Geni Chair
 Ensure assistive devices near
 Other _____

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

Risk Question 2*	Since Last Contact	
	YES	NO
1) Have you actually had thoughts about killing yourself?	LOW	
*YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
2) Have you been thinking about how you might do this?	MOD	
3) 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."		
4) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? is opposed to "I have the thoughts, but I definitely will not do anything about them."		
5) 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: _____ Time: _____