# PMH Critical Thinking Sheet

**DSM-5 Diagnosis and Brief Pathophysiology:**
Schizophrenia: mental health illness causing abnormal perception of reality

**DSM-5 Criteria** for your patient's diagnosis:
- Delusions
- hallucinations
- grossly disorganized

**Psychosocial Stressors** (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)
feelings of losing identity (powers)

**Therapeutic Communication & Nurse Patient Relationship:**

Communication strategy:
make eye contact ; avoid turning away from patient

Stage of nurse-patient relationship:
orientation

Therapeutic communication techniques appropriate for this patient:
- Reflect patients real concerns
- make sure patient doesnt think im not listening to their answers

Communication approaches to avoid:
avoid statements that exaggerate their stories

Plan of Care:

Patient problem: Disturbed sensory perception (visual)

Related to (etiology): paranoia & anxiety

As evidenced by (signs & symptoms): talking & singing to self, disorientation, sensory distortion

Outcome/Goal:
define & test reality, eliminating halluc.

Current Treatment & Interventions:

1. Observe client for s/s of halluc.
Rationale: can prevent aggressive beh.
2. dont touch bc telling
Rationale: may percieve as threatening
3. encourage them to speak about halluc. (acceptance)
drug: helps prevent self harm or harm to others
4. Dont reinforce statements
- words dont that are validate their hallucinations

Student name:

Sadie Burrow

# HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name Sadie Today's Date 08/20/2025

The HAM-D is designed to rate the severity of depression in patients. Although it contains 21 areas, calculate the patient's score on the first 17 answers.

**2** 1. DEPRESSED MOOD
(Gloomy attitude, pessimism about the future, feeling of sadness, tendency to weep)
0 = Absent
1 = Sadness, etc.
(2) = Occasional weeping
3 = Frequent weeping
4 = Extreme symptoms

**0** 2. FEELINGS OF GUILT
0 = Absent ✓
1 = Self-reproach, feels he/she has let people down
2 = Ideas of guilt
3 = Present illness is a punishment; delusions of guilt
4 = Hallucinations of guilt

**4** 3. SUICIDE
0 = Absent
1 = Feels life is not worth living
2 = Wishes he/she were dead
3 = Suicidal ideas or gestures
(4) = Attempts at suicide

**1** 4. INSOMNIA - Initial
(Difficulty in falling asleep)
0 = Absent
(1) = Occasional
2 = Frequent

**1** 5. INSOMNIA - Middle
(Complains of being restless and disturbed during the night. Waking during the night.)
0 = Absent
(1) = Occasional
2 = Frequent

**2** 6. INSOMNIA - Delayed
(Waking in early hours of the morning and unable to fall asleep again)
0 = Absent
1 = Occasional
(2) = Frequent

**0** 7. WORK AND INTERESTS
(0) = No difficulty
1 = Feelings of incapacity, listlessness, indecision and vacillation
2 = Loss of interest in hobbies, decreased social activities
3 = Productivity decreased
4 = Unable to work. Stopped working because of present illness only. (Absence from work after treatment or recovery may rate a lower score).

**0** 8. RETARDATION
(Slowness of thought, speech, and activity; apathy; stupor.)
0 = Absent
1 = Slight retardation at interview
2 = Obvious retardation at interview
3 = Interview difficult
4 = Complete stupor

**0** 9. AGITATION
(Restlessness associated with anxiety.)
0 = Absent
1 = Occasional
2 = Frequent

**0** 10. ANXIETY - PSYCHIC
(0) = No difficulty
1 = Tension and irritability
2 = Worrying about minor matters
3 = Apprehensive attitude
4 = Fears

# HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

**0** 11. ANXIETY - SOMATIC
Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

**1** 12. SOMATIC SYMPTOMS - GASTROINTESTINAL
(Loss of appetite , heavy feeling in abdomen; constipation)
0 = Absent
1 = Mild
2 = Severe

**0** 13. SOMATIC SYMPTOMS - GENERAL
(Heaviness in limbs, back or head; diffuse backache; loss of energy and fatiguability)
0 = Absent
1 = Mild
2 = Severe

**0** 14. GENITAL SYMPTOMS
(Loss of libido, menstrual disturbances)
0 = Absent
1 = Mild
2 = Severe

**0** 15. HYPOCHONDRIASIS
0 = Not present
1 = Self-absorption (bodily)
2 = Preoccupation with health
3 = Querulous attitude
4 = Hypochondriacal delusions

**0** 16. WEIGHT LOSS
0 = No weight loss
1 = Slight
2 = Obvious or severe

**0** 17. INSIGHT
(Insight must be interpreted in terms of patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: 11

0 - 7 = Normal
8 - 13 = Mild Depression
14-18 = Moderate Depression
19 - 22 = Severe Depression
≥ 23 = Very Severe Depression

**0** 18. DIURNAL VARIATION
(Symptoms worse in morning or evening. Note which it is. )
0 = No variation
1 = Mild variation; AM ( ) PM ( )
2 = Severe variation; AM ( ) PM ( )

**0** 19. DEPERSONALIZATION AND DEREALIZATION
(feelings of unreality, nihilistic ideas)
0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

**0** 20. PARANOID SYMPTOMS
(Not with a depressive quality)
0 = None
1 = Suspicious
2 = Ideas of reference
3 = Delusions of reference and persecution
4 = Hallucinations, persecutory

**1** 21. OBSESSIONAL SYMPTOMS
(Obsessive thoughts and compulsions against which the patient struggles)
0 = Absent
1 = Mild
2 = Severe

* Adapted from Hamilton, M. *Journal of Neurology, Neurosurgery, and Psychiatry*. 23:56-62, 1960.

Sadie Burrow

# URSING SHIFT ASSESSMENT

ATE: 08/20/2025

SHIFT: ☐ Day(7A-7P) ☐ Night(7P-7A)

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

**ientation**
- ☑ 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

**ought 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

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

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

**DOCUMENT ABNORMAL OCCURENCES IN MULTIDISCIPLINARY NOTES** (violence, suicide, elope, fall, hysical health) **DAILY SUICIDE RISK ASSESSMENT* Note – for frequent assessment purposes, Question 1 has been omitted**

| sk Question 2* | Since Last Contact | |
|---|---|---|
| | YES | NO |
| ) 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 | | |
| ) Have you been thinking about how you might do this? | MOD | ✓ |
| ) Have you had these thoughts and had some intention of acting on them? | HIGH | ✓ |
| 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 ould never go through with it." | | |
| ) Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan? | HIGH | ✓ |
| s opposed to "I have the thoughts, but I definitely will not do anything about them." | | |
| ) Have you done anything, started to do anything, or prepared to do anything to end your life? | HIGH | ✓ |
| Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, went o 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) Sadie Burrow Date: 08/20/2025 Time: 1056

ems Healthcare 9/2018, 12/01/2021, 10/01/2023

## 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 _____

elopement precautions

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❑Tremors ❑ Other_____

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