Student Name: [illegible] [illegible]

Unit: Oceans

Pt. Initials: [illegible]

Date: _____

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
n/a	Isotonic/ Hypotonic/ Hypertonic	n/a	n/a	n/a

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.)
Fluoxetine	SSRI	MDD	10mg QD PO	Y (N)	n/a	Suicide Ideation	1. Do not take with a MAOI 2. Notify MD if ↑ thoughts of 3. Suicide occur. 4. Do not stop taking abruptly
Hydroxyzine Pamoate	antihistamine anxiolytic sedative	ATTX	50mg QUH PRN	Y (N)	n/a	Prolonged QT	1. Do not use while breastfeeding 2. can cause dry mouth 3. Can cause drowsiness; use caution 4. with heavy machinery
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:

MDD

DSM-5 Criteria for your patient's diagnosis:

- diminished pleasure in most activities
- fatigue most of day
- feelings of worthlessness

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

relationship to parents is a stressor due 2 feeling like a disappointment

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:

> being open + clear with nurse-pt expectations

Stage of nurse-patient relationship:

Introduction Phase

Therapeutic communication techniques appropriate for this patient:

> asking open-ended Q's
> Active listening

Communication approaches to avoid:

> avoid asking "why" Q's
> avoid asking accusatory Q's
> avoid directive statements

Plan of Care:

Patient problem: MDD impaired cognition fostering a negative self view.

Related to (etiology): ADD ~~OCD~~ Pt's outlook perceived from Parents point of view

As evidenced by (signs & symptoms): Pt thinks he is a disappointment + wants to runaway

Outcome/Goal: TO improve Pt's mood + outlook

Current Treatment & Interventions:

1. Medications

Rationale: to manage + control anx + MDD

2. Group Therapy

Rationale: to bring people together + uplift mood.

3. smoke breaks

Rationale: to promote socialization

4. Spending time with client

Rationale: Presence may help improve clients Sense of self-worth

Student name: Alyssa Pagano 12/2/25

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name: Afton Eaton Today's Date: 12/2/25

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.

---

[4] 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

---

[3] 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

---

[0] 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

---

[0] 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

---

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

---

[4] 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).

---

[2] 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

---

[2] 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 patient's understanding and background.)
0 = No loss
1 = Partial or doubtfull loss
2 = Loss of insight

TOTAL ITEMS 1 TO 17: 15
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. 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: 12/2/25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: Hiren
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 Hand tremors
☐ 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*** 7 ***Locations*** back pain

Is pain causing any physical impairment in functioning today ☐ No ☐ If yes explain _____

Nursing Interventions:
☐ Close Obs. q15
☑ Milieu Therapy
☑ V/S ☐ O2 sat.
☐ Ind. Support
☐ Monitor Intake
☐ Tx Team
☐ Reality Orientation
☐ Encourage Disclosure
☐ Wt. Monitoring
☐ Toilet Q2 w/awake
☐ Neuro Checks
☐ Elevate HOB
☐ 1 to 1 Observation _____ reason (specify)
☐ Rounds Q2
☐ MD notified _____
☐ Nursing group/session (list topic): _____
☐ ADLs assist ☐ I&O ☐ 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?	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) Alyssa Yagno Date: 12/2/25 Time: 8:00 am

Oceans Healthcare 9/2018, 12/01/2021, 10/01/2023

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 _____