NURSING SHIFT ASSESSMENT

DATE: 10/31/25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Name: Label Rosemary

MR#: _____ 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☐ Withdrawn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***_____
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
☐ PRN Med per order_____
☐ 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***	✓
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."***	***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***	✓

☑ ***Low Risk*** ☐ ***Moderate Risk*** ☐ ***High Risk***

*Nurse Signature*_____ *Date:*_____ *Time:*_____

Oceans Healthcare

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:* _____

Eliminations
☐ *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* _____

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):** "Get out of the house"				

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

NURSING SHIFT ASSESSMENT

DATE: 10/22/25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

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

Orientation
☑ Person
☑ Place
☑ Time
☑ Situation

Affect
☑ Appropriate
☐ Inappropriate
☐ Flat
☐ Guarded
☐ Improved
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ADL
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Thought Content
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☐ Worthless ☐ Somatic ☐ Assaultive Ideas ☐ Logical
☐ Hopeless ☐ Helpless ☐ Homicidal thoughts

Pain: Yes (No) ***Pain scale score*** _____ ***Locations*** _____
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
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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	✓
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☐ 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
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☐ Chair alarm ☐ 1:1 observation level
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☐ Other _____

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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):** "stop, stop, stop"			

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

Coping Skills Education Check-Off Form

Participant Initials: J

Date: 10/22/25 Student name: Amaya Jones

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	☐	
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	☐	