

Central State Hospital

620 Broad St.
Milledgeville, GA 31062

INITIAL NURSING ASSESSMENT: Adult Mental Health & Forensics

ARRIVAL INFORMATION

Date of arrival: Time of arrival: Service: Adult Mental Health Forensics
Arrived by: Ambulatory Wheelchair Stretcher Ambulance Other:
Legal Status: Voluntary Involuntary Hold Order Superior Court Order Other:
Family and/or significant other(s) accompanying individual upon admission: No Yes

SOURCES OF INFORMATION

Interpreter present: N/A No Yes
Interview with the following (check only those which apply):
Individual Family member(s)
Friends
Other persons
Review of records (specify):
Other sources (if applicable):

CURRENT HOSPITALIZATION

Individual's (or family's/friend's) perception of what led to his/her need for hospitalization:
Individual's chief complaint:

BIOPHYSICAL ASSESSMENT

Instructions: For each of the following sub-sections, complete all applicable fields and describe findings in the designated space(s). Use quotes as appropriate. Indicate any areas unable to assess, and explain rationale (e.g., refusal; unstable mental or physical status). If more space is needed, document in "additional comments" at the end of this section. Notify the physician of all abnormal findings that have recovery planning implications.

A. VITAL SIGNS AND OTHER MEASUREMENTS:

Temperature: F Pulse: Respirations: Blood pressure: /
Orthostatic vital signs (if ordered / if indicated): Not applicable
Lying: Blood pressure / Pulse
Sitting: Blood pressure / Pulse
Standing: Blood pressure / Pulse
Height: feet inches Weight: pounds Waist Circumference: inches

Describe findings:

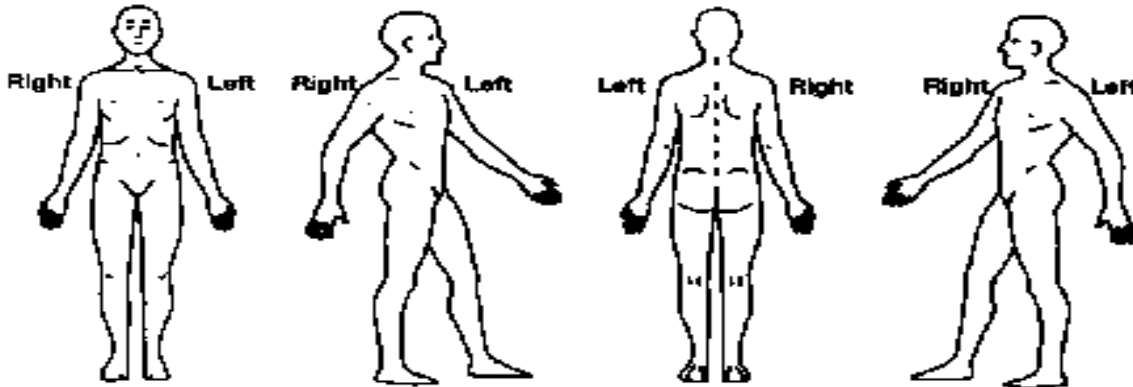
B. **ALLERGIES:** Mark the applicable box for each substance category. List all substances in which the individual has a known allergy, and describe the allergic reaction for each substance.

Substance Category	Presence of Known Allergies		*Specific Substance Name	*Description of Allergic Reaction (signs & symptoms)
Medication	<input type="checkbox"/> Denies/ No known	<input type="checkbox"/> Yes* (list)		
Food	<input type="checkbox"/> Denies/ No known	<input type="checkbox"/> Yes* (list)		
Environmental	<input type="checkbox"/> Denies/ No known	<input type="checkbox"/> Yes* (list)		
Other (e.g., latex, tape)	<input type="checkbox"/> Denies/ No known	<input type="checkbox"/> Yes* (list)		

