Aspire, AA and Oceans Reflection (300 word minimum)

Safety & Quality Describe anything you accomplished to maintain a safe, quality environment	I did my best to avoid over-crowding patients who I could tell did not want their space invaded. Also, in group therapies and activities, I was aware of the times when too many of us being in the room was going to be too overwhelming for patients. It was also very important that we make sure to close all doors behind us because it is a lockdown facility.
Clinical Judgment As you listened during group, how were you able to integrate classroom knowledge with what the patient/therapist were discussing: • 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?	Myself and the other students with me participated in a group therapy session on the topic of control. There were several instances in which one of the patients singled himself out along with the other patients and said something along the lines of "I'm speaking for us, not you (us students)" because he felt we couldn't relate. It was like he felt we were better in some way. I made sure to say that we all have things that we may need help with and that I had my fair share of problems. I think speaking up made them feel less different than us. I will continue to use this tactic in my future practice.
Patient Centered Care Identify one client in the group, what concerns, recommendations/interventions would you suggest?	The one client I had with Major Depressive disorder paired with alcohol withdrawal did not seem to be ready to quit drinking. I asked if he had considered rehab, and he ~~did not~~ said he did not want to go for 90 days. I was also concerned with the fact that when he leaves, he will be living with a relative that is having the same problems. I would recommend rehab and to try and find a new living arrangement.
Professionalism How did you maintain professionalism? You can review your clinical evaluation for ideas (What has this taught you about professional practice? About yourself?	I maintained professionalism by maintaining boundaries. I also respected my patient's autonomy and confidentiality. I continuously created a safe and comfortable environment for everyone and did my best to acknowledge patient concerns while showing empathy. There were also instances when I needed to ask uncomfortable questions, and I made the patients understand it was their choice where we talked.
Communication & Collaboration Describe how you utilized therapeutic communication/collaboration	One of my patients was having a particularly difficult time communicating with me and answering questions. I recognized the need for sitting in silence and not asking too many questions at a time. I was doing my best to be empathetic and offering my support with a nonjudgmental attitude. I respected her time and performed my assessments at the pace she needed.

Feelings • 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?	I was somewhat worried at the beginning because I didn't know what to expect and felt bad about the prospect of having to ask the patients such difficult questions. Clinicals at Oceans made me feel that I should have been exposed to an experience like this a long time ago in order to have a better understanding of psychiatric patients and mental illness. Hearing the stories of the patients made me think about all the other people out there similar to them who may be having the same problems but not have access to help. That makes me very sad. I wish I could have done more for the patients and had more time.
Evaluation What stood out the most about Aspire, AA, or (Oceans)	We were told prior to coming to Oceans that, for the most part, the mental health techs were with the patients more than the nurses, however it did surprise me that the nurses had little to no interactions with the patients besides when they were passing meds. I guess for me I would have wanted to be more involved with my patients as a nurse.

DSM-5 Diagnosis and Brief Pathophysiology:

Substance Abuse – Alcohol Addiction (Alcoholism)

Alcohol "hijacks" the brains reward system, releasing dopamine and other neurotransmitters like endorphins. Chronic use leads to tolerance to the substance's effects and withdrawal symptoms when consumption stops.

DSM-5 Criteria for your patient's diagnosis: impaired control. Physical dependence, social problems & risky use

Psychosocial Stressors (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)

Family dysfunction.
Chronic depression.
Divorce

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:

Active listening while using clarifying techniques

Stage of nurse-patient relationship:

Orientation

Therapeutic communication techniques appropriate for this patient:

Exploring
Open-ended questions
Silence

Communication approaches to avoid:

Asking "why" questions
Giving advice
Asking too many questions

Plan of Care:

Patient problem: Ineffective Coping

Related to (etiology): Inadequate support systems, inadequate coping skills, dysfunctional family system, personal vulnerability

As evidenced by (signs & symptoms): Low self-esteem, chronic depression, substance abuse, low frustration tolerance

Outcome/Goal: Client will be able to verbalize adaptive coping mechanisms to use, instead of substance abuse, in response to stress

Current Treatment & Interventions:

1. Explain the effects of substance abuse on the body. Emphasize prognosis is closely related to abstinence.

Rationale: Many clients lack knowledge regarding the deleterious effects of substance abuse on the body.

2. Establish trusting relationship with client.

Rationale: The therapeutic nurse-client relationship is built on trust.

3. Encourage client to verbalize feelings, fears and anxieties

Rationale: Verbalization of feelings in a nonthreatening environment may help client come to terms with long unresolved issues.

4. Explore with client the options available to assist with stressful situations rather than resorting to substance abuse

Rationale: Client may have persistently resorted to addictive behaviors and thus may possess little or no knowledge of adaptive responses to stress.

