Student Name: Zaney Thompson Unit: Oceans-West Pt. Initials: JC Date: 02/11/2026

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.)
Lithium carbonate	mood stabilizer	bipolar disorder	300mg PO BID	(Y) N		• fine tremor • GI upset • lithium toxicity	1. monitor lithium levels 2. monitor sodium + hydration 3. Educate on consistent salt intake 4. watch for toxicity signs
Oxcarbaze-pine	anticon-vulsant/ mood stabilizer	bipolar disorder	300mg PO BID	(Y) N		• dizziness • drowsiness • headache • nausea	1. DO NOT STOP ABRUPTLY 2. assess for CNS depression 3. Fall precautions 4. monitor sodium levels
Clonazepam	benzodiaz-epine	anxiety/ agitation	0.5mg PO BID PRN: anxiety	(Y) N		• sedation • respiratory depression • dizziness • confusion • dependence	1. monitor LOC + respirations 2. fall precautions 3. avoid alcohol/CNS depressants 4. risk for dependence - short-term use
Olanzapine	atypical antipsychotic	psychosis, mania, hallucinations	10 mg PO @ bedtime -manial/ hallucinations	(Y) N		• weight gain • sedation • metabolic syndrome • hyperglycemia • orthostatic hypotension	1. monitor weight, glucose, lipids 2. assess for EPS symptoms 3. Monitor BP (orthostatic hypotension) 4. encourage healthy diet/exercise
hydroxyzine Pamoate	antihistamine/ anxiolytic	anxiety, itching, sedation	50mg PO Q6 PRN: anxiety	(Y) N		• sedation • dry mouth • dizziness • anticholinergic effects	1. monitor sedation level 2. fall precautions 3. Avoid other CNS depressants 4. encourage fluids for dry mouth

PMH Critical Thinking Sheet

DSM-5 Diagnosis and Brief Pathophysiology:

MDD

-is described as a disturbance of mood involving depression or loss of interest or pleasure in usual activities or pastimes.

DSM-5 Criteria for your patient's diagnosis:

-Major Depressive Episode

A1, A2, A3, A6, A9

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

- abusive marriage
- 3 kids, one being 1yrs. old
- 911 dispatcher → difficult on mental health
  ↳ biggest stressor.

Therapeutic Communication & Nurse Patient Relationship:

Communication strategy:

-Use a CALM, DIRECT, SUPPORTIVE, and NON-JUDGEMENTAL approach focused on safety.

- ask direct questions, maintain therapeutic/empathetic tone, use active listening, and provide reassurance + safety.

Stage of nurse-patient relationship:

Working phase

Therapeutic communication techniques appropriate for this patient:

- Active Listening → reflect feelings and validate emotions
- Open-ended Questions → to encourage expressions
- Direct suicide assessment → don't avoid the topic.

Communication approaches to avoid:

- DO NOT minimize feelings
- DO NOT give false reassurance or promises
- AVOID judgemental language
- AVOID "why" questions
- AVOID sudden, loud, or harsh communication.

Plan of Care:

Patient problem:

- Risk for suicide

Related to (etiology):

-depressed mood, feeling trapped, has a plan and means to carry it out.

As evidenced by (signs & symptoms):

N/A

Outcome/Goal:

-client will engage in his or hers established plan to maintain personal safety.

Current Treatment & Interventions:

1. Create a safe environment for the patient. Removing all potentially harmful objects from the patient's access.

Rationale: client safety is a nursing priority.

2. Encourage the client to seek out a staff member or support person if thoughts of suicide emerge or become more intense.

Rationale: discussion of feelings w/ a trusted individual may provide assistance before the client experiences a crisis situation.

3. Maintain close observation of the client.

Rationale: necessary to ensure that client does not harm self in any way.

4. Encourage verbalization of honest feelings.

Rationale:

help the client process through thoughts and think rationally.

Student name:

NURSING SHIFT ASSESSMENT

DATE: 02/11/2026

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
☐ 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** 4/10 **Locations** back pain
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
☐ V/S ☐ O2 sat. ☑ Tx Team ☑ Wt. Monitoring ☐ Elevate HOB ☐ MD notified _____
☑ Nursing group/session (list topic): Cognitive behavioral therapy: intrusive mougnts | irrational mougnts
☐ 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 Signature(s) _____ Date: 02/11/2026 Time: 0930

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
☐ Bedded 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 _____

HAMILTON DEPRESSION RATING SCALE (HAM-D)

(To be administered by a health care professional)

Patient Name Jessica C. **Today's Date** 02/11/2026

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

[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

[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

[2]

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

[0]

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)

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

2 **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

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

2 **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: 26
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

2 **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

1 **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.