Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Neurological Assessment WDP: Y
Oriented To:

Hand Grips:

Eyes Open:
Best Motor Response:
best Verbal Response:
Total:

Movement Right Arm:
Movement Left Arm:
Movement Right Leg:
Movement Left Leg:

Neuro Comment^:

--- Eye/Ear/Nose/Throat Assessment ---
EENT Hx: GLASSES

EENT Assessment WDP: Y
Visual Impairment:

Hearing Impairment:

Throat Complaint:

Mucous Membranes:
Left Nares:

Right Nares:

EENT Comment^:

--- Cardiovascular Assessment ---
Cardiovascular Hx: DENIES

Cardiovascular Assessment WDP: Y

Skin Color:

Skin:

Associated Signs & Symptoms:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Does Patient Have a Pacemaker:
Implantable Defibrillator:

Cardiovascular Comment^:

Circulatory Assessment WDP: Y
Altered Circulatory Site:

Proximal Pulse to Affected Site Evaluated:

Proximal Pulse Character:
Amount of Edema Noted Proximal to Affected Site:

Capillary Refill Proximal to Affected Site:

Skin Proximal to Affected Site:

Skin Color Proximal to Affected Site:

Sensation Proximal to Affected Site:

Distal Pulse to Affected Site Evaluated:

Distal Pulse Character:
Amount of Edema Noted Distal to Affected Site:

Capillary Refill Distal to Affected Site:

Skin Distal to Affected Site:

Skin Color Distal to Affected Site:

Sensation Distal to Affected Site:

Circulatory Comment^:

--- Respiratory Assessment ---

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Respiratory Hx: DENIES

Previous treatment of asthma:
Tobacco Use Now or in Previous 12 Months:
NONE
Kind of tobacco:

Packs/tins per day:

How many years:
Quit? When:
Smoking Referral:

Smoking cessation instruction given to the patient and/or caregiver-

Smoking Comment^:

Is Patient Present? Y
Able to perform TB & Contagious Respiratory Infection Point of Entry Screen Y
Reason-

Is patient currently experiencing any of following in last 7 days:

Fever greater than 100.4? N (37.8 C)
Cough? N (not related to allergy or COPD)
Persistent Cough greater than 3 weeks?
Cough with blood produced?
Sore Throat? Y
Night sweats? N
Unexplained weight loss? N
Fatigue? N
Body Aches? N
Rash? N

Nasal Congestion (not related to allergies or sinus infections)? N

Pt reports prior history of TB or positive TB skin test? N
Close contact with a person who has TB? N

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Close contact with any person having an Influenza-like Illness? N

TB Point of Entry Screen:
NEGATIVE
Contagious Respiratory Infection Point of Entry Screen-
NEGATIVE
Mask applied, patient isolated, and receiving unit/department notified?

Respiratory Assessment WDP: Y
RUL Breath Sounds:

RLL Breath Sounds:

LUL Breath Sounds:

LLL Breath Sounds:

Respiratory Effort:

Cough:
Sputum Color:

Sputum Consistency:

Sputum Amount:
Capillary Refill:

--- Oxygen/Respiratory Assessment ---

On Oxygen:
O2 Delivered Per:
O2 Liters / Minute:
SpO2 Continuous Monitoring:
SpO2% After Oxygen Applied:

Respiratory Comment^:

--- Gastrointestinal Assessment ---

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Gastrointestinal Hx: DENIES

Gastrointestinal Assessment WDP: Y

GI Complaint:

Vomiting Episodes in Previous 24 Hours:
Content/Appearance of Emesis:

RUQ Bowel Sounds:
RLQ Bowel Sounds:
LUQ Bowel Sounds:
LLQ Bowel Sounds:

Last Bowel Movement: 10/30/09
Description of Stool: Normal

Abdomen Soft & Non-Tender:
Abdomen Firm/Rigid: N
Distention:
Guarding:

Rebound Tenderness:
Tenderness to Palpation:

Palpable Mass:

GI Comment^:

~~~ Nutritional Assessment ~~~
Signs of Nutritional Risk: Nutrition Consult:
None

Intervention Description | Sts | Directions | From | Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time | by | Comment | Documented Units | Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Nutritional Comments^:

Total:

~~~ Genitourinary Assessment ~~~
GU Hx: DENIES

Genitourinary Assessment WDP: Y
Sexual History: NOT Sexually Active

Sexual Orientation:

Condom used?
Reproductive-Female:

Reproductive-Male:

LMP:
Abnormal Urination:

Urine Appearance:

Catheter:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Catheter Type:

Description of Catheter Function:

Associated Signs & Symptoms:

GU Comment^:

~~~ Endocrine Assessment ~~~

Endocrine Hx: DENIES

Endocrine System WDP: Y

Endocrine Comment^:

Immune System:

Immune System Comment^:

~~~ Musculoskeletal Assessment ~~~

Musculoskeletal Hx: DENIES

Musculoskeletal Assessment WDP: Y

Generalized Weakness:
Right Upper Extremity:
Left Upper Extremity:
Right Lower Extremity:

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Left Lower Extremity:

Balance/Gait:

Paralysis:

Amputee:

Complaints of Joint Swelling/Tenderness:

Musculoskeletal Comment^:

~~~ Functional Assessment ~~~

Functional Assessment WDP: Y

Functional Comment^:

Physical Limitations Interfering with Recreational Activities: N

Describe:

Other Limitations Interfering With Recreational Activities: N

Describe:

Need special equipment/supplies for routine care? N

Special Equipment:

Do you Exercise on a Regular Basis: Y

Type of Exercise: RUNNING, WEIGHTS

Frequency of Exercise: THREE TIMES A WEEK

Any Change in Sleep patterns:

NO SLEEP PROBLEMS

~~~ Integumentary Assessment ~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Integumentary Hx: DENIES

Prior history of chronic wounds, non healing wounds? N
Prior history of staph infection? N

Integumentary Assessment WDP: Y

Presence of open or draining wounds?
Presence of wounds that resemble spider bites?

