

**Georgia Department of Behavioral Health and Developmental Disabilities
Central State Hospital**

ANNUAL NURSING ASSESSMENT: Adult Mental Health & Forensics

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 perception of why he/she still has a need for hospitalization:

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: _____

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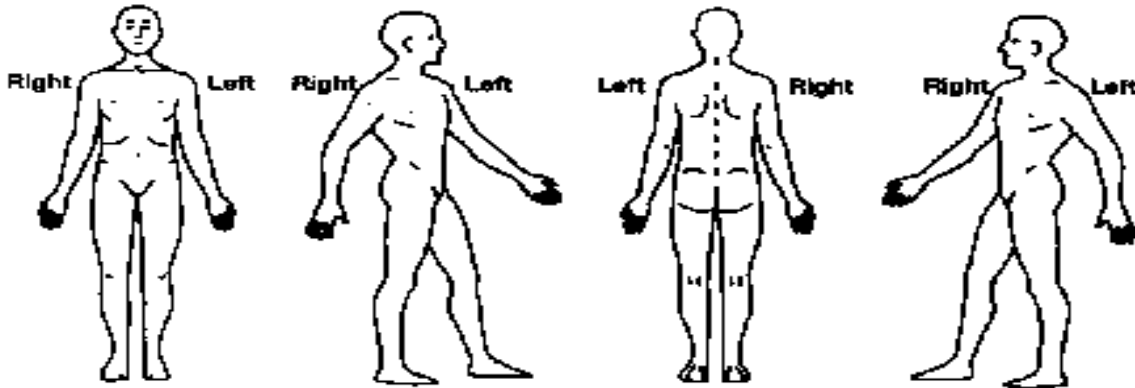
B. **ALLERGIES:** Mark the applicable box for each substance category. List all substances in which the individual has a known allergy, and describe the allergic reaction for each substance.

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.*)
 - 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: _____

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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).

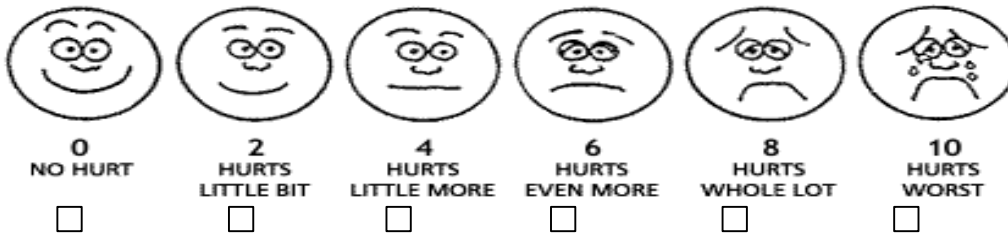
System	Presence of Abnormal Findings			*Describe <i>(Chart in designated space below table if additional space needed).</i>
	No	Yes*	U/A*	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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"/>	
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"/>	
<ul style="list-style-type: none"> • Date of last bowel movement: _____ <input type="checkbox"/> Unknown 				
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reproductive/Sexuality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<ul style="list-style-type: none"> • Are you sexually active? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> U/A • Do you use birth control? <input type="checkbox"/> No <input type="checkbox"/> Yes (Describe) _____ <input type="checkbox"/> U/A • Have you ever been tested for HIV? <input type="checkbox"/> No <input type="checkbox"/> Yes (date & results) _____ <input type="checkbox"/> U/A (Females Only): <input type="checkbox"/> Not applicable • Date of last menstrual period: _____ <input type="checkbox"/> Unknown • Are you or do you think you might be pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown 				

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***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:

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Independent with all ADL's and areas of mobility | <input type="checkbox"/> 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) | |

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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?

*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.

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RISK / PROTECTIVE ASSESSMENT

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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 annually 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.

PNS Risk Screen completed by RN

Date: _____ Time: _____ By Whom: _____

C. PERSONAL SAFETY: A RN must complete the Personal Safety Interview form annually 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 (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.

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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)	

Signature of Assessing RN Date Time Print Name

Signature of Assessing RN Date Time Print Name