Describe findings: _____

C. **SKIN OBSERVATIONS - IDENTIFYING MARKS/INJURIES:**

- no abnormalities or alteration in skin integrity observed
 alteration in skin integrity observed (Mark all that applies. Indicate location(s) of each observation on the human figures below using the number in parentheses pre-printed after each observation).
- | | | | | |
|---|---|--|--------------------------------------|---|
| <input type="checkbox"/> abrasions (1) | <input type="checkbox"/> birthmarks (2) | <input type="checkbox"/> body piercings (3) | <input type="checkbox"/> bruises (4) | <input type="checkbox"/> burns (5) |
| <input type="checkbox"/> cuts/lacerations (6) | <input type="checkbox"/> discolorations (7) | <input type="checkbox"/> lesions (8) | <input type="checkbox"/> moles (9) | <input type="checkbox"/> open wounds (10) |
| <input type="checkbox"/> pressure ulcers (11) | <input type="checkbox"/> rash (12) | <input type="checkbox"/> redness (13) | <input type="checkbox"/> scars (14) | <input type="checkbox"/> staples/sutures (15) |
| <input type="checkbox"/> tattoos (16) | <input type="checkbox"/> track marks (17) | <input type="checkbox"/> other (describe) (18) | | |



Describe findings: _____

D. **REVIEW OF SYSTEMS:** For each system listed below, mark the applicable box. Describe all abnormal findings, including observations and complaints or concerns voiced by the individual. Use direct quotes as appropriate. For any area unable to assess (U/A), explain rationale (e.g., refusal; unstable mental or physical status).

System	Presence of Abnormal Findings			*Describe (Chart in designated space below table if additional space needed).
	No	Yes*	U/A*	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Ears/Nose/Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mouth/Oral Health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

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Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine/Metabolic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

• Date of last bowel movement: _____ Unknown

Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive/Sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

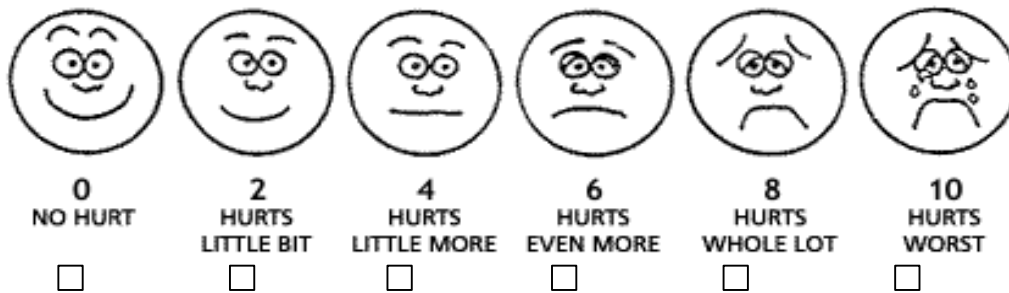
- Are you sexually active? No Yes U/A
- Do you use birth control? No Yes (Describe) _____ U/A
- Have you ever been tested for HIV? No Yes (date & results) _____ U/A
- (Females Only):** Not applicable
- Date of last menstrual period: _____ Unknown
- Are you or do you think you might be pregnant? No Yes Unknown

***Additional findings from Review of Systems:**

E. TRIGGER FOR PAIN ASSESSMENT – ACUTE AND CHRONIC:

Acute:

- Are you currently in pain? **OR** Does the individual appear to be in pain? Yes No / Denies
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:



Chronic:

- Does individual have chronic pain? No / Denies 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: _____

F. RESTORATIVE:

- no problems noted difficulty with sleep frequent naps sleep apnea sleeping aids
 other (describe)

Describe findings (include factors that affect individual's sleep pattern): _____

G. ACHIEVEMENT / FUNCTIONAL STATUS:

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

- Independent with all ADL's and areas of mobility Needs assistance with the following ADL's or areas of mobility:
- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Bathing/showering | <input type="checkbox"/> Bed making | <input type="checkbox"/> Brushing teeth/
Oral hygiene | <input type="checkbox"/> Care of clothing | <input type="checkbox"/> Choosing
appropriate clothes |
| <input type="checkbox"/> Communicating
needs | <input type="checkbox"/> Dressing/
Undressing | <input type="checkbox"/> Eating/drinking | <input type="checkbox"/> Grooming/hair
care | <input type="checkbox"/> Hygiene |
| <input type="checkbox"/> Medical treatments | <input type="checkbox"/> Menstrual care | <input type="checkbox"/> Shaving | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing |
| <input type="checkbox"/> Toileting
(bladder &/or bowel) | <input type="checkbox"/> Transferring | <input type="checkbox"/> Walking | <input type="checkbox"/> Other (describe) | |