Integumentary Comments^:

#1 Incision/Wound Location:
#1 Incision/Wound Type:
#1 Incision/Wound Dressing Clean/Dry/Intact:
#1 Incision/Wound Dressing Change Date:
#1 Incision Approximated Without Redness:
#1 Incision/Wound Size (cm):
#1 Incision/Wound Depth (cm):
#1 Incision/Wound Edges:
#1 Incision/Wound Odor:

#1 Incision/Wound Drainage Amount:
#1 Incision/Wound Dressing/Treatment:

#1 Incision/Wound Comment:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Documented Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

#2 Incision/Wound Location:
#2 Incision/Wound Type:
#2 Incision/Wound Dressing Clean/Dry/Intact:
#2 Incision/Wound Dressing Change Date:
#2 Incision Approximated Without Redness:
#2 Incision/Wound Size (cm):
#2 Incision/Wound Depth (cm):
#2 Incision/Wound Edges:
#2 Incision/Wound Odor:

#2 Incision/Wound Drainage Amount:
#2 Incision/Wound Dressing/Treatment:

#2 Incision/Wound Comment:

MEDICAL Hospitalization^:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Charge

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
GALL BLADDER 2005

Medical Conditions^:
CRRENT COLD

PSYCH Hospitalizations^:
NONE

Precautions:

Physical/Sexual/Emotional/Verbal Abuse or Neglect Hx: N
Evidence of Physical and/or Psychological Abuse: N
Does the Patient Feel Safe at Home: Y

Describe Abuse^:

~~~~MENTAL STATUS EXAM~~~~

Appearance: APPROPRIATE ATTIRE
DRESSED IN SUIT
Behavior: COOPERATIVE
TEARFUL
SUSPICIOUS
RESTLESS
"I HAVE A LOT ENERGY"
HAS ADD
Mood: ANXIOUS
"I FEEL GOOD"
SUPERFICIAL
Affect: RESTRICTED
ANXIOUS
Orientation: Oriented X3

Thought Process: INDECISIVE
BLOCKING
RAMBLING
DENIES RACING THOUGHTS
DISORGANIZED
CIRCUMSTANTIAL
Thought Content: PARANOIA
PERSEVERATIVE
CONCERN FOR JOB SECURITY
POOR MEMORY
POOR CONCENTRATION
Perceptual: DENIES

Speech: COHERENT
HESITANT
REPEATS QUESTIONS

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Motor/Activity: Normal

~~~~RISK ASSESSMENT~~~~
Suicidal Ideation: N Suicide Plan? N
Describe Suicidal Thoughts/Plan/Means^:

Previous Suicide Attempts: Y
When/How^:
IMPULSIVIELY DROVE INTO CAR AND CAUSED 2 CAR COLLISION
ON WED 10/27/09. WENT TO GEORGETOWN UNIVERSITY HOSP
YESTERDAY. HAS EXHIBITED BIZARRE BEHAVIOR SINCE THAT
TIME BUT PT IS POOR HISTORIAN AND DENIES REPORTED
BEHAVIORS

Have you known someone who has attempted/committed suicide?N
When/How/Relation/Impact^:

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Homicidal Ideation: N Homicidal Plan? N
Describe Homicidal Thoughts/Plans/Means^:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)
Homicidal/Violence Risk Factors:
N/A

Self Destructive Behavior: Y
Self Destructive/Harm Behaviors:
INTENTIONAL CAR ACCIDENT
THIS WEEK
Describe Self-Destructive Behaviors^:
SEE ABOVE

Any Recent Losses?
Recent Loss, Explain^:

Intoxicated: N
Last Use^:

Psychotic: Y
Describe Psychosis^:
REPORTEDLY PARANOID BY STATE DEPT PSYCHIATRIST.
BIZARRE BEHAVIORS R/T CAR ACCIDENT THAT ARE NOT
TYPICAL OF PT---CURSING, FEELING THAT PEOPLE WERE
FOLLOWING HER. PT C MANY, MANY QUESTIONS RE HER JOB
SECURITY TO THIS WRITER.
==RESTRAINTS==
Technique/Methods/Tools to Help Pt Control their Behavior:

As Appropriate, Pt/Family helps in identifying such Techniques:
Medical Cond. that places Pt at > Risk During Restraint/Seclus.:

Hx of Abuse that Would Increase Psychological Risk w/Restraint/Seclusion:
Pt/Family Educated on Hospitals Philosophy on Restraint/Seclusion:
Family's Role, Including Notification is Discussed as Appropriate:
~~~~CAFFEINE HISTORY~~~~

Types of Caffeine: None

Amt per Day:

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Drug Use Comment^:

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:

CDU DETOXIFICATION PROTOCOL WITHDRAWAL SEVERITY ASSESSMENT (WSAP)
~~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Documented Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Nausea/Vomiting:
Tremor:
Paroxysmal Sweats:
Anxiety:
Agitation:
Tactile Disturbances:
Auditory Disturbances:
Visual Disturbances:
Headache/Fullness in Head:
Orientation,Clouding Sensorium:
Score:

Detox Comment^:

FALL RISK ASSESSMENT:

=IMMUNIZATION/COMMUNICABLE DISEASE SCREEN=

Pneumoccal Vaccination Status-

Date:

Influenza vaccination status-

Date:

Patient candidate for vaccine(s)?

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Last Tetanus:

Hx/Assessment Comments^:

Hx-Source of Information:

-- Adolescent Specific --

Immunizations Current?
Recent Exposures:

Pre or Perinatal Event:

Disease:

PT functioning affecting Family/Guardian:

Currently receiving help from any agencies?

Special educational needs?

Difficulty learning new things?

Easiest way for pt to learn?

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

How does pt exhibit anger:

Exhibit frustration:

Exhibit sadness:

Respond to authority figures:

Discipline techniques used:

What works:

What doesn't work:

Anything preventing visiting pt:

Family/guardian involvement in treatment:

Family/guardian expectations for treatment:

Adolescent Comment^:

Education provided at this time:
Title of educator:

Person(s) educated:

Readiness to learn:

Identified learning needs:

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Learning preference:

Barriers to learning:

Teaching method:

New/Reinforcement teaching:

Specific topic(s) taught:

Response/evaluation:

Educ Content^:

~~ Medication Reconciliation ~~

Patient Compliance:
Why is Patient Non-Compliant:

Takes Daily Medications, Vitamins, Herbal or OTC Medications: Y

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Home Medications:

