

Psychiatric Nursing 2025

Meditech Orientation

Directions: Please review the following screenshots of different interventions that can be found in a client's chart on 1 South. Answer the questions for the Meditech Orientation and submit them in the corresponding dropdown by **5/28/2025 at 0800**.

If at any time you are unable to log into a computer or are having issues with Meditech, please call IS at ext. 7467.

Intervention List-

Filter	Include: Int, Out; Look Ahead: 8 H	Care Item	Last Done	Status/Due	NOW
A	1:1 Interactions	Q15M			
Io	Activity as ordered	ORDER			
A	ADM 01 - Vitals, Height & Weight	.on Admis...			
A	ADM 02 - Physical Assessment	.on Admis...			
A	ADM 03 - Risk/Screening Assessment	.on Admis...			
A	ADM 04 - General Questions	.on Admis...			
A	ADM 05 - Medication/Pharmacy Review	.on Admis...			
A	ADM 07 - Past Medical History	.on Admis...			
A	ADM 08 - Discharge Planning Assessment	.on Admis...			
A	ADM 09 - Psychiatric Assessment	.on Admis...			
A	ADM 12 - Infectious Disease/COVID Assess	NOW			
Ao	Admit to Psychiatry Unit	.prn			
Ao	Admit to Psychiatry Unit	.prn			
A	Behavior and Activity Assessment	09,15,21			
A	BHIT Group Note				
A	Care Plan Initiated/Acknowledged	.on Admis...			
A	Care Plan Reviewed/Updated	0600,1800			
A	CM - Discharge Planning Assessment	.on Disch...			
A	CM - IP BH Initial Discharge Assessment	.on admis...			
A	Discharge Assessment	.Discharge			
Io	Elevate head of bed	ONGOING			
A	Feeding Method	08,12,17			
A	Hygiene activity	1700			
A	Pain Assessment	09,21			
A	Physical Re-Assessment	0900			
Ao	Psychiatric Legal Status	AS NEEDED			
Ao	Psychiatric Legal Status	AS NEEDED			
A	Psychiatric Treatment Plan	.PRN			
A	RN Review	06,18			
A	Safety and Falls Assessment	TID			
A	Skin and DVT/VTE/PE Risk Assessments	0900			
A	Teaching Record & Core Measure Education	Q12H			
Ao	Vital Signs	3XD			
A	Weigh Patient	Mo@0900			

Intervention: 1:1 Interactions- This intervention is completed q15 mins. This is not an intervention you will be documenting on, just be aware of the intervention and its purpose.

Interventions		Thu Apr 4 07:05 by CB
1:1 Interactions Q15M		✓
Assessments		✓
1:1 Interaction		
Patient Interaction		
1:1 Interaction	<input type="checkbox"/> Level of Orientation <input type="checkbox"/> Give Simple/Clear Explanations of Interactions <input type="checkbox"/> Redirection <input type="checkbox"/> Reality Orientation <input type="checkbox"/> Assistance with ADLs <input type="checkbox"/> Identifies Coping Skills <input type="checkbox"/> Utilizes Coping Skills	<input type="checkbox"/> Positive Peer Interaction <input type="checkbox"/> Identifies Triggers/Stressors <input type="checkbox"/> Identifies Two Medications and the Need to Take Them <input type="checkbox"/> Free From Homicidal Ideation <input type="checkbox"/> Free From Suicidal Ideation <input type="checkbox"/> Able to Verbalize Thoughts/Feelings <input type="checkbox"/> Developed Relapse Prevention Plan
1:1 Conversation		<input type="checkbox"/> Verbalizes Two Community Resources <input type="checkbox"/> Demonstrates Ability to Stay on Task <input type="checkbox"/> No Episodes of Self Harm <input type="checkbox"/> Demonstrates Impulse Control <input type="checkbox"/> No Episodes of Anger/Aggression <input type="checkbox"/> Improved Socialization

This is a paper document that nurses on 1 South complete. It is completed 4x/hour and is to be completed within 20 minutes of the last documented time. It is unrealistic that the nurse can physically see and document on every one of their clients q15 minutes, that is why this sheet was implemented to help the nurses correctly document times in Meditech.

You are able to help the nurses complete this form if asked to while on clinical. With that being said, safety is a **PRIORITY**, you are to **NEVER** go to any client's room by yourself.