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

Assistive and Prosthetic Devices:

- | | | | | |
|---|---|---|------------------------------------|--|
| <input type="checkbox"/> artificial limb | <input type="checkbox"/> cane | <input type="checkbox"/> contact lenses | <input type="checkbox"/> crutches | <input type="checkbox"/> dental appliance |
| <input type="checkbox"/> dentures, full | <input type="checkbox"/> dentures, lower | <input type="checkbox"/> dentures, upper | <input type="checkbox"/> glasses | <input type="checkbox"/> hearing aid, left |
| <input type="checkbox"/> hearing aid, right | <input type="checkbox"/> orthopedic shoes | <input type="checkbox"/> ostomy devices | <input type="checkbox"/> pacemaker | <input type="checkbox"/> urinary catheter |
| <input type="checkbox"/> walker | <input type="checkbox"/> wheelchair | <input type="checkbox"/> other (describe) | | |

Comments: _____

Communication:

- verbal uses gestures to communicate uses sign language to communicate other (describe)
 does not speak, read, or understand English; language spoken _____

Describe findings: _____

H. CURRENT MEDICATIONS:

- Reviewed the hospital's designated Medication Reconciliation document for a list of current medications.

Are you taking your medications as prescribed? Yes No* – complete the following:

*What are some of the challenges you are experiencing with taking your medications?

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*How do you see your medications as supporting you in your recovery?

*What do you think could help you take your medications as prescribed?

BIOPHYSICAL ASSESSMENT ADDITIONAL COMMENTS: *Document additional comments or description of findings from any section of the biophysical assessment as indicated.*

MENTAL STATUS ASSESSMENT

Instructions: For each of the following sub-sections, mark all applicable fields and describe findings in the designated space(s). Use quotes as appropriate. Indicate any areas unable to assess, and explain rationale (e.g., refusal; unstable mental or physical status). If more space is needed, document in "additional comments" at the end of this section. Notify the physician of all abnormal findings that have recovery planning implications.

A. APPEARANCE AND BEHAVIOR:

Appearance/Hygiene: clean, well groomed dressed appropriately dressed inappropriately disheveled
 other (describe)

Attitude/Behavior: cooperative uncooperative demanding other (describe)

Describe findings: _____

B. POSTURE/MOVEMENTS:

Posture: erect rigid, tense slumping other (describe)

Ambulation: normal abnormal (describe)

Movements: normal abnormal (describe)

Describe findings: _____

C. COGNITIVE FUNCTION:

Level of Consciousness: awake/alert sleepy sedated

Oriented to: person place time situation

Describe findings: _____

D. THOUGHT PROCESS AND CONTENT:

homicidal self harm suicidal delusional hallucinations
 disorganized grandiose hopeless obsessive paranoid
 other (describe)

Describe findings: _____

E. AFFECT, SPEECH, AND MOOD:

- Affect:** appropriate happy sad labile flat other (describe)
- Speech:** normal rapid slow slurred other (describe)
- Mood:** pleasant angry irritable depressed other (describe)

Describe findings: _____

MENTAL STATUS ASSESSMENT ADDITIONAL COMMENTS: Document additional comments or description of findings from any section of the mental status assessment as indicated.

SUBSTANCE ABUSE / USE HISTORY

A. SUBSTANCE ABUSE/USE

Does the individual have a history of substance abuse / use? Unknown No Yes*

*If yes, refer to the Physician Intake Assessment for details (e.g., type of substance, date of first and last use, etc.).

B. CAGE/ALCOHOL USE

Does the individual have a history of alcohol use? Unknown No Yes

If yes, complete the following questions. If no, skip these questions and go to the next section.

