

XXX Hospital

Address

**ANNUAL NURSING ASSESSMENT: Adult Mental Health & Forensics
(Computer Version)**

The individual's Identification _____

SOURCES OF INFORMATION

Interpreter present: N/A Yes No (*explain*):

Interview with the following (mark only those which apply):

- Individual
- Family member(s) (specify name and relationship to individual):
- Friends (specify name and relationship to individual):
- Other persons (specify name and relationship to individual):

Review of records (specify, if applicable):

Other sources (specify, if applicable):

VITAL SIGNS AND OTHER MEASUREMENTS

Height: feet inches Weight: pounds Waist Circumference: inches

Temperature: °F Pulse: Respiratory Rate: Blood Pressure:

Unable to assess (*explain reason*):

Comments:

BOWEL MANAGEMENT

Bowel Management Problems? None Unable to assess (*explain reason*):

- Prune/Other juice Bran Daily Laxative Laxative PRN Enemas Suppositories Other:

Date of last bowel movement: or Unknown

Comments:

PERSONAL SAFETY INTERVIEW

Personal Safety Interview form completed at time of annual assessment? Yes No (*explain why not*):

If not done at time of annual assessment, to whom has this responsibility been referred?

NURSING SKIN ASSESSMENT

No abnormalities or alteration in skin integrity observed.

Unable to assess skin integrity (*explain reason*):

Alteration in skin integrity observed (*Mark all that apply. Indicate location(s) of each observation. Describe any positive findings in the section below*).

- | | |
|--|---|
| <input type="checkbox"/> abrasions: | <input type="checkbox"/> burns: |
| <input type="checkbox"/> cuts/lacerations: | <input type="checkbox"/> staples/sutures: |
| <input type="checkbox"/> bruises: | <input type="checkbox"/> track marks: |
| <input type="checkbox"/> open wounds: | <input type="checkbox"/> birthmarks: |
| <input type="checkbox"/> pressure ulcers: | <input type="checkbox"/> moles: |
| <input type="checkbox"/> discolorations: | <input type="checkbox"/> tattoos: |
| <input type="checkbox"/> rash: | <input type="checkbox"/> body piercings: |
| <input type="checkbox"/> lesions: | <input type="checkbox"/> scars: |
| <input type="checkbox"/> redness: | <input type="checkbox"/> other (describe) : |

Describe findings:

NURSING TRIGGER FOR PAIN ASSESSMENT – ACUTE AND CHRONIC

Acute:







- Are you currently in pain? **OR** Does the individual appear to be in pain? Yes No
If yes, go to next bullet; if no, acute pain assessment trigger is complete.
- Where is your pain? **OR** Where does it appear the individual is in pain?
- How bad is your pain? **OR** What level of pain intensity does the individual appear to have?
Mark response on pain intensity scale below in the appropriate box and complete full pain assessment:

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0 NO HURT	2 HURTS LITTLE BIT	4 HURTS LITTLE MORE	6 HURTS EVEN MORE	8 HURTS WHOLE LOT	10 HURTS WORST
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comprehensive Pain Assessment document completed: N/A Yes No (explain reason):

Chronic:

Does individual have chronic pain? Unable to assess (explain reason):

No Yes – If yes, complete the following:

Source of chronic pain:

Manner of expressing pain:

Pain normally increased by:

Pain normally relieved by:

Observable signs and symptoms/behaviors indicative of pain:

Other comments:

Describe findings:

ACHIEVEMENT/FUNCTIONAL STATUS

Activities of Daily Living (ADL's) and Mobility:

Independent with all ADL's and areas of mobility Unable to assess ADL's and Mobility (explain reason):

Needs assistance with the following ADL's or areas of mobility (mark all that apply below):

<input type="checkbox"/> Bathing/showering	<input type="checkbox"/> Sitting	<input type="checkbox"/> Choosing appropriate clothes
<input type="checkbox"/> Toileting (bladder &/or bowel)	<input type="checkbox"/> Standing	<input type="checkbox"/> Dressing/Undressing
<input type="checkbox"/> Brushing teeth/Oral hygiene	<input type="checkbox"/> Walking	<input type="checkbox"/> Care of clothing
<input type="checkbox"/> Grooming/hair care	<input type="checkbox"/> Transferring	<input type="checkbox"/> Bed making
<input type="checkbox"/> Shaving	<input type="checkbox"/> Eating/drinking	<input type="checkbox"/> Other (describe):
<input type="checkbox"/> Bathing	<input type="checkbox"/> Medical treatments	
<input type="checkbox"/> Menstrual care	<input type="checkbox"/> Communicating needs	

Describe findings (include level/type of assistance needed for each ADL and area of mobility marked):

Assistive and Prosthetic Devices Used by Individual (mark all that apply below):

<input type="checkbox"/> none	<input type="checkbox"/> walker	<input type="checkbox"/> glasses	<input type="checkbox"/> dentures, full	<input type="checkbox"/> orthopedic shoes
<input type="checkbox"/> artificial limb	<input type="checkbox"/> wheelchair	<input type="checkbox"/> contact lenses	<input type="checkbox"/> dentures, upper	<input type="checkbox"/> ostomy devices
<input type="checkbox"/> cane	<input type="checkbox"/> pacemaker	<input type="checkbox"/> hearing aid, left	<input type="checkbox"/> dentures, lower	<input type="checkbox"/> urinary catheter
<input type="checkbox"/> crutches	<input type="checkbox"/> VNS	<input type="checkbox"/> hearing aid, right	<input type="checkbox"/> dental appliance	<input type="checkbox"/> other (describe below)

