NURSING SHIFT ASSESSMENT

DATE: 10/28/25

Ky Tammie

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: Ky Tammie
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- ☐ Withdrawn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): Boundaries & Self care
- ☐ 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**

Ask Question 2*	Since Last Contact	
	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 Signatures _____ Date: 10/28/25 Time: 0920

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 _____

Ky (Tammie 20 Y/F

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:
Neurotransmitter imbalances, triggered by hormones, psychosocial factors, or genetics.

DSM-5 Criteria for your patient's diagnosis:
- A Depressed mood
- Significant wt loss
- insomnia
- Difficulty concentrating
- fatigue or loss of energy

Psychosocial Stressors (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)
Post partum (8mo old)
Isolation - primary care taker of children
over worked - working multiple jobs
Shifts

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:
Use open ended questions followed up with clarification repeat.

Stage of nurse-patient relationship:
Orientation & working

Therapeutic communication techniques appropriate for this patient: I see you
You seem &
Tell me about that statements

Communication approaches to avoid:
Why questions &
Telling her what to do.

Plan of Care:

Patient problem: Depression

Related to (etiology): Peripartum on set

As evidenced by (signs & symptoms): sleep disturbance (insomnia) irritable

Outcome/Goal: Pt will obtain at least 8 hours of sleep at ~~night~~ daily.
Pt will relinquish & delegate 2 task to husband

Current Treatment & Interventions:
1. Pharmacological
family intervention & support
Planned self care days.

Rationale:
2. Vistaril allows Pt anxiety to decrease & get rest.

Rationale:
3. Having family help with the girls relieves stress on Pt.

Rationale:
4. Spending time with other adults outside of home help mom regain identity outside of being a mother/wife

Rationale:
Time alone allows her to reflect & regroup

Student name: Bre Allen

Page 1

Student Name: Bre Allen Unit: Pt. Initials: KY Date: 10/28/25

Allergies: NKDA

Medication Worksheet – Current Medications & PRN for Last 24 Hours

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, Interventior (Precautions/Contraindications, Etc.)
OXCarbazepine (Trileptal)	mood stabilizer / Anticonvulsant	mood Change	150 mg PO BID	(Y) N		• Diplopia • hyponatremia • Dizziness • HA • Drowsiness/ sedation - CNS depression	1. DO not STOP taking suddenly 2. Take same times daily 3. Use alternativ contraceptive if on BC can reduce effectiveness 4. make sure arrangements to pick up kids as may cause drowsiness.
Hydroxyzine Pamoate (Vistaril)	First-generation antihistamine	anxiety	50 mg PO q6 PRN	(Y) N		• Diplopia • hypotension • Dry mouth • Constipation • Urinary retention • QT prolongation	1. Chew gum or peppermint for Dry mouth 2. ↑ fluid intake eat beans lentil, grain to prevent constipation 3. If lower abd pain or ↓ urine report to provider 4. maintain f/u ↑ PCP & EKG monitoring
				Y N			1. 2. 3. 4.
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