

NURSING SHIFT ASSESSMENT

DATE: 2-17-26

SHIFT: Day(7A-7P)

Night(7P-7A)



Label	
Name: _____	
MR#: _____	D.O.B: _____

- | | | | | | |
|--|---|--|--|---|---|
| Orientation | Affect | ADL | Motor Activity | Mood | Behavior |
| <input type="checkbox"/> Person | <input checked="" type="checkbox"/> Appropriate | <input type="checkbox"/> Independent | <input type="checkbox"/> Normal | <input type="checkbox"/> Irritable | <input type="checkbox"/> Withdrawn |
| <input type="checkbox"/> Place | <input type="checkbox"/> Inappropriate | <input checked="" type="checkbox"/> Assist | <input type="checkbox"/> Psychomotor retardation | <input checked="" type="checkbox"/> Depressed | <input type="checkbox"/> Suspicious |
| <input checked="" type="checkbox"/> Time | <input type="checkbox"/> Flat | <input type="checkbox"/> Partial Assist | <input type="checkbox"/> Psychomotor agitation | <input type="checkbox"/> Anxious | <input type="checkbox"/> Tearful |
| <input type="checkbox"/> Situation | <input type="checkbox"/> Guarded | <input type="checkbox"/> Total Assist | <input type="checkbox"/> Posturing | <input type="checkbox"/> Dysphoric | <input type="checkbox"/> Paranoid |
| | <input type="checkbox"/> Improved | | <input type="checkbox"/> Repetitive acts | <input type="checkbox"/> Agitated | <input type="checkbox"/> Isolative |
| | <input type="checkbox"/> Blunted | | <input type="checkbox"/> Pacing | <input type="checkbox"/> Labile | <input type="checkbox"/> Preoccupied |
| | | | | <input type="checkbox"/> Euphoric | <input type="checkbox"/> Demanding |
| | | | | | <input type="checkbox"/> Aggressive |
| | | | | | <input type="checkbox"/> Manipulative |
| | | | | | <input type="checkbox"/> Complacent |
| | | | | | <input type="checkbox"/> Sexually acting out |
| | | | | | <input checked="" type="checkbox"/> Cooperative |
| | | | | | <input type="checkbox"/> Guarded |
| | | | | | <input type="checkbox"/> Intrusive |

REVIEW OF SYSTEMS

Cardio/Pulmonary:
 OWNL 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 Gen Chair
 Ensure assistive devices near
 Other: _____

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 2 Locations Back Pain
 Is pain causing any physical impairment in functioning today No If yes explain _____

Nursing Interventions:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Close Obs. q15 | <input type="checkbox"/> Ind. Support | <input type="checkbox"/> Reality Orientation | <input type="checkbox"/> Toilet Q2 w/awake | <input type="checkbox"/> 1 to 1 Observation _____ reason (specify) |
| <input type="checkbox"/> Milieu Therapy | <input type="checkbox"/> Monitor Intake | <input type="checkbox"/> Encourage Disclosure | <input type="checkbox"/> Neuro Checks | <input type="checkbox"/> Rounds Q2 |
| <input type="checkbox"/> V/S <input type="checkbox"/> O2 sat. | <input type="checkbox"/> Tx Team | <input type="checkbox"/> Wt. Monitoring | <input type="checkbox"/> Elevate HOB | <input type="checkbox"/> MD notified _____ |
| <input type="checkbox"/> Nursing group/session (list topic): _____ | | | | |
| <input type="checkbox"/> ADLs assist | <input type="checkbox"/> I&O | <input type="checkbox"/> PRN Med per order _____ | | |

<input type="checkbox"/> 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) <u>Have you actually had thoughts about killing yourself?</u>		LOW	<input checked="" type="checkbox"/>
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6			
3) <u>Have you been thinking about how you might do this?</u>		MOD	<input checked="" type="checkbox"/>
4) <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."			<input checked="" type="checkbox"/>
5) <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."			<input checked="" type="checkbox"/>
6) <u>Have you done anything, started to do anything, or prepared to do anything to end your life?</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.			<input checked="" type="checkbox"/>

Low Risk Moderate Risk High Risk

Nurse Signatures) _____ Date: _____ Time: _____