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

II. POLICY:
   A. The standard of care at Montana State Hospital (MSH) is that patients receive nursing care based on a documented systematic assessment of their needs, strengths, and treatment expectations.
   B. Assessments will be completed by registered nurses (RNs) and documented on a standardized form. Assessments will be completed: 1) within 24 hours of admission to the hospital; 2) whenever there is a significant change in the patient’s physical and/or mental status; 3) no less than yearly.
   C. The registered nurse will formulate nursing diagnoses based on the data collected in the nursing assessment and will prioritize these diagnoses according to the patient’s needs.
   D. To the degree possible, the patient and significant others will collaborate with the registered nurse in the completion of the assessment and the formulation of the nursing diagnoses.
   E. The nursing assessment and nursing diagnoses are an integral part of the multidisciplinary treatment planning process for each individual patient.
   F. Registered Nurses will perform a head to toe assessment for patients reporting actual or potential physical health problems throughout their hospital stay. This assessment information and ongoing assessment data will be documented on the Nursing Health Assessment form.

III. DEFINITIONS: None
IV. RESPONSIBILITIES:
   A. Registered Nurses - Complete nursing assessment and diagnosis.

V. PROCEDURE:
   A. Delegate the completion of the “Physical Characteristics” and “Orientation to the Unit” segments of the assessment form to any member of the nursing staff if so desired.
   B. Select an appropriate place to perform the assessment.
   C. Inform the patient of their mutual roles and responsibilities in the assessment and diagnosis process and encourage the patient’s participation.
   D. Utilize interview, behavioral observation, and physical and mental status assessment skills to achieve a thorough and accurate assessment of patient care needs.
   E. Assess each patient at the time of admission and continuously throughout the patient’s hospitalization as warranted by changes in the patient’s care needs through the systematic collection of data in the following areas: biophysical, psychosocial, risk/environmental, educational, and discharge planning.
   F. As possible, seek out and utilize information pertinent to the assessment and diagnosis process from, not only the patient, but also from family members, significant others, and other health care providers.
   G. Formulate conclusions about actual and/or potential alterations in the patient’s biophysical/psychosocial status and establish nursing diagnosis/problem statements.
   H. Identify nursing diagnosis/problem statements related to the specific assessment categories identified on the approved assessment form and/or the North American Nursing Diagnosis Association (NANDA) guidelines.
   I. Prioritize nursing diagnosis/problem statements based on the following factors:
      1. potential danger to self and others;
      2. physical illness requiring acute medical care;
      3. patient’s/significant others perception of need priority;
      4. assessed areas of severe, moderately severe to severe impairment/dysfunction; and
   J. Document the assessment findings and identify nursing diagnoses on the MSH Nursing Assessment Form. This information is used to establish the initial plan of care which is formulated within 24 hours of the patient’s admission. Assessment data and the initial plan of care are the basis upon which the multidisciplinary treatment plan is formulated (reference Patient Treatment Plan Policy).
K. Document ongoing day-to-day assessments related to the patient’s treatment plan in the progress notes of the patient’s medical record.

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

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

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

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

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

VII. COLLABORATED WITH: Medical Director

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

IX. DISTRIBUTION: All hospital policy manuals.

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

XI. FOLLOW-UP RESPONSIBILITY: Director of Nursing Services

XII. ATTACHMENTS: Montana State Hospital Nursing Assessment

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

TYPE OF ASSESSMENT: ☐ INITIAL/ADMISSION ☐ UPDATE

ADMISSION DATE: __________ TIME: _______ COMMITMENT: ____________________________

PHYSICAL CHARACTERISTICS


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 - PLEASE COMPLETE THE ENTIRE SUBSTANCE USE SECTION:

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

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

1. How often during the last year have you had a drink containing alcohol? ☐ 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: _____________________________________________

NAME: ____________________________________________ HOSPITAL NUMBER: __________
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>Date</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

Ambulation ☐ Self ☐ Assist Toileting ☐ Self ☐ Assist
Transfer ☐ Self ☐ Assist Bathing ☐ Self ☐ Assist
Dressing ☐ Self ☐ Assist Grooming ☐ Self ☐ Assist
Eating ☐ Self ☐ Assist

Assistive Devices Needed: _______________________________________________________________