~~~ PATIENT'S HOME MEDICATION LIST ~~~

Medication-Strength	Dose/Route	Frequency (Last Dose Taken)
ADDERALL	30 MG ORAL	DAILY (10/30/09)

End of Medication List

Sources Used For This Documentation: PATIENT REPORTED

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition: NONE

****
* Home Medication queries have been *
* reviewed/updated by J.NUR.MP RN *
****

Is patient Responsive:

Fall Risk Elements:

Add'l Fall Risk Elements:

Intervention Description	Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Sts	Directions	From Change

Activity Date: 10/30/09 Time: 1459 (continued)

1002002 PSY: Admit History/Systems Assessment + (continued)

Is patient following fall prevention directions:

Update Date of Last Fall:
Month/Year of Last Fall:

Fall Risk Comment:

High Risk for Falls.

Fall Precautions:

Fall Precautions Comment:

Fall this account/visit:

Activity Date: 10/30/09 Time: 2310

Patient Notes: NURSE NOTES
- Create 10/30/09 2310 ERC 10/30/09 2317 ERC

A. MEDICATION EFFECTIVENESS: Pt. rates med efficacy as "good" at this time. Pt. denies any side effects to meds at this time.

B. SYMPTOM STATUS: Pt. up and visible in milieu, observed on the payphone in the back lounge for the majority of the shift. Pt. presents with a constricted affect and anxious mood. Pt. denies need for Tx., stated "I don't need to be here, this is just a misunderstanding". Pt. denies events and statements made prior to admission. Pt. wanted to request AMA discharge, however spoke to the CN and decided to remain at DH. Pt. denies any auditory or visual hallucinations at this time.

C. SAFETY STATUS: Pt. on a locked unit and maintained on building restriction throughout shift. Pt. maintained on routine Q15min. and mouth checks throughout shift. On 1:1 Pt. gave a safety level of 10/10 out of 10. Pt. denies any suicidal or homicidal ideation at this time.

D. PATIENT/FAMILY EDUCATION: Pt. attended all groups and unit activities this shift.
~~~

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 10/30/09 Time: 2310 (continued)

Patient Notes: NURSE NOTES (continued)
E. ADL'S: Self care, complete.

F. MEDICAL (IF INDICATED): Pt. denies any somatic complaints at this time. No s/s of distress evident at this time.

G. NUTRITIONAL STATUS: Pt. ate 100% of meals this shift.

Note Type Description
No Type None

Activity Date: 10/30/09 Time: 2314

1051009-A CARE AREA STATEMENT: MH Adult + A . At End of shift CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care Standards have been followed.
- Document 10/30/09 2314 SNR 10/30/09 2314 SNR
1) Review of Patient PROBLEMS w/Status on PLAN of CARE

1:	Developmental Age 18-40 yrs-YOUNG ADLT	:	A13:	:	
2:	CARE GOALS: Dominion MH Adult	:	A14:	:	
3:	STANDARD: DOMINION HOSPITAL WIDE CARE	:	A15:	:	
4:	PSY.PROBLEM: Anxiety	:	A16:	:	
5:	PSY:PROBLEM: Alteration in Thought Proc	:	A17:	:	
6:		:	18:	:	
7:		:	19:	:	
8:		:	20:	:	
9:		:	21:	:	
10:		:	22:	:	
11:		:	23:	:	
12:		:	24:	:	

I have reviewed the Pt problems listed above and the Treatment Plan for pt: Y
The Pt Care Standards appropriate for this patient defined for his/her patient population have been met throughout the shift (unless otherwise documented): YES (Review-SHFT F8)
Did the pt. start a new medication this shift? N
Did pt have any adverse reaction to med this shift? N If yes, follow ADR Policy to report
Comment:
Enter Note? N Shift: 3PM-11PM Signature: ROMULUS,SANDRA - RN

Activity Date: 10/31/09 Time: 0619

1051009-A CARE AREA STATEMENT: MH Adult + A . At End of shift CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care Standards have been followed.
- Document 10/31/09 0619 BRK 10/31/09 0620 BRK
1) Review of Patient PROBLEMS w/Status on PLAN of CARE

1:	Developmental Age 18-40 yrs-YOUNG ADLT	:	A13:	:	

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 0619 (continued)

1051009-A CARE AREA STATEMENT: MH Adult + (continued)

2:	CARE GOALS: Dominion MH Adult	:	A14:	:	
3:	STANDARD: DOMINION HOSPITAL WIDE CARE	:	A15:	:	
4:	PSY.PROBLEM: Anxiety	:	A16:	:	
5:	PSY:PROBLEM: Alteration in Thought Proc	:	A17:	:	
6:		:	18:	:	
7:		:	19:	:	
8:		:	20:	:	
9:		:	21:	:	
10:		:	22:	:	
11:		:	23:	:	
12:		:	24:	:	

I have reviewed the Pt problems listed above and the Treatment Plan for pt: Y
The Pt Care Standards appropriate for this patient defined for his/her patient population have been met throughout the shift (unless otherwise documented): YES (Review-SHFT F8)
Did the pt. start a new medication this shift? N
Did pt have any adverse reaction to med this shift? N If yes, follow ADR Policy to report
Comment:
Enter Note? N Shift: 11PM-7AM Signature: KAHRER,BARBARA R - RN

Activity Date: 10/31/09 Time: 0948

1002003 Psychosocial Assessment std + A CP
- Document 10/31/09 0948 AXZ 10/31/09 1008 AXZ
Reason For Admission^:
Pt is psychotic.

Does Patient Meet Criteria for Current Level of Care: Y
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:
Pt works in the State Department. She gratuated from GTU from the School of Foreign Services. She was in a car accident 10/27/09. She reported to police that she wanted to know what it would feel like to be in a car accident. Later she did not recall saying that. Pt is suspicious, talking to herself, and is exhibiting anxiety. Pt denies A/V hallucinations.

~~~FAMILY HISTORY~~~
Family Psych Hx: Y
~~~

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)

Family Psych Relationship: MA AUNT C SCHIZOPHRENIA

Describe Family Psych Hx^:

SEE ABOVE

Family Hx of Suicide: N

Family Suicide Relationship: N/A

Describe Family Hx of Suicide^:
N/A

Family CD Hx: N

Family CD Relationship: N/A

Describe Family CD Hx^:

Patient Psych/CD Treatment Hx: N

Describe Treatment Hx^:
N/A

Additional Suicide Risk Elements: Hx of risky behavior
Sev. anxiety/panic/agitat
IDS WORK AS STRESSOR

Homicidal/Violence Risk Factors:
N/A

Marital Status: Single
Sexual Orientation:

# of Marriages: 0 How Long/Current: N/A

How Long Previous Marriages^:
N/A

Number of Children: 0 Ages: N/A

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)

Living Arrangement: Own Place

Needs Alt Living Arrangement: Y

Social Support Network: Excellent

Support Person(s): Family
Friends
Treatment Participants: Parents

Support Comments^:
Pt states that she expects to be d/c today, but if she were to stay, she would like her parents to be involved in her tx here.

Describe Typical Day: work, shower, eat, talk with friends on the phone
Hobbies/Interests: Reading
Exercise
Watching movies
Studying languages

Religion: CHR CHRISTIAN

Spiritual Practices: None

Pt Believes in Higher Power: Y
Describe Higher Power^:
God

Last Grade Completed: MS
Degrees/Certificates: FOREIGN SERVICE FROM GTU

Current Student: N
Where: N/A

Change in School Performance: N
Describe Change In School Performance^:

Problems with Behavior at School: N
Truancy: N

Learning Problems/Special Education: N
Describe Learning/Behavioral Problems^:
N/A

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)

~~~~EMPLOYMENT HISTORY~~~~
Currently Employed: Y
Pt Occupation: Foreign Service
Time at Current Job: 5 months
Job Satisfaction: High
Longest Time at One Job: 2.5 years
Frequent Job Changes: N
Reason for Job Changes^:

Unemployed in Last Year: N
Reason for Unemployment^:

Parent Occupation:
Spouse Occupation:
Financial Needs: Finances are not a problem for pt.
Military Hx: N
Branch(es):

# of Years:
Military Reserve:
Discharge Type:

Year:

Discharge R/T Substance Abuse:
Discharge R/T Psych Condition:

~~~~ARREST HISTORY~~~~
Arrest or Pending Litigation/Civil Charges Hx: N
Number of Arrests:
Reason for Arrest:
Arrests Involving Violence:
DUI/DWI:
When:
Public Intoxication:

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date | Time | by | Recorded Date | Time | by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)
When:
Probation Hx:
Why/When:
Parole Hx:
Why/When:

Describe Pending Litigation/Civil Charges^:

~~~~CAFFEINE HISTORY~~~~
Pt Use Caffeine: N

Types of Caffeine: None

Amt per Day:

~~~~NICOTINE HISTORY~~~~
Nicotine Hx: N

Kind of tobacco:

Age First Used:
Packs/tins per day:

How many years:
Any Consequences:

Quit:
When:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)

Does Patient Drink Alcoholic Beverages: N
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:

Pt Believes ETOH Use a Problem: N
Negative Effects on Life: N/A

Medical Problems from CD Use:N/A

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

ETOH Sobriety/Support/Treatment Comments^:
N/A

Additional Drugs or Chemical Use: N
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)
How Long Used:
How Much:
Last Used:
Type of Drug:
How Often:
How Long Used:
How Much:
Last Used:
Drug Use Comment^:

Pt Believes Drug Use a Problem: N
Negative Effects on Life:

Medical Problems from CD Use:

Longest Sobriety:
When:
Sober Support System:
Who:
AA/NA:
Last Contact:
Sponsor:
Last Contact:

CD Sobriety/Support/Treatment Comments^:
N/A

~~~~ABUSE HISTORY~~~~
(Emotional, Physical, Neglect, Sexual) Abuse: N

Physical:
Describe Physical Abuse^:

Emotional:
Describe Emotional Abuse^:

Sexual:
Describe Sexual Abuse^:

Neglect:
Describe Neglect^:
~~~~

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)

Patient Has Hx of Abuse to Others: N
Describe Hx of Abuse to Others^:

Was CPS/APS Report Made: N
Describe CPS/APS Report^:

Describe CPS/APS Involvement^:
N/A

Abuse Comments^:
N/A

~~~~STRENGTHS/WEAKNESSES~~~~
Stability of Home Environment: Strength

Motivation for Tx: Weakness

Insight into Current Problems: Weakness

Judgement Regarding Current Problems:
Weakness
Stability and Support of Employment:
Strength
Function of Marriage/Family System:
Strength
Support System in and Beyond Family:
Strength

Education Attainment: Strength

Intellectual Skills: Strength

Range of Leisure Activities^:
Adequate

Type of Recent Leisure Activities^:
Reading, learning languages, watching movies.

What Do You Do When Bored/Lonely^:

Intervention Description	Sts	Directions	From	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 0948 (continued)

1002003 Psychosocial Assessment std + (continued)
"I'll call someone on the phone or go out to eat with
friends."

Does Your Work Schedule Interfere With Your Leisure Activities: N
Do You Belong to Any Social Groups/Community Organizations: Y

Improvement Needed in ANY of the following areas:
Pt does not identify
needing any improvements.

Pt Perception of Illness^:
"I think the car accident precipitated me being here.
I don't think I need to be here. I think there are
misunderstandings, which caused me to be here."
Pt Perception of Needs^:
"Nothing."

Pt's Goals for Treatment^:
"To be discharged as soon as possible."

Community Resources Current/Needed:
N/A. Pt seems totally
clear in her thinking at
this time.
Anticipated Treatment Mgr Role in TX/DC Planning:
DISCHARGE PLANNING
FAMILY CONTACT

Goals of Treatment: IMPROVE COPING SKILLS

Activity Date: 10/31/09 Time: 0954

1751000 VS: Monitor + A .Daily or per MD order. CP
- Document 10/31/09 0954 RFM 10/31/09 0954 RFM
Temperature: 98.1
Temp Source: TYM
Pulse: 93
Pulse Source: BRACHIAL
Respirations: 16
Blood Pressure: 110/73
BP Source: AUTO ARM R

BP Lying: HR Lying:
BP Sitting: HR Sitting:
~~~~

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 0954 (continued)

1751000 VS: Monitor + (continued)
BP Standing: HR Standing:

Activity Date: 10/31/09 Time: 1047

Patient Notes: SOCIAL SERVICES NOTES
- Create 10/31/09 1047 AXZ 10/31/09 1050 AXZ

Psychosocial Assessment was completed and placed in pt's chart. Pt denies feeling depressed in any way at this time. She denies recalling any of the statements that led to her admission here. At this time, pt appears coherent and in no danger to herself or others. She is exhibiting no sx of psychosis or depression. Pt asked questions about d/c and questions were answered. Pt plans to discuss d/c with MD.

Note Type Description
No Type None

Activity Date: 10/31/09 Time: 1258

5021012 DISCHARGE: MED REC PATIENT MED List + A CP
- Document 10/31/09 1258 DPS 10/31/09 1259 DPS
Medications Ordered to be Taken at Home: Y ~

Home Medications:
DISCHARGE - Patients Medication List

Medication-Strength	Dose/Route	Frequency
ADDERALL	30 MG ORAL	DAILY

End of Medication List

Intervention Description	Sts	Directions	From

Activity Type	Occurred Date	Time	by	Recorded Date	Time	by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 1258 (continued)

5021012 DISCHARGE: MED REC PATIENT MED List + (continued)

Sources Used For This Documentation: BOTTLE LABEL

Routine Pharmacies Used: CVS

Clarification needed for any Medication: N

Home Medication Disposition:

```
:**************************************************
*       Home Medication queries have been        *
*        reviewed/updated by J.REG.DPS RN        *
**************************************************
```

Activity Date: 10/31/09 Time: 1317

5021012 DISCHARGE: MED REC PATIENT MED List + A CP
- Document 10/31/09 1317 GSL 10/31/09 1318 GSL
Medications Ordered to be Taken at Home: N ~

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 1317 (continued)

5021012 DISCHARGE: MED REC PATIENT MED List + (continued)

Home Medications:

Sources Used For This Documentation:

Routine Pharmacies Used:

Clarification needed for any Medication:

Home Medication Disposition:

Activity Date: 10/31/09 Time: 1318

1051009-A CARE AREA STATEMENT: MH Adult + A . At End of shift CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 1318 (continued)

1051009-A CARE AREA STATEMENT: MH Adult + (continued)
Standards have been followed.
- Document 10/31/09 1318 LXT 10/31/09 1319 LXT
1) Review of Patient PROBLEMS w/Status on PLAN of CARE

1: Developmental Age 18-40 yrs-YOUNG ADLT	A13:	
2: CARE GOALS: Dominion MH Adult	A14:	
3: STANDARD: DOMINION HOSPITAL WIDE CARE	A15:	
4: PSY.PROBLEM: Anxiety	A16:	
5: PSY.PROBLEM: Alteration in Thought Proc	A17:	
6:	18:	
7:	19:	
8:	20:	
9:	21:	
10:	22:	
11:	23:	
12:	24:	

I have reviewed the Pt problems listed above and the Treatment Plan for pt: Y
The Pt Care Standards appropriate for this patient defined for his/her patient population have been met throughout the shift (unless otherwise documented): YES (Review-SHFT Fld)
Did the pt. start a new medication this shift? N
Did pt have any adverse reaction to med this shift? N If yes, follow ADR Policy to report
Comment: PT CURRENTLY NOT ON ANY MEDICATIONS
Enter Note? N Shift: 7AM-3PM Signature: TROFORT,LIONELLE - RN
5021012 DISCHARGE: MED REC PATIENT MED List + C CP
- Ed Status 10/31/09 1318 GSL 10/31/09 1318 GSL A -> C

Activity Date: 10/31/09 Time: 1339

2120365 ASSESSMENT: AT Evaluation + A . 1 Time CP
- Document 10/31/09 1339 KAO 10/31/09 1340 KAO
PROBLEMS TO BE ADDRESSED BY ACTIVITY THERAPY:

Difficulty Identifying and Expressing Feelings: Y
Poor Concentration: Y
Disorganized Thoughts: Y
Poor Impulse Control: Y
Low Frustration Tolerance:
Distractability:
Restlessness:
Low Self-Esteem:
Social Isolation/Withdrawal:
Poor Reality Testing: Y
Inadequate Social Skills:
Distorted Body Image:
Poor Leisure Time Management:
Inadequate Leisure Skills:
Leisure Time/Activities Related To Drug/Alcohol Abuse:

Other:

Physical Problems/Safety Concerns: psychosis, impulsivity

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 1339 (continued)

2120365 ASSESSMENT: AT Evaluation + (continued)
:

CONCLUSIONS: ACTIVITY THERAPY INTERVENTIONS WILL FOCUS ON
PROVISIONS OF ACTIVITIES THAT FACILITATE:

Identification and Expression of Feelings: Y
Focus of Attention and Organization of Thoughts: Y
Attending, Concentrating and Completing Tasks: Y
Feelings of Mastery and Self-Esteem:
Development of Realistic Body Image:
Social Interaction: Y
Development of More Functional Social Skills: Y
Development of Impulse Control: Y
Identification of Leisure Time Skills and Interests:
Development of Structured Leisure Plan For After Discharge:
Identification of Healty Alternatives to Drug Related Behavior:

Other:

Activity Date: 10/31/09 Time: 1440

Patient Notes: SOCIAL SERVICES NOTES
- Create 10/31/09 1440 AXZ 10/31/09 1440 AXZ

Pt did not attend group, as she was being d/c.
Note Type Description
No Type None

Activity Date: 10/31/09 Time: 1617

5021010 DISCHARGE: Complete Discharge Form + A CP
ALSO:
Complete paper form-when going home
- Document 10/31/09 1617 DPS 10/31/09 1621 DPS
PATIENT EDUCATION OUTCOME STANDARDS/DISCHARGE NOTE

At discharge pt and/or family can verbalize understand of:

Illness/Need for hospitalization Y
Signs & symptoms of recurrence Y
Need for continued treatment Y
Awareness of effective coping skills for symptom management Y
Meds: Instructions, Side effects & Food/drug interactions Y

Patient's level of understanding of D/C plan:

Adequate (sufficient, correct) Y Partial, needs reinforcement (If checked, complete:) Y
Referred to continuation of care provider Y

Intervention Description | Sts | Directions | From

Activity Type | Occurred Date Time by | Recorded Date Time by | Comment | Documented Units | Change

Activity Date: 10/31/09 Time: 1617 (continued)

5021010 DISCHARGE: Complete Discharge Form + (continued)
Issued written materials Y
Family given instructions Y

(* : N/A) Next Topic pg? ->

Patient Status at Discharge: PT SAFE AND IN CONTROL
Follow Up Destination: DOMINION PARTIAL
Therapist Who Will Follow Pt: DR ROTH

Comment: PT DENIES ANY FEELINGS TO HARM SELF OR OTHERS.
: ABLE TO VOICE UNDERSTANDING OF DISCHARGE PLANS
: THOUGHTS ARE CLEAR AND SPEECH IS LOGICAL

Following items returned:
Valuables Y Sharps Y Medications N

Discharge Time: 1600
Accompanied by: PARENTS
Relationship to Pt: MOTHER

(* : N/A)

Activity Date: 10/31/09 Time: 1623

1001070 Admission Initial Safety Assessment + D AS
* To be done on Admission *
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1001083 ADMISSION: Medication History + D AS
* Medication History to be done on Admission *
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1001451-A CARE PLAN : MH ADDITIONS + D CP
~~Use in place of Add Interventions~~
Allows customization of Patient Care Plan.
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1002001 NURSE/TRIAGE std + D AS
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1002002 PSY: Admit History/Systems Assessment + D AS
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1002003 Psychosocial Assessment std + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D

Intervention	Description	Sts	Directions	From
Activity Type	Occurred Date Time by / Recorded Date Time by / Comment / Documented Units			Change

Activity Date: 10/31/09 Time: 1623

1002030 PSY: Anxiety Disorder, Assess D CP
* Physician to assess mental status and effectiveness of medications.

* RN to assess anxiety and patient perception of effectiveness of medications.

* Patient education related to effects and side effects of medications administered to treat illness.

* Patient education regarding management of anxiety [], coping skills.

* Encourage Patient to attend group therapy related to [].

* Assist patient to identify anxiety-producing situations and plan for such events.

* Assist in the development of coping skills to manage anxiety.

- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1002051 PSY: Thought Disorder, Assess D CP
* Physician to assess mental status, and effectiveness of medications.

* RN to assess mental status and patient perception of effectiveness of medications.

* Patient education related to thought disorder and effects and side effects of medications administered to treat illness.

* Encourage patient to attend group therapy related to [].

* Assist pt to ID behaviors that alienate significant others and family members

* Collaborate with pt to identify anxious behavior and coping techniques

* Collaborate with pt to establish a daily, achievable routine

Activity Date: 10/31/09 Time: 1623 (continued)

1002051 PSY: Thought Disorder, Assess (continued) CP
* Encourage pt to explore adaptive behaviors that increase socialization

* Encourage pt to explore adaptive behaviors that help to accomplish ADL's

- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1009999 UPDATE: Clarification of Medications + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1051009-A CARE AREA STATEMENT: MH Adult + D . At End of shift CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care Standards have been followed.

- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1300006 Age Specific Care: Young Adulthood + D CP
1. Assess patient's self-perception for motivation.
2. Assess body image.
3. Assist with identifying useful coping mechanisms and support systems.
4. Encourage to talk about illness/injury - how it may affect plans,family/finances.
5. Encourage patient and family in decision making and patient care, if wanted.
6. Educate re injury prevention and healthy lifestyle.

- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1572301 ASSESS: Weight as Ordered and Record + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
1751000 VS: Monitor + D .Daily or per MD order. CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
2120363 MH Daily Nursing Assessment + D .Every 24 hours CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
2120365 ASSESSMENT: AT Evaluation + D . 1 Time CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
2120366 MH Psycho-Educational Group + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
2120370 MH SW Group Therapy Session + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
2120752 Preceptor Documentation Co-Sign + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
3766530 NUTRITION: Monitor Meals, Record % + D CP
- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D
4136600 MEDS: Administer PAIN-MEDS(prn/standing) D CP
1. Monitor effectiveness/side effects (and any adverse reactions).

- Ed Status 10/31/09 1623 his 10/31/09 1623 his A => D

Intervention	Description	Sts	Directions	From
Activity Type	Occurred Date Time by	Recorded Date Time by	Comment	Documented Units	Change

Activity Date: 10/31/09 Time: 1623

4801200	EDUCATION: Interdisciplinary +	D		CP
- Ed Status	10/31/09 1623 mis	10/31/09 1623 mis		A => D
5021010	DISCHARGE: Complete Discharge Form +	D		CP
	ALSO:			
	Complete paper form-when going home			
- Ed Status	10/31/09 1623 mis	10/31/09 1623 mis		A => D
9100004	QUICK ADMISSION DATA +	D		AS
	Nursing Quick Start			
- Ed Status	10/31/09 1623 mis	10/31/09 1623 mis		A => D

Monogram	Initials	Name	Nurse Type
AXZ	J.NUR.AXZ	ZALK,ANITA	SW
BRK	J.NUR.BRK	KAHRER,BARBARA R	RN
DPS	J.REG.DPS	SCHMITZ,DAVID	RN
ERC	J.NUR.ERC	CONCEPCION,EDGAR	MHT
GSL	J.NUR.GSL1	LEWIS,GLENNA S.	RN
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN
JLW	J.NUR.JLW	WRIGHT,JESSICA L	RN
KAO	J.NUR.KXO	OTTINGER,KIMBERLY	ACT
LXT	J.NUR.LXT	TROFORT,LIONELLE	RN
MVP	J.NUR.MP	PERRY,MARILYN	RN
RFM	J.NUR.RFM	McCALL,ROBERT	MHT
SNR	J.NUR.SR	ROMULUS,SANDRA	RN
mis		automatic by program	

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
10/30/09	2310	ERC	CONCEPCION,EDGAR	10/30/09	2317	ERC	NURSE NOTES

A. MEDICATION EFFECTIVENESS: Pt. rates med efficacy as "good" at this time. Pt. denies any side effects to meds at this time.

B. SYMPTOM STATUS: Pt. up and visible in milieu, observed on the payphone in the back lounge for the majority of the shift. Pt. presents with a constricted affect and anxious mood. Pt. denies need for Tx., stated "I don't need to be here, this is just a misunderstanding". Pt. denies events and statements made prior to admission. Pt. wanted to request AMA discharge, however spoke to the CN and decided to remain at DH. Pt. denies any auditory or visual hallucinations at this time.

C. SAFETY STATUS: Pt. on a locked unit and maintained on building restriction throughout shift. Pt. maintained on routine Q15min. and mouth checks throughout shift. On 1:1 Pt. gave a safety level of 10/10 out of 10. Pt. denies any suicidal or homicidal ideation at this time.

D. PATIENT/FAMILY EDUCATION: Pt. attended all groups and unit activities this shift.

E. ADL'S: Self care, complete.

F. MEDICAL (IF INDICATED): Pt. denies any somatic complaints at this time. No s/s of distress evident at this time.

G. NUTRITIONAL STATUS: Pt. ate 100% of meals this shift.

Note Type	Description
No Type	None

10/31/09	1047	AXZ	ZALK,ANITA	10/31/09	1050	AXZ	SOCIAL SERVICES NOTES

Psychosocial Assessment was completed and placed in pt's chart. Pt denies feeling depressed in any way at this time. She denies recalling any of the statements that led to her admission here. At this time, pt appears coherent and in no danger to herself or others. She is exhibiting no sx of psychosis or depression. Pt asked questions about d/c and questions were answered. Pt plans to discuss d/c with MD.

Note Type	Description
No Type	None

10/31/09	1440	AXZ	ZALK,ANITA	10/31/09	1440	AXZ	SOCIAL SERVICES NOTES

Pt did not attend group, as she was being d/c.

Note Type	Description
No Type	None

Monogram	Initials	Name	Nurse Type
AXZ	J.NUR.AXZ	ZALK,ANITA	SW
ERC	J.NUR.ERC	CONCEPCION,EDGAR	MHT

AT Initial Assessment 10/31/09 1339 KAO

PROBLEMS TO BE ADDRESSED BY ACTIVITY THERAPY:

Difficulty Identifying and Expressing Feelings: Y
Poor Concentration: Y
Disorganized Thoughts: Y
Poor Impulse Control: Y
Low Frustration Tolerance:
Distractability:
Restlessness:
Low Self-Esteem:
Social Isolation/Withdrawal:
Poor Reality Testing: Y
Inadequate Social Skills:
Distorted Body Image:
Poor Leisure Time Management:
Inadequate Leisure Skills:
Leisure Time/Activities Related To Drug/Alcohol Abuse:

Other:

Physical Problems/Safety Concerns: psychosis, impulsivity
:

CONCLUSIONS: ACTIVITY THERAPY INTERVENTIONS WILL FOCUS ON PROVISIONS OF ACTIVITIES THAT FACILITATE:

Identification and Expression of Feelings: Y
Focus of Attention and Organization of Thoughts: Y
Attending, Concentrating and Completing Tasks: Y
Feelings of Mastery and Self-Esteem:
Development of Realistic Body Image:
Social Interaction: Y
Development of More Functional Social Skills: Y
Development of Impulse Control: Y
Identification of Leisure Time Skills and Interests:
Development of Structured Leisure Plan For After Discharge:
Identification of Healty Alternatives to Drug Related Behavior:

Other:

Monogram	Initials	Name	Nurse Type
KAO	J.NUR.KXO	OTTINGER,KIMBERLY	ACT

	S	INIT BY	DATE	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	S
Developmental Age 18-40 yrs-YOUNG ADLT Based on Erickson's eight stages of development. --Developmental Need: *Relationships *Commitment <End of text> - PROTOCOL: AGE 18-40	D	10/30/09 MVP								
* Patient will verbalize understanding of lifestyle changes, therapy/treatment options, and resources/support groups that may be beneficial to themselves and their family. The patient will be able to make an informed decison about their health care <End of text>	D	10/30/09 MVP			* Age Specific Care: Young Adulthood + 1. Assess patient's self-perception for motivation. 2. Assess body image. 3. Assist with identifying useful coping mechanisms and support systems. 4. Encourage to talk about illness/injury - how it may affect plans,family/finances. 5. Encourage patient and family in decision making and patient care, if wanted. 6. Educate re injury prevention and healthy lifestyle. - PROTOCOL: AGE 18-40	10/30/09 MVP				D
CARE GOALS: Dominion MH Adult Related to the following Standards of Care: 1. Patient Care/Nursing Process 2. Patient Education 3. Patient Discharge Planning 4. Patient Safety/Infection Control 5. Patient Rights **********GOALS********** 1. The patient will receive care which reflects an ongoing process of interdisciplinary care based on their specific care needs. Coping responses to hospitalization will be assessed and addressed. 2. The patient and/or significant others can expect to be involved in the plan of care with attention to cultural, religious, and spiritual beliefs, privacy and confidentiality. 3. The patient and/or significant others will participate in the process of coordination of resources in preparation for discharge. 4. The patient and/or significant others will receive teaching about the nature of their health conditions, procedures, treatments, self care and post discharge care	D	10/30/09 MVP								

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
Verbalization of questions and concerns will be encouraged. 5. The patient and significant others will have their environment and care managed to minimize risk to themselves and others. 6. The patient will be supported in their effort to retain personal identity, self worth and patient rights. <End of text>										
* Standards of Practice <End of text>	D	10/30/09 MVP			* CARE AREA STATEMENT: MH Adult + ~~DOCUMENT AT END OF EVERY SHIFT~~ To be documented every shift, to review current Pt. problems and to verify that the MH Adult Patient Population Care Standards have been followed. - PROTOCOL: SOCMHADU	10/30/09 MVP		10/30/09 1410	. At End of shift	D
STANDARD: DOMINION HOSPITAL WIDE CARE Care Standards related to the following care goals: 1. Patient Care/Nursing Process 2. Patient Education 3. Patient Discharge Planning 4. Patient Safety/Infection Control 5. Patient Discomfort/PAIN 6. Patient Rights - PROTOCOL: SOCMHADU	D	10/30/09 MVP								
* The patient will receive care which reflects an ongoing process of interdisciplinary care based on the patients specific needs and the hospitals Patient Population Standards of Care. These will include those needs which are age-specific. Coping responses to hospitalization will be assessed and addressed.	D	10/30/09 MVP			* VS: Monitor + * ASSESSMENT: AT Evaluation + * ASSESS: Weight as Ordered and Record + * MH Psycho-Educational Group + * CARE PLAN : MH ADDITIONS + ~~Use in place of Add Interventions~~ Allows customization of Patient Care Plan. * Preceptor Documentation Co-Sign + * MH SW Group Therapy Session + * NUTRITION: Monitor Meals, Record % + * DISCHARGE: MED REC PATIENT MED List + * UPDATE: Clarification of Medications +	10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP 10/30/09 MVP	 10/31/09 GSL 	10/30/09 1410 10/30/09 1410	.Daily or per MD order. . 1 Time	D D D D D D D D C D
* The patient and/or significant others can expect to be involved in the plan of care with attention to cultural and religious beliefs, communication barriers, privacy and confidentiality. Effective communication methods are utilized for the hearing and speech impaired as well as barriers to language.	D	10/30/09 MVP								
* The patient and/or significant other	D	10/30/09 MVP								

	STS	UNIT BY	TRGT	COMP BY	INTERVENTIONS	UNIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
will receive teaching about the nature of their health condition, procedures, treatments, self care and post discharge care. Verbalization of questions and concerns will be encouraged.					* EDUCATION: Interdisciplinary +	10/30/09 MVP				D
* Patient and/or significant other will participate in the process of coordination of resources in preparation for discharge.	D	10/30/09 MVP			* DISCHARGE: Complete Discharge Form + ALSO: Complete paper form-when going home	10/30/09 MVP				D
* The patient will receive care which will reflect a safe environment. Infection control needs will be assessed and addressed. Care will be given in a controlled environment to reduce risk of injury or further illness.	D	10/30/09 MVP			* MH Daily Nursing Assessment +	10/30/09 MVP		10/30/09 1410	Every 24 hours	D
* The patient will be assessed for pain Assessment to include: a - (W) Words that describe (I) Intensity (L) Location (D) Duration (A) Aggrevating factors (A) Alleviating factors b - Scoring of pain intensity, utilizing appropriate pain scale. d - Effectiveness of medication/pain control method.	D	10/30/09 MVP			* MEDS: Administer PAIN-MEDS(prn/standing) 1. Monitor effectiveness/side effects (and any adverse reactions).	10/30/09 MVP				D
* The patient will be supported in their effort to retain personal identity, self worth and patient rights	D	10/30/09 MVP			* Psychosocial Assessment std +	10/30/09 MVP				D
PSY PROBLEM: Anxiety	D	10/30/09 MVP								
* STG: Patient's Anxiety will decrease AEB	D	10/30/09 MVP			* PSY: Anxiety Disorder, Assess * Physician to assess mental status and effectiveness of medications. * RN to assess anxiety and patient perception of effectiveness of medications. * Patient education related to effects and side effects of medications administered to treat illness. * Patient education regarding management of anxiety [], coping skills. * Encourage Patient to attend group therapy related to []. * Assist patient to identify anxiety-producing situations and plan for such events. * Assist in the development of coping skills to manage anxiety.	10/30/09 MVP				D
* LTG: Patient's Anxiety will decrease AEB	D	10/30/09 MVP								