Student Name: Allyson Jordan Unit: Oceans Pt. Initials: R Date: 10/21/25

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: NKDA

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

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.)
Duloxetine	Antidepressant	Depression	60mg PO Daily	(Y) N	N/A	Suicidal Thoughts, Hepato-toxicity	1. Assess mental status, BP for HTN 2. Rise slowly as this drug can cause dizziness 3. Report any new or worsening thoughts 4. Explain importance of monitoring BP especially w/ HX of HTN
Hydroxyzine	Anxiolytic	Anxiety	50mg PO Q6 PRN for anxiety	(Y) N	N/A	QT Prolongation seizures	1. Educate on good oral hygiene, frequent mouth rinses, etc. for dry mouth 2. Advise pt to rise slowly due to possible dizziness 3. Avoid alcohol as it could increase sedation effects 4. Monitor respiratory status
Lorazepam	Benzodiazepine	Alcohol Withdrawal	0.5mg PO BID	N (Y)	N/A	Respiratory Depression	1. Monitor respiratory status, depression 2. DO not stop abruptly 3. Avoid alcohol 4. Advise to rise slowly due to possible dizziness
Trazodone	Antidepressant	Insomnia r/t Depression	50mg PO Daily @ Bedtime	N (Y)	N/A	Suicidal Thoughts, Orthostatic Hypotension	1. Report any new or worsening thoughts 2. Rise slowly as this can cause dizziness 3. Take w/ food to avoid upset stomach 4. Avoid alcohol
				Y N			1. 2. 3. 4.

Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)

Patient: Richard **Date:** 10/21/25 **Time:** 0845 (24 hour clock, midnight = 00:00)

Pulse or heart rate, taken for one minute: N/A **Blood pressure:** N/A

NAUSEA AND VOMITING -- Ask "Do you feel sick to your stomach? Have you vomited?" Observation.
(0) no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES -- Ask "Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?" Observation.
(0) none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

TREMOR -- Arms extended and fingers spread apart. Observation.
0 no tremor
(1) not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

AUDITORY DISTURBANCES -- Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.
(0) not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

PAROXYSMAL SWEATS -- Observation.
(0) no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

VISUAL DISTURBANCES -- Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.
(0) not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

ANXIETY -- Ask "Do you feel nervous?" Observation.
(0) no anxiety, at ease
1 mild anxious
(2)
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD -- Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
(0) not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

AGITATION -- Observation

0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM -- Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place/or person

Total **CIWA-Ar** Score 3
Rater's Initials [illegible]
Maximum Possible Score 67

*The **CIWA-Ar** is not* copyrighted and may be reproduced freely. This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. The maximum score is 67 (see instrument). Patients scoring less than 10 do not usually need additional medication for withdrawal.

Sullivan, J.T.; Sykora, K.; Schneiderman, J.; Naranjo, C.A.; and Sellers, E.M. Assessment of alcohol withdrawal: The revised *Clinical* Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction* 84:1353-1357, 1989.

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name Traci Today's Date 10/22/25

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.

1

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

1

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

0

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

0

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

0

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

0

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

3

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).

1

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

1

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

2

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)

1 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

---

2 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

---

1 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: 14
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

---

0 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.

Coping Skills Education Check-Off Form

Participant Initials: I

Date: 10/22/25 Student name: Allyson Jordan

Topics Covered

(*Check each item as it is completed or discussed*)

#	Topic	Completed	Comments
1	Deep Breathing	☑	
2	Journaling	☑	
3	Take a shower	☑	
4	Music	☑	
5	Exercise	☑	
6	Draw/color	☑	Patient uses coloring and painting to cope
7	Count to 10	☑	
8	Dance	☑	
9	Meditate/pray	☑	
10	Watch a funny movie	☑	
11	Read a book	☑	
12	Do a puzzle	☑	
13	Talk to someone	☑	
14	Clean something	☑	

Participant Understanding

Question	Yes	Somewhat	No
Demonstrated understanding of topic	☑	☐	☐
Actively participated in discussion	☑	☐	☐
Asked questions when needed	☐	☐	☑
Expressed confidence in applying what was learned	☐	☑	☐

Educator Notes / Recommendations

_____

_____

_____

_____

NURSING SHIFT ASSESSMENT

DATE: 10/22/25

SHIFT: ☒ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: _____
MRN: _____ 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*** 0 ***Locations*** N/A

Is pain causing any physical impairment in functioning today ☐ No ☐ If yes explain N/A

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	Since Last Contact	
Ask Question 2*	YES	NO
2) Have you actually had thoughts about killing yourself?	LOW	X
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.		X

☐ Low Risk ☐ Moderate Risk ■ High Risk

Nurse Signature(s) A Jordan Date: 10/22/25 Time: 0945

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 _____

NURSING SHIFT ASSESSMENT

DATE: 10/21/25

SHIFT: ☒ Day(7A-7P) ☐ Night(7P-7A)

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

Orientation
☒ Person
☒ Place
☒ Time
☒ Situation

Affect
☒ Appropriate
☐ Inappropriate
☐ Flat
☐ Guarded
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ADL
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☐ 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 N/A

Nursing Interventions:
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☒ V/S ☒ O2 sat.
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☒ Monitor Intake
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☒ Encourage Disclosure
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☐ MD notified _____
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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."	HIGH	
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."	HIGH	
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.	HIGH	X

☐ Low Risk ☐ Moderate Risk ■ High Risk

Nurse Signature(s) _____ Date: 10/21/25 Time: 0820

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

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☐ Dizziness ☐ Headache ☐ Seizures
☐ Tremors ☐ Other _____

Musculoskeletal/Safety:
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☐ Risk for pressure ulcer
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☐ Supplement ☐ Prompting ☐ Other _____
new onset of choking risks assessed

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☐ ~~Wound~~(s) (see Wound Care Packet)
☐ Abrasion ☐ Integumentary Assess
☐ Other: _____

Elimination:
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☐ Assist with ADLs ☐ Geri Chair
☐ Ensure assistive devices near
☐ Other _____