PSYCHOSOCIAL ASSESSMENT

ANXIETY

DYSFUNCTIONAL ANXIETY

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

☐ Other (specify): _______________________________

BRIEFLY DESCRIBE: _______________________________________________________________________

MOOD/AFFECT

ALTERATION IN MOOD/AFFECT

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

☐ Other (specify): _______________________________

BRIEFLY DESCRIBE: _______________________________________________________________________

REALITY TESTING

IMPAIRED REALITY TESTING

☐ Hallucinations ☐ Delusions ☐ Suspicious/Evasive

☐ Other (specify): _______________________________

BRIEFLY DESCRIBE: _______________________________________________________________________

NAME: ________________________________________ HOSPITAL NUMBER: ___________
**IMPULSE CONTROL**

**IMPAIRED IMPULSE CONTROL**

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

BRIEFLY DESCRIBE: ____________________________

---

**POTENTIAL FOR SUICIDE/SELF-INJURY**

- [ ] Patient Denies
- [ ] Current Suicidal Ideas/Thoughts
- [ ] Current Suicidal Plans (describe): ____________________________

Past Attempts (describe): ____________________________

- [ ] History of Self-Harm/Injury
- [ ] Current Self Harm Plans (describe): ____________________________

Past Self Harm Behavior (describe): ____________________________

---

**POTENTIAL FOR HOMICIDE**

- [ ] Patient Denies
- [ ] Current Homicidal Ideas/Thoughts
- [ ] Current Homicidal Plans (describe): ____________________________

Past Attempts/Hx (describe): ____________________________

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

BRIEFLY DESCRIBE: ____________________________

---

**THOUGHT PROCESS**

**Reality Orientation**  Orientated to:  
- [ ] Time  
- [ ] Place  
- [ ] Person  
- [ ] Situation

- [ ] Incoherent Speech
- [ ] Disorganized Thoughts
- [ ] Illogical Communication Patterns
- [ ] Loose Associations
- [ ] Other

BRIEFLY DESCRIBE: ____________________________

---
SELF CARE/ADL DEFICIT RELATED TO PSYCHOSOCIAL IMPAIRMENT

☐ Psychosis ☐ Depressed ☐ Other (specify): __________________________

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

BRIEFLY DESCRIBE: _________________________________________________________________________________________________

----------------------------------------------------------------------------------------------------------------------------------

SELF PERCEPTION

ALTERATION IN SELF PERCEPTION

☐ Self Hate ☐ Self Idealization ☐ Gender/Identity/Role/Confusion

☐ Feeling of Unreality ☐ Poor Self-Esteem ☐ Entitled/Narcissistic ☐ All Good/Bad

☐ Other (specify, i.e., inferiority, superiority, delusions of grandeur, distortions in body image): __________________________________________________________________________

BRIEFLY DESCRIBE: _________________________________________________________________________________________________

----------------------------------------------------------------------------------------------------------------------------------

STIMULUS BARRIER

ALTERATION IN STIMULUS BARRIER

☐ Easily Distracted ☐ Hypersensitive ☐ Excessive Response ☐ Stimulus Seeking

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

BRIEFLY DESCRIBE: _________________________________________________________________________________________________

----------------------------------------------------------------------------------------------------------------------------------

JUDGMENT/INSIGHT

IMPAIRED JUDGMENT/INSIGHT

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

☐ Other (specify): _________________________________________________________________________________________________

BRIEFLY DESCRIBE: _________________________________________________________________________________________________

----------------------------------------------------------------------------------------------------------------------------------
PSYCHOSOCIAL ASSESSMENT

ASSESSMENT OF STRENGTHS

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

PATIENT AND FAMILY EDUCATION NEEDS/KNOWLEDGE DEFICIT

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

PATIENT GOALS (as stated by the patient)

_________________________________________________________________________________
_________________________________________________________________________________
_________________________________________________________________________________

LIVING ARRANGEMENTS

_________________________________________________________________________________
_________________________________________________________________________________

FAMILY INVOLVEMENT/SIGNIFICANT OTHERS

_________________________________________________________________________________

ADVANCE DIRECTIVE
Do you have an advance directive? ☐ YES ☐ NO
Do you wish to have more information about an advance directive? ☐ YES ☐ NO
Referred to: ___________________________________________

ASSESSMENT COMPLETED BY:
RN Signature: _____________________________ Date: _______________ Time: _________

NEED TO REASSESS WITHIN 48 HOURS? ☐ YES ☐ NO

REASSESSMENT COMPLETED BY:
RN Signature: _____________________________ Date: _______________ Time: _________

NAME: ________________________________________
HOSPITAL NUMBER: ___________