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

	STS	INIT BY	DATE	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTION	STS
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	DATE	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	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT 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								

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	PTC
PSY:PROBLEM: Alteration in Thought Proc	D	10/30/09 MVP								
* STG: PATIENT WILL HAVE DECREASE IN DISTURBED THOUGHTS AEB	D	10/30/09 MVP								
* LTG: PATIENT WILL HAVE DECREASE IN DISTURBED THOUGHTS AEB	D	10/30/09 MVP			* PSY: Thought Disorder, Assess * 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 * Encourage pt to explore adaptive behaviors that increase socialization * Encourage pt to explore adaptive behaviors that help to accomplish ADL's	10/30/09 MVP				L

ADDITIONAL INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS	SRC
* NURSE/TRIAGE std +	10/30/09 HEB				D	AS
* QUICK ADMISSION DATA + Nursing Quick Start	10/30/09 MVP				D	AS
* ADMISSION: Medication History + * Medication History to be done on Admission *	10/30/09 MVP				D	AS
* PSY: Admit History/Systems Assessment +	10/30/09 MVP				D	AS
* Admission Initial Safety Assessment + * To be done on Admission *	10/30/09 MVP				D	AS

Monogram	Initials	Name	Nurse Type
GSL	J.NUR.GSL1	LEWIS,GLENNA S.	RN
HEB	J.NUR.HEB	BLACK,ELIZABETH	RN
MVP	J.NUR.MP	PERRY,MARILYN	RN

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1441

Patient Notes: SOCIAL SERVICES NOTES
- Create 11/04/09 1441 MXS 11/04/09 1453 MXS

MEETING WITH PATIENT FOR PURPOSE OF COMPLETING PSYCHOSOCIAL HISTORY:
This CSW interviewed patient and completed psychosocial history.Patient denied any bizarre behavior at work, could not recall statements she is reported to have made following recent auto accident and stated that she is willing to comply with PHP if this is what is required by the State Department in order to return to work.
IMPRESSION:
Today patient presents well groomed, dressed in business attire, oriented x 3, mood is anxious, affect wide ranging, eye contact good, demeanor is pleasant and cooperative. Patient denies any recent symptoms of depression or other mood disturbances, denies any auditory or visual hallucinations, denies any harmful ideation to self or other. Patient acknowledges prior episodes of depression/anxiety during grad school (at Georgetown Univ SFS) for which she was treated with medication and brief therapy. Patient acknowledges diagnosis of ADD. Patient acknowledges that the four month assignment with DOD that she spent in Iraq, where she was on a base that was "mortared every day, getting closer and closer" was stressful and fearful. Upon return from Iraq patient acknowledges having sleep disturbance for several weeks but then sleep cycle regulated and patient returned to work, transferred to State Department where reportedly she has exceeded work performance expectations.
PLAN:
1. CSW voice mailed attending psychiatrist re. completion of psychosocial history and possibility of a meeting with patient and her mother on 11/6/09 at 9.0 am.
2. Patient will bring police report of accident she is purported to have caused, with her tomorrow for psychiatrist to read.
3. Patient has sought legal counsel to represent her in court over charges ensuing from accident.
4. Patient commits to safety and has her mother staying in the home with her.
5. Attending psychiatrist informed of all above.

Note Type Description
No Type None

Activity Date: 11/04/09 Time: 1533

1002003 Psychosocial Assessment std + A CP
- Document 11/04/09 1533 MXS 11/04/09 1556 MXS
Reason For Admission^:
Patient was admitted to DH on 10/30/09 and left AMA on 10/31/09. In days/weeks prior to admission patient had reportedly been behaving in a bizarre way at work (State Dept) and was then in a road traffic accident which she is reported to have deliberately caused. Today patient presents stating that she is not sure why she has been admitted to PHP except "that the State Department has ordered this".

Does Patient Meet Criteria for Current Level of Care: Y

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)
Supervisor Informed:

Primary Language: ENGLISH ENGLISH

Social/Cultural/Educational Influences^:
Patient is one of two sibs born to middle class parents, raised in suburb of Atlanta, attended Spellman College for undergrad, progressed to grad school at Georgetown SFS, was then employed by DOD, sent to Iraq for four months (2007) , returned to DOD where she reports having exceeded work performance expectations, then moved to State Dept in March 09. Patient has supportive parents (retired educators)Patient lives alone in apt in DC and currently works for State Dept as an analyst.

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

Family Psych Relationship: Aunt

Describe Family Psych Hx^:
Schizophrenia in maternal aunt.

Family Hx of Suicide: N

Family Suicide Relationship:

Describe Family Hx of Suicide^:

Family CD Hx: N

Family CD Relationship:

Describe Family CD Hx^:
~~~~

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)

Patient PSych/CD Treatment Hx: Y

Describe Treatment Hx^:
Outpatient treatment at Georgetown Univ Counseling Center for depression, anxiety, sleep disturbance in 2006. Overnight in DH on 10/30/09 and then AMA discharge.

Additional Suicide Risk Elements: Hx of risky behavior

Homicidal/Violence Risk Factors:
Patient denies

Marital Status: Single
Sexual Orientation:

# of Marriages: 0 How Long/Current: 0

How Long Previous Marriages^:
0

Number of Children: 0 Ages: 0

Living Arrangement: Own Place

Needs Alt Living Arrangement: N

Social Support Network: Good

Support Person(s): Family
Friends
Treatment Participants: Patient's parents who are in town

Support Comments^:
"My parents came because my cousin in Baltimore called them. My cousin took me to the ER at Georgetown two days after my accident because ..I did not receive any medical treatment ..I was just taken by the police and put in a cell, finger printed.. and then charged with leaving the scene of an accident"

Describe Typical Day: Wake at 7.0 am
Work by 8.30 - 5.30
Evening - outdoor running or work out in gym
Dinner alone or with a friend
Bed 11.0 pm
Hobbies/Interests: Exercise

Religion: CHR CHRISTIAN

Spiritual Practices: Church

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

Last Grade Completed: Graduate degree
Degrees/Certificates: Masters in Foreign Relati

Current Student: N
Where:

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

Problems with Behavior at School:
Truancy:

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

~~~~EMPLOYMENT HISTORY~~~~
Currently Employed: Y
Pt Occupation: Analyst
Time at Current Job: 4.5 years
Job Satisfaction: High
Longest Time at One Job: 4.5 years
Frequent Job Changes: N
Reason for Job Changes^:

Unemployed in Last Year: N
Reason for Unemployment^:
~~~~

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)

Parent Occupation:
Spouse Occupation:
Financial Needs: Denies any stressors
Denies debts
Denies compulsive spendin
States she manages
money "very well and
I have good savings"
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: Y
Number of Arrests: 1
Reason for Arrest: leaving scene of accident
Arrests Involving Violence: N
DUI/DWI: N
When:
Public Intoxication: N
When:
Probation Hx: N
Why/When:
Parole Hx: N
Why/When:

Describe Pending Litigation/Civil Charges^:
See above note re. recent charges.
Patient has retained an attorney

~~~~CAFFEINE HISTORY~~~~

Pt Use Caffeine: Y

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)

Types of Caffeine: Coffee

Amt per Day: 1-2

~~~~NICOTINE HISTORY~~~~

Nicotine Hx: N

Kind of tobacco:

Age First Used:
Packs/tins per day:

How many years:
Any Consequences:

Quit:
When:

Does Patient Drink Alcoholic Beverages: Y
Type of Alcohol: WINE
How Often: 1 - 2 times/month
How Long: 10 years
How Much: glass
Last Drink:
Type of Alcohol:
How Often:
How Long:
How Much:
Last Drink:
Type of Alcohol:
~~~~

Intervention Description	Activity Type	Occurred Date	Occurred Time	by	Recorded Date	Recorded Time	by	Sts	Directions / Comment	Documented Units	From / Change
Activity Date: 11/04/09 Time: 1548 (continued)											
1001083 ADMISSION: Medication History + (continued)											
Sources Used For This Documentation:											
Routine Pharmacies Used:											
Clarification needed for any Medication:											
Home Medication Disposition:											
1001451-A CARE PLAN : MH ADDITIONS + ~~Use in place of Add Interventions~~ Allows customization of Patient Care Plan.	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
1002003 Psychosocial Assessment std +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
1051013 CARE AREA STATEMENT: PHP Adult + ~~DOCUMENT AT END OF EVERY SHIFT~~ To be documented every shift, to review current Pt. problems and to verify that the PHP Adult Patient Population Care Standards have been followed.	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A	. at end of each day		CP
1572301 ASSESS: Weight as Ordered and Record +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
1751000 VS: Monitor +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A	.X 1 on admission		CP
2120363 MH Daily Nursing Assessment +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A	. Every 24 hrs		CP
2120365 ASSESSMENT: AT Evaluation +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A	. 1 X		CP
2120366 MH Psycho-Educational Group +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
2120370 MH SW Group Therapy Session +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
2120752 Preceptor Documentation Co-Sign +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
4801200 EDUCATION: Interdisciplinary +	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
5021010 DISCHARGE: Complete Discharge Form + ALSO: Complete paper form-when going home	- Create	11/04/09	1548	EMW	11/04/09	1548	EMW	A			CP
Activity Date: 11/05/09 Time: 0855											
2120365 ASSESSMENT: AT Evaluation +	- Document	11/05/09	0855	KDO	11/05/09	0855	KDO	A	. 1 X		CP

PROBLEMS TO BE ADDRESSED BY ACTIVITY THERAPY:

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

Other:

Physical Problems/Safety Concerns: decreased ability to cope.
: hx of stress/anxiety

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: Y
Development of Realistic Body Image:
Social Interaction:
Development of More Functional Social Skills:

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)

How Often:
How Long:
How Much:
Last Drink:
Alcohol Comment^:
Patient denies any abuse of alcohol and states she seldom drinks

Pt Believes ETOH 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:

ETOH Sobriety/Support/Treatment Comments^:
None

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^:

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

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)

Medical Problems from CD Use:

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

CD Sobriety/Support/Treatment Comments^:
Patient denies any CD recent or past

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

Physical:
Describe Physical Abuse^:

Emotional:
Describe Emotional Abuse^:

Sexual:
Describe Sexual Abuse^:

Neglect:
Describe Neglect^:

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^:
~~~~

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)

Abuse Comments^:

~~~~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^:
Mostly exercise

Type of Recent Leisure Activities^:
Running, working out in gym

What Do You Do When Bored/Lonely^:
Go running on the mall

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

Improvement Needed in ANY of the following areas:
Patient denies

Pt Perception of Illness^:
Patient is bewildered as to why she is here.

Intervention Description	Sts	Directions	From

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

Activity Date: 11/04/09 Time: 1533 (continued)

1002003 Psychosocial Assessment std + (continued)
Patient states that her co-worker who reported her bizarre behavior at work is disgruntled, leaving his job and moving to California. She contends that she has had a conflictual relationship with this co-worker.
Pt Perception of Needs^:
Patient states she will "do whatever you tell me here and whatever I need to get back to my job"
Pt's Goals for Treatment^:
Return to work
Have attorney advocate that legal charges be dropped
Be able to convince her boss that she is stable

Community Resources Current/Needed:
Unable to assess

Anticipated Treatment Mgr Role in TX/DC Planning:
FAMILY CONTACT
COORDINATION OF CARE/OPP
DISCHARGE PLANNING
REFERRAL TO COMM. RESOURC

Goals of Treatment: STABILIZE MOOD
IMPROVE COPING SKILLS

Activity Date: 11/04/09 Time: 1547

1001451-A	CARE PLAN : MH ADDITIONS + ~~Use in place of Add Interventions~~ Allows customization of Patient Care Plan.			CP
- Create	11/04/09 1547 EMW	11/04/09 1547 EMW		
- Ed Status	11/04/09 1547 EMW	11/04/09 1547 EMW		A => C
1002003	Psychosocial Assessment std +		C	CP
- Create	11/04/09 1547 EMW	11/04/09 1547 EMW		
- Ed Status	11/04/09 1547 EMW	11/04/09 1547 EMW		A => C
1002030	PSY: Anxiety Disorder, Assess		A	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
~~~~

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

Activity Date: 11/04/09 Time: 1547

4136600	MEDS: Administer PAIN-MEDS(prn/standing) + 1. Monitor effectiveness/side effects (and any adverse reactions).	C		CP
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
4801200	EDUCATION: Interdisciplinary +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
5021010	DISCHARGE: Complete Discharge Form + ALSO: Complete paper form-when going home	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
5021012	DISCHARGE: MED REC PATIENT MED List +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
9100004	QUICK ADMISSION DATA + Nursing Quick Start	A		AS
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Document	11/04/09 1547 EMW 11/04/09 1547 EMW			

*** QUICK ADMIT ***

Location/Service: J.3PA
Patient Care Type: AGE: 33
Arrival Time: 1130

Activity Date: 11/04/09 Time: 1548

1001070	Admission Initial Safety Assessment + * To be done on Admission *	A	. * To be done on Admission *	CP
- Create	11/04/09 1548 EMW 11/04/09 1548 EMW			
- Document	11/04/09 1548 EMW 11/04/09 1556 EMW			

What are your goals for this hospitalization: "Adequately address any concerns about my
: ability to return to work and cope with stress"

Any History of Abuse or Neglect: N

History of Aggressive/Assaultive Behavior: None
Access to Lethal Means: N
If Yes please explain:
Patients Social Worker notified: N

History of Suicide Attempts: N

Does the patient have any thoughts of suicide:DENIES
Does the patient have any intent of suicide: DENIES
Does the patient have a plan for suicide: DENIES

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

Activity Date: 11/04/09 Time: 1548 (continued)

1001070 Admission Initial Safety Assessment + (continued)
Does the patient have a history of self harm: N Types of Self Harm Behaviors:
Head Banging: N Scratching/Cutting: N Manipulating others to harm self: N
Fire Setting: N Hanging: N Overdosing: N Burning: N Self Strangulation: N
Jump in front of car, window, metro: N Poison: N Self Biting: N Other: N
Triggers: NA
:

Level of Impulsivity: Low

Admission history/symptoms indicate potential for self-harm: N
Commits to notify staff of self harm thoughts,intent, or plans:Y
Patient's Protective Barriers against Suicide/Self Harm: Coping Skills
Currently Employed/School
Positive Attitude
Social Supports
Ability Reality Test
Precipitating Factors:If applicable what does the pt identify as the cause
of loss of control or acting out behavior? "MY JOB'S CONCERN AFTER THE ACCIDENT REPORT
: FOLLOWING MY CAR ACCIDENT ON OCT 27, 2009"

Techniques used to help patient control behavior: "I HAVE BEEN IN CONTROL
: OF MY MOOD, NOT OUT OF CONTROL, EXCEPT WHEN DISORIENTED FEW DAYS AFTER ACC.

<<NURSING ADMISSION NOTE>>
Oriented to unit: Y
Appearance: WELL GROOM : PT ADMITTED TO ADULT PARTIAL PROGRAM TODAY. STATES
Additional Comments: SHE WAS DISORIENTED AFTER HER CAR ACCIDENT FOR A FEW DAYS BUT DENIES
: LOSS OF CONTROL OF MOOD OR BEHAVIOR RECENTLY. HAS AN INTERVIEW AT WORK
: TODAY; VERY ELEGANTLY AND NEATLY DRESSED IN BUSINESS SUIT. DENIES SI/HI/SIB
: GIVES SL=10
:
:
:

1001083	ADMISSION: Medication History + * Medication History to be done on Admission *	A		AS
- Create	11/04/09 1548 EMW 11/04/09 1548 EMW			
- Document	11/04/09 1548 EMW 11/04/09 1548 EMW			

Home Medications:

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

Activity Date: 11/04/09 Time: 1547 (continued)

1002030	PSY: Anxiety Disorder, Assess (continued) 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.			
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
1002051	PSY: Thought Disorder, Assess * 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 * Encourage pt to explore adaptive behaviors that increase socialization * Encourage pt to explore adaptive behaviors that help to accomplish ADL's	A		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
1009999	UPDATE: Clarification of Medications +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C

Activity Date: 11/04/09 Time: 1547

1051009-A	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.	C	. At End of shift	CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
1300006	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.	A		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
1572301	ASSESS: Weight as Ordered and Record +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
1751000	VS: Monitor +	C	.Daily or per MD order.	CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
2120363	MH Daily Nursing Assessment +	C	.Every 24 hours	CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
2120365	ASSESSMENT: AT Evaluation +	C	. 1 Time	CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
2120366	MH Psycho-Educational Group +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
2120370	MH SW Group Therapy Session +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
2120752	Preceptor Documentation Co-Sign +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
3766530	NUTRITION: Monitor Meals, Record % +	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			
- Ed Status	11/04/09 1547 EMW 11/04/09 1547 EMW			A => C
4136600	MEDS: Administer PAIN-MEDS(prn/standing) 1. Monitor effectiveness/side effects (and any adverse reactions).	C		CP
- Create	11/04/09 1547 EMW 11/04/09 1547 EMW			

Intervention Description	Sts	Directions	From

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

Activity Date: 11/05/09 Time: 0855 (continued)

2120365 ASSESSMENT: AT Evaluation + (continued)
Development of Impulse Control:
Identification of Leisure Time Skills and Interests: Y
Development of Structured Leisure Plan For After Discharge:
Identification of Healty Alternatives to Drug Related Behavior:

Other:

Activity Date: 11/05/09 Time: 1608

Patient Notes: NURSE NOTES
- Create 11/05/09 1608 MJ 11/05/09 1608 MJ

ACTIVITY/EXPRESSIVE THERAPY GROUP NOTE

GROUP TOPIC: Movement Therapy Self-Esteem

Observation of Symptomology: Minimal

Group Participation: Involved
Affect: Flat
Mood: Calm
Peer Interaction: Minimal
Staff Interaction: Compliant
Impulse Control: Good

Pt/Family Education Done: Yes
Person Taught: Patient
Readiness to Learn: Receptive
Teaching Method: Group Session/Class
Outcome: Comm. Understanding
Comments:

Note Type	Description
No Type	None

Activity Date: 11/05/09 Time: 1630

2120363 MH Daily Nursing Assessment + A . Every 24 hrs CP
- Document 11/05/09 1630 MVP 11/05/09 1635 MVP
~ ~~~Mental Status Exam~~~
LOC: Alert
Orientation: Oriented x 3
Knowledge of Illness: Yes
Eye Contact: Fleeting
Thought Content: Self-Accepting
Appearance: Clean and Neat
Mood: Anxious
Insight: Fair
Comment: PATIENT WAS FOCUSED ON GROUP SESSIONS
Concentration: Good
Memory: Intact
Speech: Clear/Well Modulated
Behavior: Cooperative
Thought Process: Coherent/Logical
Affect: Appropriate
Motor: Steady/No Extraneous Move
Judgement: Fair

Suicidal Ideation: N

Intervention Description	Sts	Directions	From

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

Activity Date: 11/05/09 Time: 1630 (continued)

2120363 MH Daily Nursing Assessment + (continued)
Thoughts:
Intent to Harm Self:
Plan:

Self Harm: N Type:
Identify Current Triggers:

Homicidal Ideation: N
Thoughts:
Intent to Harm Others:
Plan:

Aggressive/Assaultive Behavior Level: Low Impulse Control: Mod
Safety Level: 9-10
Comments: PATIENT SAYS SAFETY IS 10

~~APPETITE~~
Nutritional Status: PATIENT SAYS APPETITE IS GOOD
Comments:

~~~ADL/HYGIENE~~~
Grooming/Dress: Appropriate/Neat/Clean
Comments:

~~MEDICATIONS~~
Is patient compliant with medication regimen: Y
If no, explain:

Medication Side Effects: N
If yes, explain:

Monitoring of effects of medications to include:
Staff observations of effect(s):
Pt's perceptions of effect(s):

Physical Complaints:
:

Sleep Pattern Disturbance: N Difficulty Falling Asleep: Early A.M. Awakening:
Day/Night Reversal: Nightmares:
Sleep Walking: Hypersomnia:
Other:

Is this a change in patient's regular sleep pattern:

Comment:

Pt/Family Education Done: Y Enter Note?

Person Taught: Patient
~~~

Intervention Description — Sts — Directions — From

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

Activity Date: 11/05/09 Time: 1630 (continued)

2120363 MH Daily Nursing Assessment + (continued)
Readiness to Learn: Receptive
Teaching Method: Verbal/Written
Discipline: Nursing
Medication Education: N
If FDI Ed. which drug:
1st Time Dose Instruction:
Medication Name(s):
Medication Information Taught:
Medication Info Cont.:
Medication Info. Cont.:
Content Area: Treatment
Outcome: Comm. Understanding

Education Notes: GOAL SETTING
: SUPPORT
: SAFETY

Activity Date: 11/05/09 Time: 1635

Patient Notes: NURSE NOTES
- Create 11/05/09 1635 MVP 11/05/09 1638 MVP

PATIENT PRESENT FOR GROUP SESSION TODAY INVOLVED AFFECT ANXIOUS SAYS SHE WENT TO THE GYM YESTERDAY ATE DINNER AND TALKED WITH FRIENDS. SOCIAL WITH PEERS. SET GOAL TO CONTINUE TO PROGRESS AT RESOLVING CONCERNS FROM JOB. SAY SHE HAS NO SAFETY ISSUES AND RATES SAFETY AT LEVEL 10. PATIENT SAYS SHE IS SLEEPING OK AND APPETITE IS GOOD. EXPRESSED FEELING HAPPY CALM DETERMINED AND CALM.

Note Type Description
Diagnosis PSY PROBLEM: Anxiety

Activity Date: 11/06/09 Time: 1155

2120363 MH Daily Nursing Assessment + A . Every 24 hrs CP
- Document 11/06/09 1155 EMW 11/06/09 1159 EMW
~ ~~~Mental Status Exam~~~
LOC: Alert
Concentration: Fair
Orientation: Oriented x 3
Memory: Intact
Knowledge of Illness: Yes
Speech: Clear/Well Modulated
Eye Contact: Direct
Behavior: Composed
Thought Content: positive self-talk
Thought Process: Coherent/Logical
Appearance: Clean and Neat
Affect: Appropriate
Mood: Pleasant
Motor: Steady/No Extraneous Move
Insight: Fair
Judgement: Fair
Comment:

Suicidal Ideation: N
Thoughts:

Intervention Description — Sts — Directions — From

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

Activity Date: 11/06/09 Time: 1155 (continued)

2120363 MH Daily Nursing Assessment + (continued)
Intent to Harm Self:
Plan:

Self Harm: N Type:
Identify Current Triggers:

Homicidal Ideation: N
Thoughts:
Intent to Harm Others:
Plan:

Aggressive/Assaultive Behavior Level: Low Impulse Control: Mod
Safety Level: 9-10
Comments: SL=10, denies SI/HI/SIB

~~APPETITE~~
Nutritional Status: reports appetite good
Comments:

~~~ADL/HYGIENE~~~
Grooming/Dress: Appropriate/Neat/Clean
Comments: elegantly dressed in business suit

~~MEDICATIONS~~
Is patient compliant with medication regimen: Y
If no, explain:

Medication Side Effects: N
If yes, explain:

Monitoring of effects of medications to include:
Staff observations of effect(s): affect appropriate, composed; participates in groups
Pt's perceptions of effect(s): not taking (none prescribed by Dominion)

Physical Complaints: none reported or observed
:

Sleep Pattern Disturbance: N Difficulty Falling Asleep: Early A.M. Awakening:
Day/Night Reversal: Nightmares:
Sleep Walking: Hypersomnia:
Other:

Is this a change in patient's regular sleep pattern:

Comment: reports sleep ok

Pt/Family Education Done: Y Enter Note? N

Person Taught: Patient
Readiness to Learn: Receptive
Teaching Method: Group Session/Class
~~~

Intervention Description | Sts | Directions | From

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

Activity Date: 11/06/09 Time: 1155 (continued)

2120363 MH Daily Nursing Assessment + (continued)
Discipline: Nursing
Medication Education: N
If FDI Ed. which drug:
1st Time Dose Instruction:
Medication Name(s):
Medication Information Taught:
Medication Info Cont.:
Medication Info. Cont.:
Content Area: Home Care
Outcome: Demo Independently

Education Notes: group: weekend planning

Activity Date: 11/06/09 Time: 1159

Patient Notes: NURSE NOTES
- Create 11/06/09 1159 EMW 11/06/09 1202 EMW

Pt states she is "proud she has been able to withstand everything, not spiraling into a deep depression or internalize the things people have said about me." Denies safety issues, SI=10.
Note Type Description
Diagnosis PSY:PROBLEM: Alteration in Thought Proc

Activity Date: 11/06/09 Time: 1224

Patient Notes: PHP GROUP NOTE
- Create 11/06/09 1224 AVB 11/06/09 1225 AVB

PSYCHOEDUCATION GROUP NOTE

GROUP TOPIC: Stress Management Stress Management

Observation of Symptomology: Minimal

Group Participation: Appropriate
Affect: Appropriate
Mood: Anxious
Peer Interaction: Appropriate to all peers
Staff Interaction: Compliant
Impulse Control: Good
Affect: Appropriate

Pt/Family Education Done: No

Intervention Description | Sts | Directions | From

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

Activity Date: 11/06/09 Time: 1224 (continued)

Patient Notes: PHP GROUP NOTE (continued)
Person Taught:
Readiness to Learn:
Teaching Method:
Outcome:
Comments:pt sharing w/e plans and concerns about court date on tues, accepting supportive fb about same
Note Type Description
No Type None

Activity Date: 11/06/09 Time: 1238

Patient Notes: PHP GROUP NOTE
- Create 11/06/09 1238 MXS 11/06/09 1242 MXS

SOCIAL WORK GROUP NOTE

GROUP TOPIC: Coping/Survival Skills

Observation of Symptomology: Minimal
Group Participation: Appropriate
Affect: Flat
Mood: Anxious
Peer Interaction: Appropriate to all peers
Staff Interaction: Compliant
Impulse Control: Good
Affect: Constricted
Comments: Group focused on ambivalence and resistance to treatment. Patient sat silently listening for most of group. Close to end of group she talked about "doing more thinking" about the recent series of events that resulted in her referral here. She then went on to say she had experienced several bouts of severe depression in recent years but attributed these to situational stressors in her life e.g. academic demands of grad school.
Note Type Description
No Type None

Activity Date: 11/06/09 Time: 1410

1051013 CARE AREA STATEMENT: PHP Adult + A . at end of each day CP
--DOCUMENT AT END OF EVERY SHIFT--
To be documented every shift, to review current Pt. problems and to verify that the PHP Adult Patient Population Care Standards have been followed.
- Document 11/06/09 1410 MVP 11/06/09 1411 MVP
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 : C14:
3: STANDARD: DOMINION HOSPITAL WIDE CARE : C15:
4: PSY.PROBLEM: Anxiety : A16:
5: PSY:PROBLEM: Alteration in Thought Proc: A17:

Intervention Description	Sts	Directions	From

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

Activity Date: 11/06/09 Time: 1410 (continued)

1051013 CARE AREA STATEMENT: PHP Adult + (continued)
6: CARE GOALS: Dominion PHP Adult : A18: :
7: STANDARD: DOMINION HOSPITAL PHP : A19: :
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)

Comment:
Enter Note? N Shift: 7AM-3PM Signature: PERRY,MARILYN - RN

Activity Date: 11/09/09 Time: 1027

Patient Notes: SOCIAL SERVICES NOTES
- Create 11/09/09 1027 MXS 11/09/09 1034 MXS

MEETING WITH PATIENT:
This CSW met with patient for purpose of assessment and discharge planning. Patient reported that her mother is continuing to stay with her and provide support. Patient had spent weekend in a highly structured way, exercising, eating out with her mother or with friends and remaining busy most of the time.
IMPRESSION:
Today patient presents dressed in business attire with good grooming. Her mood is anxious, affect is congruent with ideation, eye contact is good, thinking is clear and goal directed. Patient denies any harmful ideation toward self or other, acknowledges some sleep disturbance over the weekend which she attributes to her anxiety about court date tomorrow and the ongoing employment status investigation that she has to face with her governmental agency. Patient continues to offer plausible explanation for her traffic accident and flat out denies other accusations of bizarre behavior at work. Patient denies any symptoms suggestive of a psychotic episode.
PLAN:
1. Patient will attend court hearing in the AM with her mother and friends as a support system.
2. Patient will either return to PHP after court or return on Wed 11/11/09.
3. Patient encouraged to find OP providers so that she can follow up after discharge from PHP.
5. Attending psychiatrist informed of all above.
Note Type Description
No Type None

Intervention Description	Sts	Directions	From

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

Activity Date: 11/09/09 Time: 1230

2120363 MH Daily Nursing Assessment + A . Every 24 hrs CP
- Document 11/09/09 1230 DPS 11/09/09 1235 DPS
~ ~~~Mental Status Exam~~~
LOC: Alert
Orientation: Oriented to Person only
Knowledge of Illness: Yes
Eye Contact: Direct
Thought Content: Self-Accepting
Appearance: Clean and Neat
Mood: Calm
Insight: Fair
Comment:
Concentration: Fair
Memory: Intact
Speech: Clear/Well Modulated
Behavior: Composed
Thought Process: Coherent/Logical
Affect: Blunted
Motor: Steady/No Extraneous Move
Judgement: Fair

Suicidal Ideation: N
Thoughts:
Intent to Harm Self:
Plan:

Self Harm: N Type:
Identify Current Triggers:

Homicidal Ideation: N
Thoughts:
Intent to Harm Others:
Plan:

Aggressive/Assaultive Behavior Level: Low Impulse Control: High
Safety Level: 9-10
Comments: NO UNSAFE BEHAVIOR NOTED

~~APPETITE~~
Nutritional Status: GOOD
Comments:

~~~ADL/HYGIENE~~~
Grooming/Dress: Appropriate/Neat/Clean
Comments:

~~MEDICATIONS~~
Is patient compliant with medication regimen: N
If no, explain: NOT ON MEDS

Medication Side Effects: N
If yes, explain:

Monitoring of effects of medications to include:
Staff observations of effect(s): NOT ON MEDS
Pt's perceptions of effect(s): NOT ON MEDS

Physical Complaints: NONE
:
~~~

Intervention Description	Sts	Directions	From

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

Activity Date: 11/09/09 Time: 1230 (continued)

2120363 MH Daily Nursing Assessment + (continued)

Sleep Pattern Disturbance: N Difficulty Falling Asleep: Early A.M. Awakening:
Day/Night Reversal: Nightmares:
Sleep Walking: Hypersomnia:
Other:

Is this a change in patient's regular sleep pattern:

Comment: SLEPT 8 HOURS

Pt/Family Education Done: Y Enter Note? N

Person Taught: Patient
Readiness to Learn: Passively Receptive Teaching Method: Verbal
Discipline: Nursing
Medication Education: N
If FDI Ed. which drug:
1st Time Dose Instruction:
Medication Name(s):
Medication Information Taught:
Medication Info Cont.:
Medication Info. Cont.:
Content Area: Activity
Outcome: Comm. Understanding

Education Notes: TALKED ABOUT STAYING ACTIVE

Activity Date: 11/09/09 Time: 1235

Patient Notes: NURSE NOTES
- Create 11/09/09 1235 DPS 11/09/09 1237 DPS

PT STATES SHE SPENT TIME LAST NIGHT WITH FRIENDS AND WORKED OUT.DENIES ANY SXS OF DEPRESSION OR FEELINGS TO HARM SELF OR OTHERS.PRE-OCCUPIED WITH COURT DATE COMING UP BUT STAYING POSITIVE.NO UNSAFE BEHAVIOR NOTED.THOUGHTS ARE CLEAR AND SPEECH IS LOGICAL

Note Type Description
Diagnosis PSY PROBLEM: Anxiety

Activity Date: 11/09/09 Time: 1248

Patient Notes: PHP GROUP NOTE
- Create 11/09/09 1248 MXS 11/09/09 1250 MXS

SOCIAL WORK GROUP NOTE

GROUP TOPIC: Coping/Survival Skills

Observation of Symptomology: Absent
Group Participation: Appropriate
Affect: Constricted
Mood: Anxious
Peer Interaction: Appropriate to all peers
Staff Interaction: Compliant
Impulse Control: Good
Affect: Flat
Comments: Group focused on need for a support system during recovery. Patient talked about having family and friends as support during this time of crisis.

Note Type Description
No Type None

Activity Date: 11/10/09 Time: 1352

Patient Notes: NURSE NOTES
- Create 11/10/09 1352 EMW 11/10/09 1352 EMW

Pt not in attendance today due to scheduled transition day.

Note Type Description
No Type None

Activity Date: 11/11/09 Time: 1221

Patient Notes: SOCIAL SERVICES NOTES
- Create 11/11/09 1221 MXS 11/11/09 1223 MXS

DISCHARGE PLANNING NOTE:
Patient emphatically declined aftercare appointments with an OP psychiatrist or therapist. Patient does not feel she is in need of further treatment. However, she is planning to discuss this further with the psychiatrist at the State Department.

Note Type Description
No Type None

Activity Date: 11/11/09 Time: 1535

5021010 DISCHARGE: Complete Discharge Form + A CP
ALSO:
Complete paper form-when going home
- Document 11/11/09 1535 EMW 11/11/09 1536 EMW
PATIENT EDUCATION OUTCOME STANDARDS/DISCHARGE NOTE

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

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

Activity Date: 11/11/09 Time: 1535 (continued)

5021010 DISCHARGE: Complete Discharge Form + (continued)

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

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

Adequate (sufficient, correct) N Partial, needs reinforcement (If checked, complete:) Y
Referred to continuation of care provider N
Issued written materials Y
Family given instructions N

(* : N/A)

Next Topic pg2-->

Patient Status at Discharge: PATIENT COMPOSED, ALERT, ORIENTED;
Follow Up Destination: HOME
Therapist who will Follow Pt: PT DECLINES AFTERCARE APPOINTMENTS

Comment: PT STATES "I AM WAITING FOR GUIDANCE FROM MY
: EMPLOYER"
:

Following items returned:
Valuables Y Sharps Y Medications Y

Discharge Time: 1100
Accompanied by: SELF
Relationship to Pt: *

(* : N/A)

Activity Date: 11/11/09 Time: 1536

10010/0	Admission Initial Safety Assessment + * To be done on Admission *							* To be done on Admission *		D		CP
- Ed Status	11/11/09 1536 his				11/11/09 1536 his							A => D
1001083	ADMISSION: Medication History + * Medication History to be done on Admission *									D		AS
- Ed Status	11/11/09 1536 his				11/11/09 1536 his							A => D

Activity Date: 11/11/09 Time: 1536

1001451-A	CARE PLAN : MH ADDITIONS + ~~Use in place of Add Interventions~~ Allows customization of Patient Care Plan.									D		CP
- Ed Status	11/11/09 1536 his				11/11/09 1536 his							A => D
1002003	Psychosocial Assessment std +									D		CP
- Ed Status	11/11/09 1536 his				11/11/09 1536 his							A => D
1002030	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.									D		CP
- Ed Status	11/11/09 1536 his				11/11/09 1536 his							A => D
1002051	PSY: Thought Disorder, Assess * 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									D		CP

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

Activity Date: 11/11/09 Time: 1536 (continued)

1002051 PSY: Thought Disorder, Assess (continued)

* Collaborate with pt to identify anxious behavior and coping techniques

* Collaborate with pt to establish a daily, achievable routine

* Encourage pt to explore adaptive behaviors that increase socialization

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

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

1051013 CARE AREA STATEMENT: PHP Adult + D . at end of each day CP
~~DOCUMENT AT END OF EVERY SHIFT~~
To be documented every shift, to review current Pt. problems and to verify that the PHP Adult Patient Population Care Standards have been followed.

- Ed Status 11/11/09 1536 his 11/11/09 1536 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 11/11/09 1536 his 11/11/09 1536 his A => D

1572301 ASSESS: Weight as Ordered and Record + D CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

1751000 VS: Monitor + D .X 1 on admission CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

2120363 MH Daily Nursing Assessment + D . Every 24 hrs CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

2120365 ASSESSMENT: AT Evaluation + D . 1 X CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

2120366 MH Psycho-Educational Group + D CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

2120370 MH SW Group Therapy Session + D CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

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

Activity Date: 11/11/09 Time: 1536

2120752 Preceptor Documentation Co-Sign + D CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

4801200 EDUCATION: Interdisciplinary + D CP

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

5021010 DISCHARGE: Complete Discharge Form + D CP
ALSO:
Complete paper form-when going home

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

9100004 QUICK ADMISSION DATA + D AS
Nursing Quick Start

- Ed Status 11/11/09 1536 his 11/11/09 1536 his A => D

Monogram	Initials	Name	Nurse Type
AVB	J.NUR.AVB	BOOMSA,ANN V	RN
DPS	J.REG.DPS	SCHMITZ,DAVID	RN
EMW	J.NUR.EMW2	WITTING,ELIZABETH	RN
KDO	J.NUR.KDO	OVERSTREET,KRISTIN D	ACT
MJ	J.NUR.MJ	JOHNSON,MELANIE	ACT
MVP	J.NUR.MP	PERRY,MARILYN	RN
MXS	J.NUR.MFS1	SANDIFORD,MARY	SW
his		automatic by program	

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
11/04/09	1441	MXS	SANDIFORD,MARY	11/04/09	1453	MXS	SOCIAL SERVICES NOTES

MEETING WITH PATIENT FOR PURPOSE OF COMPLETING PSYCHOSOCIAL HISTORY:
This CSW interviewed patient and completed psychosocial history.Patient denied any bizarre behavior at work, could not recall statements she is reported to have made following recent auto accident and stated that she is willing to comply with PHP if this is what is required by the State Department in order to return to work.
IMPRESSION:
Today patient presents well groomed, dressed in business attire, oriented x 3, mood is anxious, affect wide ranging, eye contact good, demeanor is pleasant and cooperative. Patient denies any recent symptoms of depression or other mood disturbances, denies any auditory or visual hallucinations, denies any harmful ideation to self or other. Patient acknowledges prior episodes of depression/anxiety during grad school (at Georgetown Univ SFS) for which she was treated with medication and brief therapy. Patient acknowledges diagnosis of ADD. Patient acknowledges that the four month assignment with DOD that she spent in Iraq, where she was on a base that was "mortared every day, getting closer and closer" was stressful and fearful. Upon return from Iraq patient acknowledges having sleep disturbance for several weeks but then sleep cycle regulated and patient returned to work, transferred to State Department where reportedly she has exceeded work performance expectations.
PLAN:
1. CSW voice mailed attending psychiatrist re. completion of psychosocial history and possibility of a meeting with patient and her mother on 11/6/09 at 9.0 am.
2. Patient will bring police report of accident she is purported to have caused, with her tomorrow for psychiatrist to read.
3. Patient has sought legal counsel to represent her in court over charges ensuing from accident.
4. Patient commits to safety and has her mother staying in the home with her.
5. Attending psychiatrist informed of all above.

Note Type	Description
No Type	None

11/05/09	1608	MJ	JOHNSON,MELANIE	11/05/09	1608	MJ	NURSE NOTES

ACTIVITY/EXPRESSIVE THERAPY GROUP NOTE

GROUP TOPIC: Movement Therapy Self-Esteem

Observation of Symptomology: Minimal

Group Participation: Involved
Affect: Flat
Mood: Calm
Peer Interaction: Minimal
Staff Interaction: Compliant
Impulse Control: Good

Pt/Family Education Done: Yes
Person Taught: Patient
Readiness to Learn: Receptive
Teaching Method: Group Session/Class

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category

11/05/09 1608 MJ JOHNSON,MELANIE 11/05/09 1608 MJ (continued)

Outcome: Comm. Understanding

Comments:

Note Type	Description
No Type	None

11/05/09 1635 MVP PERRY,MARILYN 11/05/09 1638 MVP NURSE NOTES

PATIENT PRESENT FOR GROUP SESSION TODAY INVOLVED AFFECT ANXIOUS SAYS SHE WENT TO THE GYM YESTERDAY ATE DINNER AND TALKED WITH FRIENDS. SOCIAL WITH PEERS. SET GOAL TO CONTINUE TO PROGRESS AT RESOLVING CONCERNS FROM JOB. SAY SHE HAS NO SAFETY ISSUES AND RATES SAFETY AT LEVEL 10. PATIENT SAYS SHE IS SLEEPING OK AND APPETITE IS GOOD. EXPRESSED FEELING HAPPY CALM DETERMINED AND CALM.

Note Type	Description
Diagnosis	PSY.PROBLEM: Anxiety

11/06/09 1159 EMW WITTING,ELIZABETH 11/06/09 1202 EMW NURSE NOTES

Pt states she is "proud she has been able to withstand everything, not spiraling into a deep depression or internalize the things people have said about me." Denies safety issues, SL=10.

Note Type	Description
Diagnosis	PSY:PROBLEM: Alteration in Thought Proc

11/06/09 1224 AVB BOOMSA,ANN V 11/06/09 1225 AVB PHP GROUP NOTE

PSYCHOEDUCATION GROUP NOTE

GROUP TOPIC: Stress Management Stress Management

Observation of Symptomology: Minimal

Group Participation: Appropriate
Affect: Appropriate
Mood: Anxious
Peer Interaction: Appropriate to all peers
Staff Interaction: Compliant
Impulse Control: Good
Affect: Appropriate

Pt/Family Education Done: No
Person Taught:
Readiness to Learn:
Teaching Method:
Outcome:
Comments:pt sharing w/e plans and concerns about court date on tues, accepting supportive fb about same

Note Type	Description
No Type	None

11/06/09 1238 MXS SANDIFORD,MARY 11/06/09 1242 MXS PHP GROUP NOTE

SOCIAL WORK GROUP NOTE

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category
11/06/09	1238	MXS	SANDIFORD,MARY	11/06/09	1242	MXS	(continued)

GROUP TOPIC: Coping/Survival Skills

Observation of Symptomology: Minimal
Group Participation: Appropriate
Affect: Flat
Mood: Anxious
Peer Interaction: Appropriate to all peers
Staff Interaction: Compliant
Impulse Control: Good
Affect: Constricted
Comments: Group focused on ambivalence and resistance to treatment. Patient sat silently listening for most of group. Close to end of group she talked about "doing more thinking" about the recent series of events that resulted in her referral here. She then went on to say she had experienced several bouts of severe depression in recent years but attributed these to situational stressors in her life e.g. academic demands of grad school.

Note Type Description

No Type None

11/09/09 1027 MXS SANDIFORD,MARY 11/09/09 1034 MXS SOCIAL SERVICES NOTES

MEETING WITH PATIENT:
This CSW met with patient for purpose of assessment and discharge planning. Patient reported that her mother is continuing to stay with her and provide support. Patient had spent weekend in a highly structured way, exercising, eating out with her mother or with friends and remaining busy most of the time.
IMPRESSION:
Today patient presents dressed in business attire with good grooming. Her mood is anxious, affect is congruent with ideation, eye contact is good, thinking is clear and goal directed. Patient denies any harmful ideation toward self or other, acknowledges some sleep disturbance over the weekend which she attributes to her anxiety about court date tomorrow and the ongoing employment status investigation that she has to face with her governmental agency. Patient continues to offer plausible explanation for her traffic accident and flat out denies other accusations of bizarre behavior at work. Patient denies any symptoms suggestive of a psychotic episode.
PLAN:
1. Patient will attend court hearing in the AM with her mother and friends as a support system.
2. Patient will either return to PHP after court or return on Wed 11/11/09.
3. Patient encouraged to find OP providers so that she can follow up after discharge from PHP.
5. Attending psychiatrist informed of all above.

Note Type Description

No Type None

11/09/09 1235 DPS SCHMITZ,DAVID 11/09/09 1237 DPS NURSE NOTES

PT STATES SHE SPENT TIME LAST NIGHT WITH FRIENDS AND WORKED OUT.DENIES ANY SXS OF DEPRESSION OR FEELINGS TO HARM SELF OR OTHERS.PRE-OCCUPIED WITH COURT DATE COMING UP BUT STAYING POSITIVE.NO UNSAFE BEHAVIOR NOTED.THOUGHTS ARE CLEAR AND SPEECH IS LOGICAL

Occurred Date	Time	by	Author	Recorded Date	Time	by	Notes: All Categories Category

11/09/09 1235 DPS SCHMITZ,DAVID 11/09/09 1237 DPS (continued)

Note Type	Description
Diagnosis	PSY.PROBLEM: Anxiety

11/09/09 1248 MXS SANDIFORD,MARY 11/09/09 1250 MXS PHP GROUP NOTE

SOCIAL WORK GROUP NOTE

GROUP TOPIC: Coping/Survival Skills

Observation of Symptomology: Absent
Group Participation: Appropriate
Affect: Constricted
Mood: Anxious
Peer Interaction: Appropriate to all peers
Staff Interaction: Compliant
Impulse Control: Good
Affect: Flat
Comments: Group focused on need for a support system during recovery. Patient talked about having family and friends as support during this time of crisis.

Note Type	Description
No Type	None

11/10/09 1352 EMW WITTING,ELIZABETH 11/10/09 1352 EMW NURSE NOTES

Pt not in attendance today due to scheduled transition day.

Note Type	Description
No Type	None

11/11/09 1221 MXS SANDIFORD,MARY 11/11/09 1223 MXS SOCIAL SERVICES NOTES

DISCHARGE PLANNING NOTE:
Patient emphatically declined aftercare appointments with an OP psychiatrist or therapist. Patient does not feel she is in need of further treatment. However, she is planning to discuss this further with the psychiatrist at the State Department.

Note Type	Description
No Type	None

Monogram Initials		Name	Nurse Type
AVB	J.NUR.AVB	BOOMSA,ANN V	RN
DPS	J.REG.DPS	SCHMITZ,DAVID	RN
EMW	J.NUR.EMW2	WITTING,ELIZABETH	RN
MJ	J.NUR.MJ	JOHNSON,MELANIE	ACT
MVP	J.NUR.MP	PERRY,MARILYN	RN
MXS	J.NUR.MFS1	SANDIFORD,MARY	SW

AT Initial Assessment 11/05/09 0855 KDO

PROBLEMS TO BE ADDRESSED BY ACTIVITY THERAPY:

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

Other:

Physical Problems/Safety Concerns: decreased ability to cope,
: hx of stress/anxiety

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: Y
Development of Realistic Body Image:
Social Interaction:
Development of More Functional Social Skills:
Development of Impulse Control:
Identification of Leisure Time Skills and Interests: Y
Development of Structured Leisure Plan For After Discharge:
Identification of Healty Alternatives to Drug Related Behavior:

Other:

Monogram Initials	Name	Nurse Type
KDO J.NUR.KDO	OVERSTREET,KRISTIN D	ACT

Age/Sex: 3[illegible]
Unit #: J000018122
Admitted:
Status: REG RCR

Attending: Roth,Richard L
Account #: J84090218118
Location: J.3PA
Room/Bed:

WIL[illegible]S,LYNNAE D

Dominion Hospital Patient Care *Live*
Patient's Plan Of Care

Status: Active
Initiated: 11/04/09
Completed:
Protocol:

	SIS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	SIS
PSY:PROBLEM: Anxiety	A	11/04/09 EMW								
* STG: Patient's Anxiety will decrease AEB DAILY GROUP ATTENDANCE AND PARTICIPATION	A	11/04/09 EMW	11/16/09		* 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.	11/04/09 EMW				A
* LTG: Patient's Anxiety will decrease AEB PT SELF-REPORT DURING DAILY ASSESSMENT REGARDING BOTH HERE AND AT HOME	A	11/04/09 EMW	11/23/09							
PSY:PROBLEM: Alteration in Thought Proc	A	11/04/09 EMW								
* STG: PATIENT WILL HAVE DECREASE IN DISTURBED THOUGHTS AEB DECREASE/LACK OF BEHAVIORS INDICATING DECREASED CONCENTRATION OR ALTERED THOUGHT PROCESSES. ALSO AEB PT SELF-REPORT	A	11/04/09 EMW	11/16/09							
* LTG: PATIENT WILL HAVE DECREASE IN DISTURBED THOUGHTS AEB PT SELF-REPORT REGARDING THINKING AND FUNCTIONING IMPROVEMENT BOTH HERE AND AT HOME	A	11/04/09 EMW	11/23/09		* PSY: Thought Disorder. Assess * 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	11/04/09 EMW				A

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
					* Collaborate with pt to establish a daily, achievable routine * Encourage pt to explore adaptive behaviors that increase socialization * Encourage pt to explore adaptive behaviors that help to accomplish ADL's					
PSY:PROBLEM: Discharge Planning	A	11/09/09 EMW								
* STG/LTG: APPROPRIATE AFTERCARE APPOINTMENTS WILL BE OBTAINED	A	11/09/09 EMW	11/23/09							
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	A	11/04/09 EMW								
* 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>	A	11/04/09 EMW			* 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	11/04/09 EMW				A
CARE GOALS: Dominion PHP 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 PHP Program will be assessed and addressed. 2. The patient and/or significant others can expect to be involved in the Treatment Plan with attention to cultural, religious, and	A	11/04/09 EMW								

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
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. 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> - PROTOCOL : SOCMHPHP									
* Standards of Practice <End of text>	A	11/04/09 EMW			* CARE AREA STATEMENT: PHP Adult + ~~DOCUMENT AT END OF EVERY SHIFT~~ To be documented every shift. to review current Pt. problems and to verify that the PHP Adult Patient Population Care Standards have been followed. - PROTOCOL : SOCMHPHP	11/04/09 EMW		11/04/09 1548	. at end of each day	A
STANDARD: DOMINION HOSPITAL PHP 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 : SOCMHPHP	A	11/04/09 EMW								
* The patient will receive care which reflects an ongoing process of interdisciplinary care based on the patients specific needs and the PHP Patient Population Standards of Care. These will include those needs which are age-specific. Coping responses will be assesses and addressed.	A	11/04/09 EMW			* VS: Monitor + * 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 + * ASSESS: Weight as Ordered and Record + * MH Daily Nursing Assessment +	11/04/09 EMW 11/04/09 EMW 11/04/09 EMW 11/04/09 EMW 11/04/09 EMW 11/04/09 EMW 11/04/09 EMW		11/04/09 1548 11/04/09 1548	.X 1 on admission . Every 24 hrs	A A A A A A A

	STS	INIT BY	TRGT	COMP BY	INTERVENTIONS	INIT BY	COMP BY	DATE & TIME	DIRECTIONS	STS
* 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.	A	11/04/09 EMW								
* The patient and/or significant other 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.	A	11/04/09 EMW			* EDUCATION: Interdisciplinary +	11/04/09 EMW				A
* Patient and/or significant other will participate in the process of coordination of resources in preparation for discharge.	A	11/04/09 EMW			* DISCHARGE: Complete Discharge Form + ALSO: Complete paper form-when going home	11/04/09 EMW				A
* 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.	A	11/04/09 EMW			* Admission Initial Safety Assessment + * To be done on Admission *	11/04/09 EMW		11/04/09 1548	. * To be done on Admission *	A
* The patient will be supported in their effort to retain personal identity, self worth and patient rights.	A	11/04/09 EMW			* Psychosocial Assessment std +	11/04/09 EMW				A
* Participates in age appropriate activities and programs at level of activity. Able to identify daily, evening, and weekend treatment goals with minimal assistance.	A	11/04/09 EMW			* ASSESSMENT: AT Evaluation +	11/04/09 EMW		11/04/09 1548	. 1 X	A
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	C	11/04/09 EMW		11/04/09 EMW						
* 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.	C	11/04/09 EMW		11/04/09 EMW						
* 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	C	11/04/09 EMW		11/04/09 EMW						