FIRELANDSHEALTH
Firelands Regional Medical Center



* S A F E R O N *

PATIENT LABEL

Patient Safety Monitor Record

Date: _____

MONITORING LEVEL		<input type="checkbox"/> 4 checks/1 hour, no more than 20 min. apart <input type="checkbox"/> Line of sight <input type="checkbox"/> 1:1			
LOCATION CODES		BEHAVIOR CODES			
A = Pt Room	G = Green Room	1 = Sleeping	6 = Interacting with visitors	11 = Watching TV	16 = Quiet
B = Bathroom	H = Hallway	2 = Walking	7 = Talking on phone	12 = Reading	17 = Yelling
C = Courtyard	I = MPF	3 = Pacing	8 = Interacting with peers	13 = In bed	18 = Combative
D = Day Room	J = Shower Room	4 = Sitting	9 = Interacting with staff	14 = In group	19 = Showering
E = Rec Therapy	K = Intake	5 = Eating	10 = Physical activity	15 = Court	20 = Using Toilet
F = Off Unit	L = Laundry				

Time	Location/ Behavior Code	Staff Initials									
0600-0630			0600-0700			1200-1300			1800-1900		
0630-0700			0700-0800			1300-1400			1900-2000		
0700-0800			0800-0900			1400-1500			2000-2100		
0800-0900			0900-1000			1500-1600			2100-2200		
0900-1000			1000-1100			1600-1700			2200-2300		
1000-1100			1100-1200			1700-1800			2300-2400		

Staff Name/Title	Initials	Staff Name/Title	Initials
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Intervention- BHIT Group Note: This is the **ONLY** intervention that you will document on the day that you are in charge of running a Nursing Therapy Group. You will document on every client, regardless of if they participated or not. You will sit with your clinical faculty, go into each client's chart and document this intervention.

Interventions		Thu Apr 4 06:58 by CB	
BHIT Group Note			
Assessments			
Group Note			
Type of Group	<input type="checkbox"/> Community <input type="checkbox"/> Spirituality <input type="checkbox"/> Medication Education <input type="checkbox"/> Coping Skills <input type="checkbox"/> Relaxation <input type="checkbox"/> Nursing Education <input type="checkbox"/> Problem Solving <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Relapse Prevention <input type="checkbox"/> Leisure <input type="checkbox"/> Patio <input type="checkbox"/> Nursing Activity <input type="checkbox"/> Goals/Goals Wrap Up <input type="checkbox"/> Mental Health <input type="checkbox"/> Therapeutic Rec <input type="checkbox"/> Anger Management <input type="checkbox"/> Exercise/ ROM <input type="checkbox"/> Other <input type="checkbox"/> Self-Awareness	If other, see comment below	
Type of Group Comment			
Name of Group			
Participation Level	<input type="checkbox"/> Did Not Attend <input type="checkbox"/> Attempts to Monopolize <input type="checkbox"/> Left Group <input type="checkbox"/> Passive <input type="checkbox"/> Invited but did not attend <input type="checkbox"/> Disruptive <input type="checkbox"/> Active <input type="checkbox"/> Cooperative <input type="checkbox"/> Minimal <input type="checkbox"/> None <input type="checkbox"/> Other- See Comment <input type="checkbox"/> Accepts Structure		
Affect Description	<input type="checkbox"/> Calm <input type="checkbox"/> Full Range <input type="checkbox"/> Appropriate to Situation/Subject <input type="checkbox"/> Inappropriate to Situation/Subject <input type="checkbox"/> Hostile <input type="checkbox"/> Blunted <input type="checkbox"/> Flat <input type="checkbox"/> Sad/Depressed <input type="checkbox"/> Delusional <input type="checkbox"/> Suspicious/Paranoia <input type="checkbox"/> Anxious/Nervous <input type="checkbox"/> Relaxed <input type="checkbox"/> Cheerful/Glad/Happy <input type="checkbox"/> Tearful <input type="checkbox"/> Angry/Mad <input type="checkbox"/> Fearful/Scared <input type="checkbox"/> Constricted	<input type="checkbox"/> Labile <input type="checkbox"/> Other (Comment Below)	
Cognitive Cognitive Comment	<input type="checkbox"/> Alert <input type="checkbox"/> Appropriate <input type="checkbox"/> Confused <input type="checkbox"/> Good Problem Solving <input type="checkbox"/> Hallucinating <input type="checkbox"/> Oriented x3 <input type="checkbox"/> Short Attention <input type="checkbox"/> Other		
Mode of Intervention	<input type="checkbox"/> Activity <input type="checkbox"/> Education <input type="checkbox"/> Video <input type="checkbox"/> Reality Testing <input type="checkbox"/> Discussion <input type="checkbox"/> Handout		
Reported Sleep	<input type="checkbox"/> N/A <input type="checkbox"/> Difficulty Falling Asleep <input type="checkbox"/> Difficulty Staying Asleep <input type="checkbox"/> Hypersomnia <input type="checkbox"/> Improved <input type="checkbox"/> Normal <input type="checkbox"/> Other (comment below)		
Reported Appetite	<input type="checkbox"/> N/A <input type="checkbox"/> Above Normal <input type="checkbox"/> Improved <input type="checkbox"/> Minimal <input type="checkbox"/> No Appetite <input type="checkbox"/> Normal		
Group Note Summary	<input type="checkbox"/> Other:		

Intervention- Behavior and Activity Assessment: This is not an intervention you will be documenting on. This intervention has specific assessment findings related to mental status and the client's activity.

