

NURSING SHIFT ASSESSMENT

DATE: 11/14

SHIFT:

Day (7A-7P)

Night (7P-7A)

Name: NM Label
 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Behavior Withdrawn Suspicious Tearful Paranoid Isolative Preoccupied Demanding Aggressive Manipulative Compliant Sexually acting out Cooperative Guarded Intrusive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 _____ Locations _____
 Is pain causing any physical impairment in functioning today No If yes explain _____

Nursing 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

N/S 2 sat. Tx Team Wt. Monitoring Elevate HOB MD notified _____

Nursing group/session (list topic): _____ PRN Med per order _____

ADLs assist I&O _____

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
1) <u>Have you actually had thoughts about killing yourself?</u>	YES	NO	
2) <u>Have you been thinking about how you might do this?</u>	MOD		
3) <u>Have you had these thoughts and had some intention of acting on them?</u> 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."			
4) <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."			
5) <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</u>			
6) <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.</u>			

Risk Assessment: Low Risk Moderate Risk High Risk

Nurse Signature(s): [Signature] Date: 11/14 Time: 0830

REVIEW OF SYSTEMS

Cardio/Pulmonary: DMNL Elevated BP D₁ BP Chest Pain Edema: upper lower

Respiratory/Breath sounds: Clear Rales Crackles Wheezing Cough S.O.B. Other _____

O₂ @ _____ Urin Cont PRN Via nasal cannula face mask

Neurological / L.O.C.: Unimpaired Athergic Sedated Dizziness Headache Seizures Tremors Other _____

Musculoskeletal/Safety: Ambulatory MAE Full ROM Walker D/W/C Dimobile 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 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 Geni 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): "Go to sleep and have a safe flight"			

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

Student Name: Aiina Elizarraraz

Unit: Oceans

Pt. Initials: NM

Date: 11-4

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Allergies: Dairy & Kelchur

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

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.)
Risperidone	Antipsychotic	Severe psychosis	1.5mg PO QHS	<input checked="" type="checkbox"/> Y	NA	Sedation, HA, dizziness, ERS, tachycardia, pruritus QT, orthostatic hypotension	<ol style="list-style-type: none"> 1. Watch BR & HR, out of bed slowly 2. Watch for HMs from ERS: altered mentals status 3. Fall precautions: altered sedation, HA 4. Increase fiber & fluids for constipation
Olanzapine	Antipsychotic	Severe psychosis	10mg PO Qb PRN	<input checked="" type="checkbox"/> Y	NA	Sedation, dizziness, weight gain, appetite, hyperreflexic, constipation, tachycardia	<ol style="list-style-type: none"> 1. Obtain baseline wt. Possible SIS - gain 2. Periodically check blood glucose for metabolic syndrome 3. Takes 1-2 wk for full effect 4. Healths diet encouraged, plus fiber & water
Hydroxyzine	Antihistamine	Antihist	50mg PO Qb PRN	<input type="checkbox"/> N	NA	Sedation, HA, constipation, dry mouth, blurred vision, loss of appetite, ataxia	<ol style="list-style-type: none"> 1. Watch for pruritus QT, obtain before 2. Fall risk: dizziness, drowsy 3. Sugar free candy ice for dry mouth 4. Watch for rest. depression with other CNS
				<input type="checkbox"/> Y			<ol style="list-style-type: none"> 1. 2. 3. 4.

PMH Critical Thinking Sheet

<p>DSM-5 Diagnosis and Brief Pathophysiology:</p> <p>Schizophrenia:</p> <p>Chronic brain disorder, imbalance of neurotransmitters like excess dopamine, which causes hallucinations.</p>	<p>Therapeutic Communication & Nurse Patient Relationship:</p> <p>Communication strategy:</p> <p>Trauma Informed Care</p>	<p>Plan of Care:</p> <p>Patient problem: Schizophrenia</p> <p>Related to (etiology): dysfunction in perception, inferential thinking, language, memory, & executive function.</p> <p>As evidenced by (signs & symptoms): Hallucinations - Audial, Visual, olfactory, Olfactory, anhedonia, flatness & delirium</p> <p>Outcome/Goal: Short - within 1 week Pt. will recognize signs of anxiety Long - client will not harm self/others</p> <p>Current Treatment & Interventions: 1. Maintain low level of stimuli in environment EX: low light, few people, low noise</p> <p>Rationale: anxiety & with a stimulating environment 2. Observe Pt. behavior & listen.</p> <p>Rationale: TO ensure Pt. & other safety 3. Redirect violent behavior with physical outlets</p> <p>Rationale: Physical exercise is a safe & effective way to relieve tension 4. Have sufficient staff available to show strength to client if necessary</p> <p>Rationale: Shows Pt. control, who has control over situation & provide physical security for staff.</p>
<p>DSM-5 Criteria for your patient's diagnosis:</p> <ul style="list-style-type: none"> • hallucination • disorganized speech • Grossly disorganized • Continuous disturbance > 6 months 	<p>Stage of nurse-patient relationship:</p> <p>Orientation</p> <p>Therapeutic communication techniques appropriate for this patient:</p> <ul style="list-style-type: none"> • Assess for safety • Modulate affect • Assess pain, discomfort, anxiety • hallucination, self harm • HX of trauma/abuse • reassure availability <p>Communication approaches to avoid: harsh, abrupt, or demanding language • Minimizing statements - "I feel" • read to Pt. attempt to analyze/analyze • sarcasm • NO ultimate threats • NO threats • NO ultimatums</p>	
<p>Psychosocial Stressors (Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.)</p> <p>NA</p>		

Student name: **Aina Elizarraraz**