Georgia Department of Behavioral Health and Developmental Disabilities

XXX Hospital

Address

ANNUAL NURSING ASSESSMENT: Adult Mental Health & Forensics (Paper 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

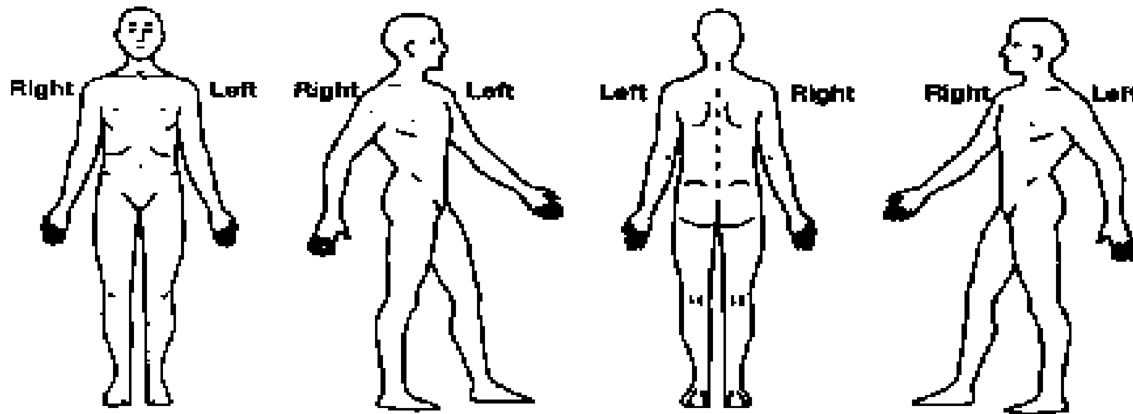
☐ Personal Safety Interview form completed at time of annual assessment? ☐ Yes ☐ No *(explain why not)*:_______________

☐ 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 on the human figures below using the number in parentheses printed after each observation).*

☐ abrasions (1)	☐ birthmarks (2)	☐ body piercings (3)	☐ bruises (4)	☐ burns (5)
☐ cuts/lacerations (6)	☐ discolorations (7)	☐ lesions (8)	☐ moles (9)	☐ open wounds (10)
☐ pressure ulcers (11)	☐ rash (12)	☐ redness (13)	☐ scars (14)	☐ staples/sutures (15)
☐ tattoos (16)	☐ track marks (17)	☐ other (describe) (18)		

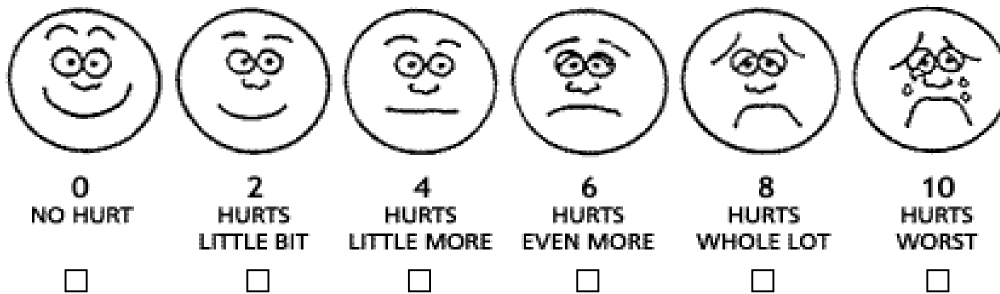


Describe findings:

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:



☐	☐	☐	☐	☐	☐

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)*:

☐ Bathing/showering	☐ Sitting	☐ Choosing appropriate clothes
☐ Toileting (bladder &/or bowel)	☐ Standing	☐ Dressing/Undressing
☐ Brushing teeth/Oral hygiene	☐ Walking	☐ Care of clothing
☐ Grooming/hair care	☐ Transferring	☐ Bed making
☐ Shaving	☐ Eating/drinking	☐ Other (describe):
☐ Bathing	☐ Medical treatments	___
☐ Menstrual care	☐ 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)*:

☐ none	☐ walker	☐ glasses	☐ dentures, full	☐ orthopedic shoes
☐ artificial limb	☐ wheelchair	☐ contact lenses	☐ dentures, upper	☐ ostomy devices
☐ cane	☐ pacemaker	☐ hearing aid, left	☐ dentures, lower	☐ urinary catheter
☐ crutches	☐ VNS	☐ hearing aid, right	☐ dental appliance	☐ 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, 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 ☐ Not Applicable *(explain reason)*: ___

(Any) history of aspiration pneumonia	☐ Y ☐ N ☐ U
History of choking incident (within the past five years)	☐ Y ☐ N ☐ U
History of stroke (within the past year only)	☐ Y ☐ N ☐ U
Current dysphagia diagnosis	☐ Y ☐ N ☐ U
Drooling with difficulty managing secretions	☐ Y ☐ N ☐ U
Edentulous *or* acute dental issues which may impact chewing	☐ Y ☐ N ☐ U
Difficulty swallowing or chewing	☐ Y ☐ N ☐ U

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

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	
Name/title of Dietitian notified (if applicable)	Date	Time	☐ Not applicable
Name/title of other staff notified (if applicable)	Date	Time	☐ Not applicable

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