

NURSING SHIFT ASSESSMENT

DATE: 11/5

SHIFT: Day(7A-7P)



Night(7P-7A)

Name: R Label
 MAR: 008

- 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- Withdrawn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
 - Intrusive
 - Aggressive
 - Manipulative
 - Complacent
 - Sexually acting out
 - Cooperative
 - Guarded

- 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
 - Hopeless
 - Helpless
 - Homicidal thoughts
 - Logical

Pain: Yes No **Pain scale score** 3 **Locations** WA
 Is pain causing any physical impairment in functioning today No if yes explain _____

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

DOCUMENT ABNORMAL OCCURRENCES 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*	YES	NO	Since Last Contact
2) <u>Have you actually had thoughts about killing yourself?</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>LOW</u>
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6			
3) <u>Have you been thinking about how you might do this?</u>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>MOD</u>
4) <u>Have you had these thoughts and had some intention of acting on them?</u> Eg., "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."	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>✓</u>
5) <u>Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?</u> As opposed to "I have the thoughts, but I definitely will not do anything about them."	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>✓</u>
6) <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u> 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.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<u>✓</u>

Risk

Low Risk Moderate Risk High Risk

Nurse Signatures) AW EB

Date: 11/5 Time: 0815

REVIEW OF SYSTEMS

- Cardio/Pulmonary:**
- MNL Elevated B/P B/P
 - Chest Pain
 - Edema: upper lower
- Respiratory/Breath sounds:**
- Clear Rales Crackles Wheezing
 - Cough S.O.B. Other: _____
 - O2 @ _____ Urin Cont PPN
 - Via nasal cannula face mask
- Neurological / L.O.C.:**
- Unimpaired Lethargic Sedated
 - Dizziness Headache Seizures
 - Tremors Other: _____
- Musculoskeletal/Safety:**
- Ambulatory MAE Full ROM
 - Walker DW/C Dim/mobile
 - 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 Non-skid footwear
 - DBR light ambulate with assist
 - Call bell Clear path
 - Bed to call for assist Bed alarm
 - Chair alarm 1:1 observation level
 - Assist with ADLs Geri Chair
 - Ensure assistive devices near
 - Other _____

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name Rhonda

Today's Date 11/15

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. **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

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

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

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

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

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

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).

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

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

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)

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

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

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

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

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

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

17. INSIGHT
(Insight must be interpreted in terms of pa-
tient's understanding and background.)
 0 = No loss
1 = Partial or doubtful loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: 19

0 - 7 = Normal

8 - 13 = Mild Depression

14 - 18 = Moderate Depression

19 - 22 = Severe Depression

≥ 23 = Very Severe Depression

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 (✓)

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

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

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