Comments:

Unable to assess Assistive and Prosthetic Devices (explain reason):

PHYSICAL AND NUTRITIONAL SUPPORT (PNS) RISK SCREEN: Complete sections A, B, and C annually unless the individual is already determined to be at high risk in that area (in which case the appropriate Evaluation or Risk Assessment will be completed instead). Always complete section D annually. Mark the "Not applicable" box only if completion of a specific section is not presently indicated, and explain reason not indicated. Otherwise, mark Y (Yes), N (No), or U (Unknown) for all risk factors in each section; do not leave any blanks. Use several sources of information,

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including individual and family/significant other report, other hospital staff, and current and past medical records. Mark "Unknown" only if unable to find information from any available source. Make notifications if the individual is determined to be at potential risk, and document as indicated below.

A. Choking and Aspiration Risk <input type="checkbox"/> Not Applicable (<i>explain reason</i>):	
(Any) history of aspiration pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
History of choking incident (within the past five years)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
History of stroke (within the past year only)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Current dysphagia diagnosis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Drooling with difficulty managing secretions	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Edentulous <u>or</u> acute dental issues which may impact chewing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Difficulty swallowing or chewing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Altered level of consciousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Dysphasia/slurred speech	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Currently receives non-oral nutrition, medication, and/or hydration	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
B. Fall Risk <input type="checkbox"/> Not Applicable (<i>explain reason</i>):	
Fall within the past six months	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Altered level of consciousness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Dementia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Seizure disorder with one or more seizures in the past 6 months	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Movement disorder	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Report of dizziness, lightheadedness or lower limb weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Uses assistive device and/or wheelchair for mobility <u>or</u> requires total assistance for mobility and transfer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Incontinence <u>or</u> nocturia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Shuffling or unsteady gait	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Blind <u>or</u> non-corrected visual impairment (e.g., needs glasses but does not wear)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
C. Decubitus Ulcer Risk <input type="checkbox"/> Not Applicable (<i>explain reason</i>):	
Confined to bed	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Requires use of a wheelchair for mobility	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
(Any) history of a pressure ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Observation of reddened areas over bony prominences	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Incontinence	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
D. Nutritional Risk	
Diabetes mellitus (new onset <u>or</u> insulin-requiring) <u>or</u> diabetes insipidus	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Anorexia or bulimia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Current decubitus ulcer or non-healing wound	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Receives dialysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Severe or multiple food allergies (e.g., rash, difficulty breathing)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Unintentional weight loss/gain of 10 pounds or more in the past month	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Receives non-oral nutrition, hydration, and/or medication	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Recent unexplained decrease in food/fluid intake	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Excessive water intake	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Pregnant or lactating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
Hallucinations and/or delusions that impact nutritional status (e.g., thinks food is being poisoned; hears voices saying not to eat)	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

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SUMMARY OF PNS RISK SCREEN FINDINGS: If one or more risk factors within a section is marked "yes", the individual is at *potential* risk for that condition, and further assessments and notifications are required. Based on the above findings, the individual is at potential risk for:

Choking and aspiration? N Y – *Choking and Aspiration Risk Assessment is indicated; immediately notify physician/APRN and Unit Charge Nurse.* N/A (*screen not completed; previously determined to be at high risk*)

Fall? N Y – *Fall Risk Assessment is indicated; immediately notify physician/APRN and Unit Charge Nurse.*

N/A (*screen not completed; previously determined to be at high risk*)

Decubitus Ulcer? N Y – *Decubitus Ulcer Risk Assessment is indicated; immediately notify physician/APRN and Unit Charge Nurse.* N/A (*screen not completed; previously determined to be at high risk*)

Nutritional Problems? N Y – *Nutrition Assessment is indicated; immediately notify physician/APRN, Unit Charge Nurse, and dietitian.*

NOTIFICATIONS REQUIRED? N Y (*If yes, complete the information below*)

_____	_____	_____	
Name/title of Physician/APRN notified	Date	Time	
_____	_____	_____	
Name/title of Unit Charge Nurse notified	Date	Time	
_____	_____	_____	<input type="checkbox"/> Not applicable
Name/title of Dietitian notified (if applicable)	Date	Time	
_____	_____	_____	<input type="checkbox"/> Not applicable
Name/title of other staff notified (if applicable)	Date	Time	

NURSES' SUMMARY OF FINDINGS

No clinically significant findings.
 Clinically significant findings identified (*Include a synthesis of all clinically significant findings and recommended interventions for treatment and recovery planning*):

ASSESSING RN #1	_____	_____	_____
	PRINTED NAME	SIGNATURE WITH PROVIDER NUMBER	DATE AND TIME
ASSESSING RN #2 (if applicable)	_____	_____	_____
	PRINTED NAME	SIGNATURE WITH PROVIDER NUMBER	DATE AND TIME