Interventions		Thu Apr 4 06:58 by CB	
Behavior and Activity A...			
Assessments			
Mental Status Exam			
Level of Alertness	<input type="checkbox"/> Alert <input type="checkbox"/> Active <input type="checkbox"/> Drowsy <input type="checkbox"/> Patient Asleep		
Comprehension Ability	<input type="checkbox"/> Able to Comprehend <input type="checkbox"/> Unable to Comprehend		
Attention Span Ability	<input type="checkbox"/> Capable of Focused Attention <input type="checkbox"/> Capable of Sustained Attention <input type="checkbox"/> Unable to Focus <input type="checkbox"/> Unable to Sustain Attention		
Ability to Follow Directions	<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		
Memory Description	<input type="checkbox"/> Intact <input type="checkbox"/> Recent Intact <input type="checkbox"/> Remote Intact <input type="checkbox"/> Recent Impaired <input type="checkbox"/> Remote Impaired		
Patient Appearance	<input type="checkbox"/> Appropriate <input type="checkbox"/> Well groomed <input type="checkbox"/> Personal hygiene issues <input type="checkbox"/> Disheveled <input type="checkbox"/> Inappropriate		
Mood Description	<input type="checkbox"/> Appropriate to situation <input type="checkbox"/> Inappropriate to situation <input type="checkbox"/> Angry <input type="checkbox"/> Blunted <input type="checkbox"/> Cheerful <input type="checkbox"/> Depressed <input type="checkbox"/> Flat <input type="checkbox"/> Fearful <input type="checkbox"/> Labile <input type="checkbox"/> Tearful <input type="checkbox"/> Appropriate to situation <input type="checkbox"/> Inappropriate to situation <input type="checkbox"/> Angry <input type="checkbox"/> Blunted <input type="checkbox"/> Cheerful <input type="checkbox"/> Depressed <input type="checkbox"/> Flat <input type="checkbox"/> Fearful <input type="checkbox"/> Labile <input type="checkbox"/> Tearful <input type="checkbox"/> Inappropriate to situation <input type="checkbox"/> Anxious <input type="checkbox"/> Calm <input type="checkbox"/> Depressed <input type="checkbox"/> Flat <input type="checkbox"/> Sad <input type="checkbox"/> Withdrawn		
Behavior/Activity	<input type="checkbox"/> Cooperative <input type="checkbox"/> Agitated <input type="checkbox"/> Aggressive Physically <input type="checkbox"/> Aggressive Verbally <input type="checkbox"/> Quiet <input type="checkbox"/> Restless <input type="checkbox"/> Uncooperative		
Speech, Tone, Pace	<input type="checkbox"/> Clear <input type="checkbox"/> Aphasic <input type="checkbox"/> Garbled <input type="checkbox"/> Hypervocal <input type="checkbox"/> Mumbling <input type="checkbox"/> Rambling <input type="checkbox"/> Slow <input type="checkbox"/> Slurred <input type="checkbox"/> Stuttering <input type="checkbox"/> Yelling		
Voice Loudness	<input type="checkbox"/> Normal <input type="checkbox"/> Loud <input type="checkbox"/> Monotone <input type="checkbox"/> Quiet		
Thought Content	<input type="checkbox"/> Intact <input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Disoriented <input type="checkbox"/> Racing <input type="checkbox"/> Poverty of Content <input type="checkbox"/> Preoccupation <input type="checkbox"/> Other (Describe) <input type="checkbox"/> Circumstantial <input type="checkbox"/> Goal Oriented <input type="checkbox"/> Linear <input type="checkbox"/> Perseveration <input type="checkbox"/> Slowed Thinking <input type="checkbox"/> Fragmented <input type="checkbox"/> Loose Associations <input type="checkbox"/> Thought Blocking <input type="checkbox"/> Incoherent <input type="checkbox"/> Logical <input type="checkbox"/> Hypochondriasis <input type="checkbox"/> Jumps Topics <input type="checkbox"/> Tangential <input type="checkbox"/> Disorganized <input type="checkbox"/> Evasive <input type="checkbox"/> Concrete <input type="checkbox"/> Obsessive <input type="checkbox"/> Abstract		
Hallucinations	<input type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Command <input type="checkbox"/> Gustatory <input type="checkbox"/> Olfactory <input type="checkbox"/> Tactile <input type="checkbox"/> Visual <input type="checkbox"/> Other (Describe)		
Delusions	<input type="checkbox"/> None <input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Bizarre <input type="checkbox"/> Persecution <input type="checkbox"/> Depersonalization <input type="checkbox"/> Other (Describe) <input type="checkbox"/> Paranoid Ideation <input type="checkbox"/> Grandiose <input type="checkbox"/> Somatic <input type="checkbox"/> Sexual <input type="checkbox"/> Religious Ideations		
Comments			
Activity Assessment			
Patient Activity	<input type="checkbox"/> Resting in Bed-Awake <input type="checkbox"/> Playing Pool <input type="checkbox"/> Walking Around Unit <input type="checkbox"/> Group <input type="checkbox"/> Out for Meals Only <input type="checkbox"/> Resting in Bed-Eyes Closed <input type="checkbox"/> Visiting Family <input type="checkbox"/> Pacing <input type="checkbox"/> 1:1 With Staff/Therapy <input type="checkbox"/> Withdrawn <input type="checkbox"/> Reading <input type="checkbox"/> Visiting Friends <input type="checkbox"/> Coloring <input type="checkbox"/> In Bed Agitated/Restless <input type="checkbox"/> Interacting with Peers <input type="checkbox"/> Watching TV <input type="checkbox"/> Playing Cards/Boardgame <input type="checkbox"/> Up in Chair <input type="checkbox"/> Isolation in Room <input type="checkbox"/> Other, Specify Below		
Other Patient Activity			

