MONTANA STATE HOSPITAL
POLICY AND PROCEDURE

NURSING ASSESSMENT AND DIAGNOSIS

Effective Date: December 11, 2015 **Policy #:** NS-03

I. PURPOSE:

A. To systematically collect relevant data about the patient as the initial step of the nursing care process.

B. To continually collect and review patient specific data throughout the patient's hospitalization.

C. To accurately document assessment findings on an approved form in the Medical Record.

D. To identify and prioritize the appropriate nursing diagnosis (es) which provide the focus for the development of the patient's plan of care and discharge plan.

II. POLICY:

A. The standard of care at Montana State Hospital (MSH) is that patients receive nursing care based on a documented systematic assessment of their needs, strengths, and treatment expectations.

B. Assessments will be completed by registered nurses (RNs) and documented on a standardized form. Assessments will be completed: 1) within 24 hours of admission to the hospital; 2) whenever there is a significant change in the patient's physical and/or mental status; 3) no less than yearly.

C. The registered nurse will formulate nursing diagnoses based on the data collected in the nursing assessment and will prioritize these diagnoses according to the patient's needs.

D. To the degree possible, the patient and significant others will collaborate with the registered nurse in the completion of the assessment and the formulation of the nursing diagnoses.

E. The nursing assessment and nursing diagnoses are an integral part of the multi-disciplinary treatment planning process for each individual patient.

F. Registered Nurses will perform a head to toe assessment for patients reporting actual or potential physical health problems throughout their hospital stay. This assessment information and ongoing assessment data will be documented on the Nursing Health Assessment form.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:

A. Registered Nurses - Complete nursing assessment and diagnosis.

V. PROCEDURE:

A. Delegate the completion of the "Physical Characteristics" and "Orientation to the Unit" segments of the assessment form to any member of the nursing staff if so desired.

B. Select an appropriate place to perform the assessment.

C. Inform the patient of their mutual roles and responsibilities in the assessment and diagnosis process and encourage the patient's participation.

D. Utilize interview, behavioral observation, and physical and mental status assessment skills to achieve a thorough and accurate assessment of patient care needs.

E. Assess each patient at the time of admission and continuously throughout the patient's hospitalization as warranted by changes in the patient's care needs through the systematic collection of data in the following areas: biophysical, psychosocial, risk/environmental, educational, and discharge planning.

F. As possible, seek out and utilize information pertinent to the assessment and diagnosis process from, not only the patient, but also from family members, significant others, and other health care providers.

G. Formulate conclusions about actual and/or potential alterations in the patient's biophysical/psychosocial status and establish nursing diagnosis/problem statements.

H. Identify nursing diagnosis/problem statements related to the specific assessment categories identified on the approved assessment form and/or the North American Nursing Diagnosis Association (NANDA) guidelines.

I. Prioritize nursing diagnosis/problem statements based on the following factors:
   1. potential danger to self and others;
   2. physical illness requiring acute medical care;
   3. patient's/significant others perception of need priority;
   4. assessed areas of severe, moderately severe to severe impairment/dysfunction; and
   5. Maslow's Theory of Needs.

J. Document the assessment findings and identify nursing diagnoses on the MSH Nursing Assessment Form. This information is used to establish the initial plan of care which is formulated within 24 hours of the patient's admission. Assessment data and the initial plan of care are the basis upon which the multidisciplinary treatment plan is formulated (reference Patient Treatment Plan Policy).

K. Document ongoing day-to-day assessments related to the patient's treatment plan in the progress notes of the patient's medical record.

L. If, at the time of admission, sufficient assessment data is unable to be collected due to the severity of the patient's symptoms, the patient will be re-assessed within 48 hours of admission. Completion of the admission assessment must be coordinated by RNs assigned to the unit where the admission occurs. Nurse Supervisors are available to assist with the assessment when necessary.

M. If, at the time of admission, sufficient assessment data is unable to be collected due to the severity of the patient's symptoms, re-assess the patient within 48 hours of admission and complete the Nursing Assessment Form.

N. Identify potential risk factors and establish an initial plan of care at the time of admission based on data from other sources if the patient is unable to participate in the assessment process.

