



Daily Nurse Progress Note

Date: 8/2/2025
Room #: 238B

CLOSED JK
DOB: 238B ADMIT:
MR#: 238B A#:
PROGRAM: GENDER:

Medical Necessity/Reason For Admission: Psychiatric Problems

Active Medical Problems

2300-0700 Sleep / Behaviors Note

Hours of Sleep:

Restful Restless Frequent Waking Report Nightmares/Bad Dreams Enuresis Snoring Other:
Ordered: CPAP/BIPAP Wedge Other: N/A

Used ordered intervention(s)
Refused ordered intervention(s) N/A

Comments:

Nurse Signature:

Date: 8/20/25 Time: 2:18

0700-1900

1900-0700

Table with columns for ADLs, Orientation, Behavior / Events, and various clinical categories like Affect, Mood, Speech, Thought Process, etc.

Review of previous CSSRS screen nurse Initials: 0700-1900

CSSRS

Review of previous CSSRS screen nurse Initials: 1900-0700

Table with 6 rows of CSSRS questions regarding suicidal thoughts and intentions, with checkboxes for No/Yes.

S: If screens YES, initiate suicide precautions, contact physician, & perform CSSRS Assessment. If screen is positive and/or higher than previous screen, call physician.

Physician Name:

Time:



Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

- In the past few weeks, have you wished you were dead? Yes No
- In the past few weeks, have you felt that you or your family would be better off if you were dead? Yes No
- In the past week, have you been having thoughts about killing yourself? Yes No
- Have you ever tried to kill yourself? Yes No

If yes, how? _____

When? _____

If the patient answers **Yes** to any of the above, ask the following acuity question:

- Are you having thoughts of killing yourself right now? Yes No

If yes, please describe: _____

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a **positive screen**. Ask question #5 to assess acuity:
 - "Yes" to question #5 = **acute positive screen** (imminent risk identified)
 - Patient requires a **STAT** safety/full mental health evaluation. **Patient cannot leave until evaluated for safety.**
 - Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.
 - "No" to question #5 = **non-acute positive screen** (potential risk identified)
 - Patient requires a **brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
 - Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741

