Camryn

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:
Depression

DSM-5 Criteria for your patient's diagnosis:
HAM-D

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

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:
Use silence, use active listening, offer hope, encourage expression of feelings

Stage of nurse-patient relationship:
Orientation Phase

Therapeutic communication techniques appropriate for this patient:
open ended questions, restating/ Paraphrasing, focusing on strengths

Communication approaches to avoid:
False reassurance, advice, judging, minimizing feelings

Plan of Care:

Patient problem: PDD

Related to (etiology): feeling trapped, purposelessness grief, SI

As evidenced by (signs & symptoms): depressed mood that occurs for most of the day, more days than not, for at least 2 years

Outcome/Goal: Client will seek staff when feeling urge to harm self. Collab w/ trusted staff for emergency plan
Client will remain free of harm to self

Current Treatment & Interventions:
1. Safe environment, ~~assess risk fx~~, ~~encourage client to seek staff if SI emerge~~

Rationale: Client safety is priority
2. Assess risk factors

Rationale: ↑ potential for open/ honest discussion
3. Encourage client to seek staff if SI emerges

rationale: discussion of feeling w/ a trusted adult individual may provide assistance before client experiences crisis

DSM-5 Criteria - PDD

- depressed mood for at least 2 years
- while depressed: low energy, feeling of hopelessness, low self esteem
- never been without symptoms for more than 2 mo.
- no history of mania, and criteria for cyclothymic disorder not met
- Symptoms not better explained by another mental disorder, substance or medical condition
- Symptoms cause significant distress or impairment in social, occupational, or other areas of functioning

Student name:

Student Name: Camryn Cowley Unit: _____ Pt. Initials: CH Date: 11/4/25

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, Interventions (Precautions/Contraindications, Etc.)
Escitalo-pram oxalate	[redacted] SSRI	[redacted] anti-depressant	[redacted] 10 PO Daily	(Y) N	N/A	nausea Drowsy or Insomnia Headache	1. Assess mood, anxiety, SI, HI 2. monitor for serotonin syndrome 3. may take 2-4 weeks 4. DO not stop abruptly
Hydroxy-zine	Anti-histamin	MDD anxiety	50mg PO Q6 PRN	(Y) N	N/A	Drowsy Dry mouth Dizzy	1. Assess LOC before giving 2. monitor VS / Mental status 3. Provide oral care for dry mouth 4. Ensure safety - fall risk
Lorazе-pam	Benzo	anti-anxiety	1mg PO QHS	(Y) N	N/A	Drowsy/ sedation Dizzy hypotension	1. Assess LOC/ VS 2. monitor for respiratory depression 3. ensure safety: fall precaution 4. DO not stop abruptly
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name _____ **Today's Date** _____

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.

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3 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

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0 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

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2 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

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1 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

---

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

---

2 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).

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3 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

---

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

---

3 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)

[0] 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

[0] 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

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

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

[2] 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: 18
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 (✓)

[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.

NURSING SHIFT ASSESSMENT

DATE: 11/4/25

SHIFT: ☐ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: _____
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 ☐ Aggressive
☐ Suspicious ☐ Manipulative
☐ Tearful ☐ Complacent
☐ Paranoid ☐ Sexually acting out
☐ Isolative ☑ Cooperative
☐ Preoccupied ☐ Guarded
☐ Demanding ☐ 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
☐ 1 to 1 Observation _____ reason (specify)
☑ Rounds Q2
☐ MD notified _____
☐ PRN Med per order _____

☐ ***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?***	yes	***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?***	yes	***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."***	[redacted]		NO
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."***			NO
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.***			NO

☐ ***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
☐ 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):** harm self			

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

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