- Have you ever felt you should cut down on drinking? No Yes
- Have people annoyed you by criticizing your drinking? No Yes
- Have you ever felt bad or guilty about your drinking? No Yes
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover? No Yes

Clinical Institute of Withdrawal Assessment–Alcohol (CIWA-A) completed (if physician ordered) Yes N/A

Describe findings: _____

RISK / PROTECTIVE ASSESSMENT

Instructions: For each of the following sub-sections, mark all applicable fields and describe findings in the designated space(s). Use quotes as appropriate. Indicate any areas unable to assess, and explain rationale (e.g., refusal; unstable mental or physical status). If more space is needed, document in “additional comments” at the end of this section. Notify the physician of all abnormal findings that have recovery planning implications.

A. BEHAVIORAL RISKS:

- no behavioral risks identified elopement fire setting homicide
- self-injurious behavior suicide violence to others other (describe)

Describe findings: _____

B. PHYSICAL AND NUTRITIONAL SUPPORT RISK SCREEN: A RN must complete the Physical and Nutritional Support (PNS) Risk Screen upon admission for all individuals. Mark the box below indicating completion of all sections of the Risk Screen (i.e., Choking and Aspiration Risk, Fall Risk, Decubitus Ulcer Risk, and Nutritional Risk), and fill in the requested information.

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PNS Risk Screen completed by RN upon admission

Date: _____ Time: _____ By Whom: _____

C. PERSONAL SAFETY: A RN must complete the Personal Safety Interview form upon admission for all individuals. Mark the box below indicating completion of all sections of this form, and fill in the requested information.

Personal Safety Interview form completed by RN upon admission (see attachment)

Date: _____ Time: _____ By Whom: _____

D. PHYSICIAN ORDERED LEVEL OF OBSERVATION:

Routine (30 minute checks) Line of Sight 1:1 2:1 Other: _____

Reason: Suicidal Homicidal Assaultive Elopement/Escape
(If other Unpredictable Medical Fall Risk Seizure Risk
than Significant psychosis Other: _____
routine)

Forensic/Hold Order: Yes No Legal Status: N/A NGRI IST

Charges: _____

RISK/PROTECTIVE ASSESSMENT ADDITIONAL COMMENTS: Document additional comments or description of findings from any section of the risk/protective assessment as indicated.

HEALTH TEACHING (Mark all that apply)

Instructions: For each of the following sub-sections, mark all applicable fields and describe findings in the designated space(s). Use quotes as appropriate. Indicate any areas unable to assess, and explain rationale (e.g., refusal; unstable mental or physical status). If more space is needed, document in "additional comments" at the end of this section.

Factors That May Impact Learning:

none identified behavioral barrier cognitive barrier difficulty reading emotional barrier
 language barrier other (describe)

Describe all factors that are checked: _____

Preferred Method(s) of Learning (check all that apply): 1:1 group

doing listening observing reading other (describe)

Comments: _____

Initial Education Provided to Individual and/or Family/Friend: none (explain rationale) _____

Topic	Description of Material Taught	Evaluation of Learning	Need for Follow-Up

HEALTH TEACHING ASSESSMENT ADDITIONAL COMMENTS: *Document additional comments or description of findings from any section of the health teaching assessment as indicated.*

NURSING ASSESSMENT IMPLICATIONS FOR RECOVERY PLANNING

For each category listed below, summarize relevant nursing assessment findings that have implications for recovery planning, along with recommended interventions.

Assessment Findings with Recovery Planning Implications:	Recommended Interventions (e.g., consultations, education, special observations/precautions, etc.):
<u>Biophysical Issues:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	
<u>Mental Status Issues:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	
<u>Substance Abuse/Use Issues:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	
<u>Behavioral Risks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	
<u>Medical Risks:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	
<u>Other:</u> <input type="checkbox"/> No <input type="checkbox"/> Yes (describe)	

The Initial Nursing Assessment was completed by a RN, and the HST/CNA/FST generated admission workup was reviewed by a RN (if applicable).

Signature of Initial Assessing RN Date Time Print Name

Georgia Department of Behavioral Health and Developmental Disabilities

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The individual's Identification

Signature of Subsequent Assessing RN

Date

Time

Print Name

Signature of Subsequent Assessing RN

Date

Time

Print Name