NURSING SHIFT ASSESSMENT

DATE: 12/2/25

SHIFT: ☑ Day(7A-7P) ☐ Night(7P-7A)

Label
Name: Norton
MR#: _____ D.O.B. 12/2/67
57y/o

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☐ Withdrawn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) Auditory

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
☐ 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) Nicholas Moreno Date: 12/2/25 Time: 8:00 am

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 _____

12/2/25

PMH Critical Thinking Sheet

Nikkita Moreno

DSM-5 Diagnosis and Brief Pathophysiology:

Schizophrenia
- genetic
- alterations in brain biochem

DSM-5 Criteria for your patient's diagnosis:

dysfunction in perception, thinking, memory, executive functions
+ symptoms
- symptoms for months

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

substance use

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:

Validate feelings but do not play into hallucinations

Stage of nurse-patient relationship:

Introduction phase

Therapeutic communication techniques appropriate for this patient:

- Acknowledge feelings
- Assess what pt is hearing
- Avoid arguing w/ Pt

Communication approaches to avoid:

Asking why
encouraging or validating hallucinations

Plan of Care: Safety / ↓ symptoms

Patient problem:

Auditory / visual hallucinations

Related to (etiology):

schizophrenia (drug induced)

As evidenced by (signs & symptoms):

loose associations, visual & auditory hallucinations, Avolition,

Outcome/Goal:

No auditory / visual commands
safety, ↓ risk for violence

Current Treatment & Interventions:

1. Antipsychotic meds (& symptoms)
→ observe for signs of hallucinations
↳ early intervention to prevent aggressive response

Rationale:

2. → • Avoid touching to prevent aggressive response

3.

4. Do not reinforce the hallucination
- So that the pt can realize the hallucinations aren't real

Student name:

12/12/25

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):**			

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

Student Name: Nikkita Moreno Unit: Oceans Pt. Initials: N.M. Date: 12/2/25

Allergies: dairy, beans

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			

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.)
hydroxyzine pamoate	antihistamine	Anxiety	50mg PO q6hr PRN	(Y) N		drowsiness dizzy vision dry mouth constipation headache	1. Monitor sedation/drowsiness 2. Safety precautions 3. Assess therapeutic response (↓ anxiety) 4. Frequent oral care
olanzapine	atypical antipsychotic	severe psychosis	10 mg PO BID	(Y) N		weight gain drowsiness metabolic changes	1. monitor for metabolic changes 2. daily weights 3. monitor therapeutic response 4. Ensure safety
risperidone	typical antipsychotic	severe psychosis	10 mg PO BID	(Y) N		movement disorders heart problems dementia related psychosis	1. caution gNins to elderly 2. monitor for signs of movement disorders 3. monitor vitalsigns for Nms 4. consider giving IV benadryl
				Y N			1. 2. 3. 4.
				Y N			1. 2. 3. 4.

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☐ Low Risk ☐ Moderate Risk ☑ High Risk

Nurse Signature(s) Nikkita Moreno Date: 12/13/25 Time: 0756

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HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name Dolly **Today's Date** 12/13/25

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.

---

[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

---

[1] **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

---

[4] **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

---

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

---

[1] **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

---

[1] **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).

---

[0] **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

---

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

---

[4] **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)

1

11. ANXIETY - SOMATIC

Gastrointestinal, indigestion
Cardiovascular, palpitation, Headaches
Respiratory, Genito-urinary, etc.

0 = Absent
1 = Mild
2 = Moderate
3 = Severe
4 = Incapacitating

0

12. SOMATIC SYMPTOMS - GASTROINTESTINAL

(Loss of appetite , heavy feeling in abdomen; constipation)

0 = Absent
1 = Mild
2 = Severe

1

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

0

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

0

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

0

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.

Coping Skills Education Check-Off Form

Participant Initials: D

Date: 12/3/25 Student name: Nikkita Moreno

Topics Covered

(*Check each item as it is completed or discussed*)

#	Topic	Completed	Comments
1	Deep Breathing	☑	
2	Journaling	☑	
3	Take a shower	☐	
4	Music	☑	
5	Exercise	☐	
6	Draw/color	☑	
7	Count to 10	☐	
8	Dance	☐	
9	Meditate/pray	☑	
10	Watch a funny movie	☑	
11	Read a book	☐	
12	Do a puzzle	☐	
13	Talk to someone	☑	
14	Clean something	☑	

Participant Understanding

Question	Yes	Somewhat	No
Demonstrated understanding of topic	☑	☐	☐
Actively participated in discussion	☑	☐	☐
Asked questions when needed	☑	☐	☐
Expressed confidence in applying what was learned	☑	☐	☐

Educator Notes / Recommendations

_____

_____

_____