Intervention- Psychiatric Treatment Plan: This is not an intervention you will be documenting in. You need to be aware of the different assessment data and how it effects the client's plan of care.

Thu Apr 4
09:40
by CB

Assessments

▼ Treatment Plan

Psychiatric

▼ Type of Treatment Plan

Multidisciplinary Treatment Care Plan

Initial - Admit Initial - Treatment Team 72 Hour Weekly

Other:

▼ Patient Data

Psychiatric Diagnosis

Adjustment Disorder Bipolar Major depressive disorder Mood disorder PTSD Schizophrenia

Anxiety / Panic Dementia with behaviors Medical conditions Psychosis Schizoaffective disorder Substance abuse

Other Psychiatric diagnosis

As evidenced by

Anxiety Guarded Medication non compliance Restlessness

Auditory Hallucinations Helplessness No or low energy SI plan

Change in appetite High risk sexual behavior Olfactory Hallucinations SI thoughts

Command hallucinations Hopelessness Overwhelmed Sleep disturbances

Crying Inability to follow directions Paranoia Suicide attempt

Delusional thoughts Increased depression Physical or verbal thoughts to harm others Suspicious

Euphoria Impulsivity Poor ADL's Tactile Hallucinations

Excessive spending Intrusive Poor concentration Thought blocking

Fear Irritability Pressured speech Visual Hallucinations

Feeling persecuted Isolative Property destruction Worthlessness

Flight of ideas Lack of interest Racing thoughts Worry

Other behaviors or actions

Substance Abuse

Alcohol Amphetamines Barbiturates Benzodiazepines Cocaine Marijuana Opiate Tobacco

Medical Condition

Cardiac Diabetes Gastrointestinal Mobility / Fall risk Nutritional deficit Respiratory Vascular

Chronic Pain Dialysis Kidney Neurology Pregnancy Skin integrity / wound

Trauma history (AD) Combat Criminal history Denies Domestic violence Emotional Natural disaster Physical Sexual Trauma

Other conditions or history

Functional strength

Able to communicate Adequate finances Insight into illness Motivated Stable housing

Able to make decisions Established community resources Manages health care Seeking help Support system intact

Able to meet basic needs Goal oriented Medication compliant Spiritual beliefs Willing to participate in treatment

Barriers to treatment

Difficulty communicating Increased confusion / cognitive deficits Physical limitations Poor judgement Unable to meet basic needs

Financial difficulties Needs 24hr care Placement issues Poor support system

Homeless Non compliance Poor insight Transportation

Other barriers to treatment

Patient stated goal

▼ Treatment Plan

Review

Treatment team update

Psychiatric treatment plan reviewed with patient? Yes No Comment:

Patient agrees with treatment plan? Yes No Comment:

▼ Discharge Planning

Discharge criteria

Consistent mood stabilization Decreased or no delusions Decreased or no paranoia Free from thoughts of harm to others

Decreased agitation Decreased or no hallucinations Free from thoughts of SI / self harm Reduction of target symptoms

CM (AD) Group home Home health Outpatient therapy PCP appointment Skilled nursing facility

discharge planning Home Homeless shelter Partial hospitalization program Police hold Substance use treatment / rehab

Additional discharge planning information

Case manager responsible party: