I. PURPOSE:
A. To systematically collect relevant data about the patient as the initial step of the nursing care process.
B. To continually collect and review patient specific data throughout the patient’s stay.
C. To accurately document assessment findings on an approved form in the Medical Record.
D. To identify and prioritize the appropriate nursing diagnosis(es) which provide the focus for the development of the patient’s plan of care and discharge plan.

II. POLICY:
A. The standard of care at the Montana State Hospital (MSH) Forensic Mental Health Facility (FMHF) is that patients receive nursing care based on a documented systematic assessment of their needs, strengths, and treatment expectations.
B. Assessments will be completed by registered nurses (RNs) and documented on a standardized form. Assessments will be completed: 1) within 48 hours of admission to the FMHF; 2) whenever there is a significant change in the patient’s physical and/or mental status; 3) no less than yearly.
C. The registered nurse will formulate nursing diagnoses based on the data collected in the nursing assessment and will prioritize these diagnoses according to the patient’s needs.
D. To the degree possible, the patient and significant others will collaborate with the registered nurse in the completion of the assessment and the formulation of the nursing diagnoses.
E. The nursing assessment and nursing diagnoses are an integral part of the multi-disciplinary treatment planning process for each individual patient.
F. Registered Nurses will perform a head to toe assessment for patients reporting actual or potential physical health problems throughout their hospital stay. This
assessment information and ongoing assessment data will be documented on the Nursing Health Assessment form.

III. DEFINITIONS: None

IV. RESPONSIBILITIES:
A. Registered Nurses - Complete nursing assessment and diagnosis.

V. PROCEDURE:
A. Delegate the completion of the “Physical Characteristics” and “Orientation to the Unit” segments of the assessment form to any member of the nursing staff if so desired.

B. Select an appropriate place to perform the assessment.

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

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

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

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

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

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

I. Prioritize nursing diagnosis/problem statements based on the following factors:
1. potential danger to self and others;
2. physical illness requiring acute medical care;
3. patient’s/significant others perception of need priority;
4. assessed areas of severe, moderately severe to severe impairment/dysfunction; and
J. Document the assessment findings and identify nursing diagnoses on the MSH Nursing Assessment Form. This information is used to establish the initial plan of care which is formulated within 48 hours of the patient’s admission. Assessment data and the initial plan of care are the basis upon which the multidisciplinary treatment plan is formulated.

K. Document assessments of the patient’s progress towards treatment objectives in the progress notes of the patient’s medical record.

L. If, at the time of admission, sufficient assessment data is unable to be collected due to the severity of the patient’s symptoms, the patient will be re-assessed within 72 hours of admission. Completion of the admission assessment must be coordinated by RNs assigned to the FMHF. Nurse Supervisors are available to assist with the assessment when necessary.

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

VI. REFERENCES: M.C.A. 53-21-162. MSH policies Treatment Plan; MSH Nursing Procedure Nursing Physical Health Assessment. Administrative Rule of Montana 37.106.1915 and 37.106.1621.

VII. COLLABORATED WITH: Medical Director; Director of Nursing; Hospital Administrator; Clinical Services Director.

VIII. RESCISSIONS: None, new MSH FMHF policy.

IX. DISTRIBUTION: All MSH FMHF policy manuals.

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

XI. FOLLOW-UP RESPONSIBILITY: Director of Nursing Services

XII. ATTACHMENTS: Montana State Hospital Nursing Assessment

___________________________/___/__  ____________________________/___/__
John W. Glueckert               Date               David Olson                 Date
Hospital Administrator          Director of Nursing Services
MONTANA STATE HOSPITAL NURSING ASSESSMENT

TYPE OF ASSESSMENT: ☐ INITIAL/ADMISSION ☐ UPDATE

ADMISSION DATE: ______________ TIME: _________ COMMITMENT: ____________________________

PHYSICAL CHARACTERISTICS
Height: _____ Weight: _____ Hair Color/Description: _______________ Eye Color: ________
Race: _______ Age: _____ Gender: ☐ M ☐ F Date of Last Physical Exam: ______________________

Hygiene/Appearance: ___________________________________________________________________________

Prosthetic Device: ☐ Yes ☐ No Glasses; ☐ Yes ☐ No Contact Lenses; ☐ Yes ☐ No Hearing Aide: ☐ Left ☐ Right

Dentures: ☐ Full ☐ Partial; Own Teeth: ☐ Yes ☐ No

Existing wounds, cuts, bruises (identify on diagram and describe):

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

Body check (search):
Signature: ___________________________ Date: ______________ Time: _______________

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

Signature: ___________________________________________ Date: ______________ Time: _______________

ADMISSION ASSESSMENT (completed by RN)

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

Family Involvement/Support System: _______________________________________________________________

Previous Psychiatric Hospitalizations: _______________________________________________________________

ABUSE/NEGLECT ASSESSMENT
Evidence of: ☐ Physical Assault ☐ Domestic Abuse
☐ Rape or other Sexual Molestation ☐ Elder Abuse

Describe: _______________________________________________________________________________________

Patient’s Account: _______________________________________________________________________________

PHYSICIAN NOTIFIED: Dr. _______________________________________________________________________

☐ HISTORY OF ABUSE (describe): ___________________________________________________________________

NAME: ________________________________________ HOSPITAL NUMBER: ___________
IMMUNIZATIONS/HISTORY
- PPD last date given ______  Infections Disease;  HIV  Hepatitis  TB
- DT last date given ______  Pneumovax last date given ____________________________
- Influenza last date given ______  Other (specify) ____________________________

MEDICATION ASSESSMENT/HISTORY
CURRENT MEDICATION (prescription, OTC and herbals)
____________________________________________________

Patient understanding of medication purposes: ______________________________________________________

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

Medication compliance (indicate patient concerns): _____________________________________________________

ALLERGIES/ADVERSE DRUG REACTIONS:

Substance Use:
Caffeine: Within 72 hours  □ Yes  □ No  Hx  □ Yes  □ No  Amt/Day ______  # of YRS: ______
Tobacco: Within 72 hours  □ Yes  □ No  Hx  □ Yes  □ No  Amt/Day ______  # of YRS: ______

FAGERSTROM TEST FOR NICOTINE DEPENDENCE

1. How soon after you wake up do you smoke your first cigarette?
   □ After 60 minutes  (0)
   □ 31-60 minutes  (1)
   □ 6-30 minutes  (2)
   □ Within 5 minutes  (3)

2. Do you find it difficult to refrain from smoking in places where it is forbidden?
   □ No  (0)
   □ Yes  (1)

3. Which cigarette would you hate most to give up?
   □ The first in the morning  (1)
   □ Any other  (0)

4. How many cigarettes per day do you smoke?
   □ 10 or less  (0)
   □ 11-20  (1)
   □ 21-30  (2)
   □ 30 or more  (3)

5. Do you smoke more frequently during the first hours after awakening than during the rest of the day?
   □ No  (0)
   □ Yes  (1)

6. Do you smoke even if you are so ill that you are in bed most of the day?
   □ No  (0)
   □ Yes  (1)

Score: _______  Level of dependence on nicotine is: _________

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

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

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

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

### Street Drugs

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

### Infection Prevention

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

### PHYSICAL ASSESSMENT/REVIEW OF SYSTEMS

#### ALTERATION IN SKIN INTEGRITY
- [ ] No Problem
- [ ] Itching
- [ ] Bruise
- [ ] Rash
- [ ] Lesions
- [ ] Other (specify): _______________________

BRIEFLY DESCRIBE: _______________________________________________________________________

#### ALTERATION IN SENSORY FUNCTION
- [ ] No Problem
- [ ] Vision Problem
- [ ] Hearing Problem
- [ ] Loss of Sensation
- [ ] Change in Taste or Smell
- [ ] Other (specify): _______________________

BRIEFLY DESCRIBE: _______________________________________________________________________

#### ALTERATION IN RESPIRATORY FUNCTION
- [ ] No Problem
- [ ] Dyspnea
- [ ] Cough
- [ ] Sinus Problem
- [ ] Wheeze
- [ ] Pain
- [ ] SOB
- [ ] Asthma
- [ ] Other (specify): _______________________

BRIEFLY DESCRIBE: _______________________________________________________________________

#### ALTERATION IN CARDIOVASCULAR FUNCTION
- [ ] No Problem
- [ ] Edema
- [ ] High Blood Pressure
- [ ] Increase in Fatigue
- [ ] Arrhythmia History
- [ ] Pain (location): _______________________
- [ ] Other (specify): _______________________

BRIEFLY DESCRIBE: _______________________________________________________________________
ALTERATION IN NEUROLOGICAL FUNCTION

☐ No Problem ☐ Dizziness ☐ Headaches ☐ Painting ☐ Seizures ☐ Numbness/Tingling ☐ Tremors
☐ Learning Disability ☐ Head Trauma ☐ Other (specify): ________________________________
BRIEFLY DESCRIBE: ___________________________________________________________________

ALTERATION IN NUTRITION

☐ No Problem ☐ Weight Loss ☐ Weight Gain ☐ Balanced Diet ☐ Diabetes ☐ Skin Turgor
☐ Irregular Pattern of Eating ☐ Increased Appetite ☐ Decreased Appetite
☐ Difficulty Chewing ☐ Difficulty Swallowing ☐ Special Diet
☐ Other (specify): ________________________________
BRIEFLY DESCRIBE: ___________________________________________________________________

ALTERATION IN ELIMINATION

☐ No Problem ☐ Diarrhea/Constipation ☐ Change in Bowel Habits ☐ Laxative Use
☐ Urinary Problems/Infections ☐ Blood in Urine ☐ Blood in Stool Last BM _________________
Last Prostate Exam __________ Last Colonoscopy ______________
Above Exams Abnormal? (specify) _________________________________________________
☐ Other (specify): ________________________________
BRIEFLY DESCRIBE: ___________________________________________________________________

ALTERATION IN REPRODUCTIVE/SEXUAL FUNCTION

☐ No Problem ☐ Sexual Concerns ☐ Genital Discharge ☐ Menopausal
☐ History of Sexually Transmitted Diseases Last Menses _________
Last Pap __________ Last Mammogram __________ Abnormal Pap or Mammogram ______________
☐ Other (specify): ________________________________
BRIEFLY DESCRIBE: ___________________________________________________________________

ALTERATION IN MOBILITY

☐ No Problem ☐ Stiffness/Soreness in Joints ☐ Problems with Walking
☐ Back Pain ☐ History of Falls ☐ Other (specify): ________________________________
BRIEFLY DESCRIBE: ___________________________________________________________________
# FALL RISK ASSESSMENT

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

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

Score of 0-10  Patient is Low Risk

Score of 11-18 *Patient is High Risk*

*Implement fall prevention strategies. Notify LIP.

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

- [ ] No Problem
- [ ] Difficulty with Sleep
- [ ] Sedative Use
- [ ] Change in Sleep Patterns

**Hours of Sleep Per Night**: ______________

**Other** (specify): ____________________________

**BRIEFLY DESCRIBE**: ___________________________________________________________________

### SELF-CARE NEEDS

**ADL STATUS**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Self Assist</th>
<th>Toileting</th>
<th>Self Assist</th>
<th>Bathing</th>
<th>Self Assist</th>
<th>Grooming</th>
<th>Self Assist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assistive Devices Needed**: ____________________________________________________________

### PSYCHOSOCIAL ASSESSMENT

### ANXIETY

**DYSFUNCTIONAL ANXIETY**

- [ ] Moderate
- [ ] Severe
- [ ] Phobias
- [ ] Panic
- [ ] Dissociation
- [ ] Agitation
- [ ] Rituals

**Other** (specify): ____________________________

**BRIEFLY DESCRIBE**: ___________________________________________________________________

### MOOD/AFFECT

**ALTERATION IN MOOD/AFFECT**

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

**Other** (specify): ____________________________

**BRIEFLY DESCRIBE**: ___________________________________________________________________

### REALITY TESTING

**IMPAIRED REALITY TESTING**

- [ ] Hallucinations
- [ ] Delusions
- [ ] Suspicious/Evasive

**Other** (specify): ____________________________

**BRIEFLY DESCRIBE**: ___________________________________________________________________
IMPULSE CONTROL

IMPAIRED IMPULSE CONTROL
- Hx of Running Away
- Violence/Aggression
- Accident Prone
- Hyperactivity
- Response to Command Hallucinations
- Hypersexual
- Eating Disorder
- Excessive Fluid Consumption
- Other (specify): __________________________

BRIEFLY DESCRIBE: ______________________________________________________________________

POTENTIAL FOR SUICIDE/SELF-INJURY

- Patient Denies
- Current Suicidal Ideas/Thoughts
- Current Suicidal Plans (describe): ______________________________________________________________________

Past Attempts (describe): ______________________________________________________________________

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

Past Self Harm Behavior (describe): ______________________________________________________________________

POTENTIAL FOR HOMICIDE

- Patient Denies
- Current Homicidal Ideas/Thoughts
- Current Homicidal Plans (describe): ______________________________________________________________________

Past Attempts/Hx (describe): ______________________________________________________________________

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

BRIEFLY DESCRIBE: ______________________________________________________________________

THOUGHT PROCESS

Reality Orientation Orientated to:  □ Time  □ Place  □ Person  □ Situation
- Incoherent Speech
- Disorganized Thoughts
- Illogical Communication Patterns
- Loose Associations
- Other

BRIEFLY DESCRIBE: ______________________________________________________________________
SELF CARE/ADL DEFICIT RELATED TO PSYCHOSOCIAL IMPAIRMENT

- Psychosis
- Depressed
- Other (specify):

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

  BRIEFLY DESCRIBE:


SELF PERCEPTION

ALTERATION IN SELF PERCEPTION

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

  BRIEFLY DESCRIBE:


STIMULUS BARRIER

ALTERATION IN STIMULUS BARRIER

- Easily Distracted
- Hypersensitive
- Excessive Response
- Stimulus Seeking
- Sensory Deprivation
- Stimulus Withdrawal
- Other (specify):

  BRIEFLY DESCRIBE:


JUDGMENT/INSIGHT

IMPAIRED JUDGMENT/INSIGHT

- Poor Decision Making
- Dangerous/Reckless Behavior
- non-Compliance
- Impaired Insight
- Other (specify):

  BRIEFLY DESCRIBE:
**PSYCHOSOCIAL ASSESSMENT**

**ASSESSMENT OF STrengths**

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

**PATIENT AND FAMILY EDUCATION NEEDS/KNOWLEDGE DEFICIT**

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

**PATIENT GOALS (as stated by the patient)**

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

**LIVING ARRANGEMENTS**

_________________________________________________________________________________

_________________________________________________________________________________

**FAMILY INVOLVEMENT/SIGNIFICANT OTHERS**

_________________________________________________________________________________

_________________________________________________________________________________

**ADVANCE DIRECTIVE**

Do you have an advance directive? ☐ YES ☐ NO

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

Referred to: ___________________________________________________________

**ASSESSMENT COMPLETED BY:**

RN Signature: _____________________________ Date: _______________ Time: _________

**NEED TO REASSESS WITHIN 48 HOURS?** ☐ YES ☐ NO

**REASSESSMENT COMPLETED BY:**

RN Signature: _____________________________ Date: _______________ Time: _________