O. Completion of the admission assessment will be coordinated by all RNs assigned to the unit where the admission occurs. Nurse Supervisors are available to assist with the assessment when necessary.

VI. REFERENCES: M.C.A. 53-21-162. MSH policies *Patient Treatment Plan* and *Patient Assessment*; MSH Nursing Procedure *Nursing Physical Health Assessment*

VII. COLLABORATED WITH: Medical Director

VIII. RESCISSIONS: #NS-03, *Nursing Assessment and Diagnosis,* dated February 3, 2011; #NS-03, *Nursing Assessment and Diagnosis*, dated January 25, 2008; #NS-03, *Nursing Assessment and Diagnosis,* dated October 24, 2003; #NS-03, *Nursing Assessment and Diagnosis* dated February 14, 2000; HOPP #NS-01-01, *Nursing Assessment and Diagnosis*, dated June 15, 1996.

IX. DISTRIBUTION: All hospital policy manuals.

X. ANNUAL REVIEW AND AUTHORIZATION: This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.

XI. FOLLOW-UP RESPONSIBILITY: Director of Nursing Services

XII. ATTACHMENTS: Montana State Hospital Nursing Assessment

_____/___/__ _____/___/__

John W. Glueckert Date — David Olson Date

Hospital Administrator — Director of Nursing Services

MONTANA STATE HOSPITAL NURSING ASSESSMENT

TYPE OF ASSESSMENT: ☐ **INITIAL/ADMISSION** ☐**UPDATE**
ADMISSION DATE: _____ TIME: _____ COMMITMENT: _____

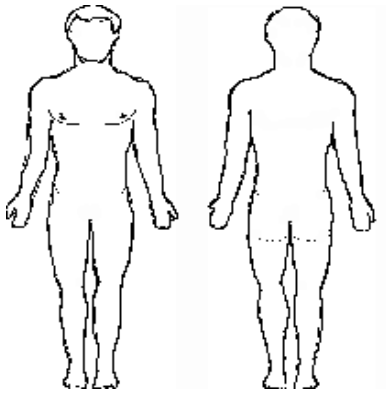
PHYSICAL CHARACTERISTICS

T: _____ P: _____ R: _____BP: _____ Waist Circumference: _____ O^2 Sat: _____

Height: _____ Weight: _____ Hair Color/Description: _____ Eye Color: _____

Race: _____ Age: _____ Gender: ☐ M ☐ F Date of Last Physical Exam: _____

Hygiene/Appearance: _____
Prosthetic Device: ☐Yes ☐ No Glasses; ☐Yes ☐ No Contact Lenses; ☐Yes ☐ No
Hearing Aide: ☐Left ☐ Right
Dentures: ☐Full ☐ Partial; Own Teeth: ☐Yes ☐ No
Existing wounds, cuts, bruises (identify on diagram and describe):



Scars, tattoos, birthmarks (identify on diagram and describe):

Body check (search):
Signature: _____ **Date:** _____**Time:** _____

ORIENTATION TO UNIT

Introduced to: Staff ☐Yes ☐ No Patients ☐Yes ☐ No Provided Tour of Unit ☐Yes ☐ No
Provided Unit Handbook ☐Yes ☐ No

Signature: _____ **Date:** _____**Time:** _____

ADMISSION ASSESSMENT (completed by RN)

Evidence for emergent need to be seen by: MEDICAL DOCTOR ☐Yes ☐ No PSYCHIATRIST ☐Yes ☐ No
Reason for Hospitalization/Continued Stay: _____

_____

_____

Family Involvement/Support System: _____

Previous Psychiatric Hospitalizations: _____

ABUSE/NEGLECT ASSESSMENT

Evidence of: ☐ Physical Assault ☐Domestic Abuse
☐Rape or other Sexual Molestation ☐Elder Abuse
Describe: _____

_____

Patient's Account: _____

_____

PHYSICIAN NOTIFIED: **Dr.**_____

☐ HISTORY OF ABUSE (describe): _____

_____

NAME: _____**HOSPITAL NUMBER:** _____

IMMUNIZATIONS/HISTORY

☐ PPD last date given _____ Infections Disease; ☐HIV ☐Hepatitis ☐TB

☐ DT last date given _____ ☐Pneumovax last date given _____

☐ Influenza last date given _____ ☐Other (specify) _____

MEDICATION ASSESSMENT/HISTORY

CURRENT MEDICATION (prescription, OTC and herbals)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Patient understanding of medication purposes: _____

_____

Patient report regarding medications that have helped in the past: _____

_____

Medication compliance (indicate patient concerns): _____

_____

ALLERGIES/ADVERSE DRUG REACTIONS: _____

_____

_____

Substance Use:

Caffeine: Within 72 hours ☐ Yes ☐ No Hx ☐ Yes ☐ No Amt/Day _____ **#** of YRS: _____

Tobacco: Within 72 hours ☐ Yes ☐ No Hx ☐ Yes ☐ No Amt/Day _____ **#** of YRS: _____

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

1. How soon after you wake up do you smoke your first cigarette?

☐ After 60 minutes (0)
☐ 31-60 minutes (1)
☐ 6-30 minutes (2)
☐ Within 5 minutes (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?

☐ No (0)
☐ Yes (1)

3. Which cigarette would you hate most to give up?

☐ The first in the morning (1)
☐ Any other (0)

4. How many cigarettes per day do you smoke?

☐ 10 or less (0)
☐ 11-20 (1)
☐ 21-30 (2)
☐ 30 or more (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?

☐ No (0)
☐ Yes (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?

☐ No (0)
☐ Yes (1)

Score: _____ Level of dependence on nicotine is: _____

*** (0-2** Very Low; **3-4** Low Dependence; **5** Medium Dependence; **6-7** High Dependence;**8-10** Very High Dependence)*

NAME: _____HOSPITAL NUMBER: _____

Alcohol Assessment- PLEASE COMPLETE THE ENTIRE SUBSTANCE USE SECTION-

1. Have you ever or do you currently use alcohol? ☐ **Yes** ☐ **No**
2. Have you ever tried to cut down on your drinking and/or drug use? ☐ **Yes** ☐ **No**
3. **Do you** get annoyed when people talk about your drinking and/or drug use? ☐ **Yes** ☐ **No**
4. **Do you** feel guilty about your drinking and/or drug use? ☐ **Yes** ☐ **No**
5. Have you ever had an "eye-opener" (a drink or other drug first thing in the morning? ☐**Yes** ☐ **No**

Circle appropriate number and total: _____ If = > 11, notify Physician.

1. How often during the last year have you had a drink containing alcohol? **0** never; **1** monthly or less; **2** 2 to 4 times a month; **3** 2 to 3 times a week; **4** 4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when drinking? **0** none; **1** 1 or 2; **2** 3 or 4; **3** 5 or 6; **4** 7 or 9; **5** 10 or more
3. How often during the last year have you had six or more drinks on one occasion? **0** never; **1** less than monthly; **2** monthly; **3** weekly; **4** daily or almost daily

Street Drugs

1. Have you used any street drugs in the last 72 hours? ☐ Yes ☐ No
2. If **Yes**, what type, quantity, route: _____
3. Describe use of street drugs in the last year: _____

Infection Prevention

Pediculosis

☐No Problem ☐Evidence of lice/nits on scalp, body or clothing
☐Intense itching ☐Supervisor/LIP notified
☐Initial TX provided ☐Isolation procedures per policy

PHYSICAL ASSESSMENT/REVIEW OF SYSTEMS

ALTERATION IN SKIN INTEGRITY

☐No Problem ☐Itching ☐Bruise ☐Rash ☐Lesions

☐Other (specify): _____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN SENSORY FUNCTION

☐No Problem ☐Vision Problem ☐Hearing Problem ☐Loss of Sensation

☐Change in Taste or Smell ☐Other (specify):_____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN RESPIRATORY FUNCTION

☐No Problem ☐Dyspnea ☐Cough ☐Sinus Problem ☐Wheeze ☐Pain ☐SOB ☐Asthma

☐Other (specify): _____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN CARDIOVASCULAR FUNCTION

☐No Problem ☐Edema ☐High Blood Pressure ☐Increase in Fatigue ☐Arrhythmia History
☐Pain (location): _____ ☐Other (specify): _____

BRIEFLY DESCRIBE: _____

NAME: _____ **HOSPITAL NUMBER:** _____

_____

ALTERATION IN NEUROLOGICAL FUNCTION

☐No Problem ☐Dizziness ☐Headaches ☐Fainting ☐Seizures ☐Numbness/Tingling ☐Tremors

☐Learning Disability ☐Head Trauma ☐Other (specify): _____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN NUTRITION

☐No Problem ☐Weight Loss ☐Weight Gain ☐Balanced Diet ☐Diabetes ☐Skin Turgor

☐Irregular Pattern of Eating ☐Increased Appetite ☐Decreased Appetite

☐Difficulty Chewing ☐Difficulty Swallowing ☐Special Diet

☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN ELIMINATION

☐ No Problem ☐Diarrhea/Constipation ☐Change in Bowel Habits ☐Laxative Use

☐ Urinary Problems/Infections ☐Blood in Urine ☐Blood in Stool Last BM _____

Last Prostrate Exam _____ Last Colonoscopy _____

Above Exams **Abnormal? (**specify) _____

☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN REPRODUCTIVE/SEXUAL FUNCTION

☐No Problem ☐Sexual Concerns ☐Genital Discharge ☐Menopausal

☐History of Sexually Transmitted Diseases Last Menses _____

Last Pap _____ Last Mammogram _____ Abnormal Pap or Mammogram _____

☐Other (specify): _____

BRIEFLY DESCRIBE: _____

_____

ALTERATION IN MOBILITY

☐No Problem ☐Stiffness/Soreness in Joints ☐Problems with Walking

☐Back Pain ☐History of Falls ☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

FALL RISK ASSESSMENT

				Date
CRITERIA	**Score = 0**	**Score = 1**	**Score = 2**	**Score**
Appliances in use at this time	No Equipment Needed	Leg brace, w/c Cane, walker	None in use at this time, but strongly recommended	
Awareness level	Understands and follows directions	Can follow simple directions	Does not follow directions or understand them	
Physical Status	Good muscle tone	Generalized weakness	Paralysis, Amputee, or contractures	
Weight Bearing Status	Full weight bearing	Partial weight bearing	Non-weight bearing	
Mobility	With strong gait, no history of falls	Unsteady gait, past history of falls	Does not ambulate and/or recent falls	
Transfer Ability	Independent	Min. assist	Max. Assist	
*Medications	No medications	1 Medication	2 or more medications	
Vision	Good	Fair	Poor/Blind	
Incontinence	Totally continent of B/B	Partially Incontinent of B/B	Totally incontinent Of B/B	
			TOTAL SCORE	

***Medication categories:** Antihistamines, antihypertensives, anticonvulsants, antianxiety, antidepressants, diuretics, cathartics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics

Score of 0-10 Patient is Low Risk **Score of 11-18 *Patient is High Risk***
***Implement fall prevention strategies. Notify LIP.**

Regardless of score, any patient with previous falls will be considered High Risk until fall-free for six months.

NAME: _____ **HOSPITAL NUMBER:** _____

ALTERATION IN SLEEP PATTERNS

☐ No Problem ☐Difficulty with Sleep ☐Sedative Use ☐Change in Sleep Patterns
Hours of Sleep Per Night _____ ☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

SELF-CARE NEEDS

ADL STATUS

Ambulation ☐Self ☐Assist **Toileting** ☐Self ☐Assist
Transfer ☐Self ☐Assist **Bathing** ☐Self ☐Assist
Dressing ☐Self ☐Assist **Grooming** ☐Self ☐Assist
Eating ☐Self ☐Assist
Assistive Devices Needed: _____

_____

_____

PSYCHOSOCIAL ASSESSMENT

ANXIETY

DYSFUNCTIONAL ANXIETY

☐Moderate ☐Severe ☐Phobias ☐Panic ☐Dissociation ☐Agitation ☐Rituals

☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

_____

MOOD/AFFECT

ALTERATION IN MOOD/AFFECT

☐Depressed ☐Worthless ☐Hopeless ☐Labile ☐Angry ☐Incongruent
☐Trouble with Decisions ☐Grandiose ☐Euphoric ☐Vegetative Signs of Depression
☐Guilt Feelings ☐Hyperactive/Intrusive

☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

REALITY TESTING

IMPAIRED REALITY TESTING

☐Hallucinations ☐Delusions ☐Suspicious/Evasive

☐Other(specify): _____

BRIEFLY DESCRIBE: _____

_____

IMPULSE CONTROL

IMPAIRED IMPULSE CONTROL

☐Hx of Running Away ☐Violence/Aggression ☐Accident Prone ☐Hyperactivity
☐Response to Command Hallucinations ☐Hypersexual ☐Eating Disorder
☐Excessive Fluid Consumption ☐Other (specify):_____

_____

BRIEFLY DESCRIBE: _____

POTENTIAL FOR SUICIDE/SELF-INJURY

☐Patient Denies ☐Current Suicidal Ideas/Thoughts
☐Current Suicidal Plans (describe): _____

_____

Past Attempts (describe): _____

_____

☐History of Self-Harm/Injury ☐Current Self Harm Plans (describe): _____

_____

Past Self Harm Behavior (describe): _____

_____

POTENTIAL FOR HOMICIDE

☐Patient Denies ☐Current Homicidal Ideas/Thoughts

☐Current Homicidal Plans (describe): _____

_____

Past Attempts/Hx (describe): _____

_____

_____

Have you ever been charged with a crime of a sexual/violent nature? ☐ Yes ☐ No

BRIEFLY DESCRIBE: _____

_____

_____

THOUGHT PROCESS

Reality Orientation Orientated to: ☐ Time ☐ Place ☐ Person ☐ Situation

☐Incoherent Speech ☐Disorganized Thoughts ☐Illogical Communication Patterns
☐Loose Associations ☐Other

_____

_____

BRIEFLY DESCRIBE: _____

_____

SELF CARE/ADL DEFICIT RELATED TO PSYCHOSOCIAL IMPAIRMENT

☐Psychosis ☐Depressed ☐Other (specify): _____

☐Needs assistance (specify, i.e., leisure time, dressing, hygiene, money management, medication): _____

_____

BRIEFLY DESCRIBE: _____

_____

_____

SELF PERCEPTION

ALTERATION IN SELF PERCEPTION

☐Self Hate ☐Self Idealization ☐Gender/Identity/Role/Confusion
☐Feeling of Unreality ☐Poor Self-Esteem ☐Entitled/Narcissistic ☐All Good/Bad
☐Other (specify, i.e., inferiority, superiority, delusions of grandeur, distortions in body image): _____

_____

BRIEFLY DESCRIBE: _____

_____

_____

STIMULUS BARRIER

ALTERATION IN STIMULUS BARRIER

☐Easily Distracted ☐Hypersensitive ☐Excessive Response ☐Stimulus Seeking

☐Sensory Deprivation ☐Stimulus Withdrawal ☐Other (specify): _____

_____

BRIEFLY DESCRIBE: _____

_____

JUDGMENT/INSIGHT

IMPAIRED JUDGMENT/INSIGHT

☐Poor Decision Making ☐Dangerous/Reckless Behavior ☐non-Compliance ☐Impaired Insight

☐Other (specify): _____

BRIEFLY DESCRIBE: _____

_____

PSYCHOSOCIAL ASSESSMENT

ASSESSMENT OF STRENGTHS

_____

_____

_____

_____

PATIENT AND FAMILY EDUCATION NEEDS/KNOWLEDGE DEFICIT

_____

_____

_____

_____

PATIENT GOALS (as stated by the patient)

_____

_____

_____

LIVING ARRANGEMENTS

_____

_____

FAMILY INVOLVEMENT/SIGNIFICANT OTHERS

_____

_____

ADVANCE DIRECTIVE

Do you have an advance directive? ☐ YES ☐ NO

Do you wish to have more information about an advance directive? ☐ YES ☐ NO

Referred to: _____

ASSESSMENT COMPLETED BY:

RN Signature: _____ **Date:** _____ **Time:** _____

NEED TO REASSESS WITHIN 48 HOURS? ☐ YES ☐ NO

REASSESSMENT COMPLETED BY:

RN Signature: _____ **Date:** _____ **Time:** _____

NAME: _____ **HOSPITAL NUMBER:** _____