CVH-171a **CONNECTICUT VALLEY HOSPITAL** Patient Name: _____
New 5/18 **ANNUAL NURSING RE-ASSESSMENT**
[ ] General Psychiatry Division MPI# _____ *Print or Addressograph Imprint*

I. BIOPHYSICAL ASSESSMENT

A. VITAL DATA

Height _____ Weight _____ Blood Pressure _____ Temperature _____

Pulse _____ Respirations _____ Pulse Ox _____ % Room Air

Allergies and/or type of adverse reaction: _____

Date of last PPD skin test or Quantiferon TB-ELISA (blood test) _____ Results: _____

B. EXISTING HEALTH PROBLEMS *Check all current health problems*

[ ] Arthritis	[ ] Hepatitis	Comments:
[ ] Asthma	[ ] A	
[ ] Cancer	[ ] B	
[ ] Cardiac Disease	[ ] C	
[ ] Constipation	[ ] History of Seizures	
[ ] COPD	[ ] HIV/AIDS	
[ ] CVA	[ ] Hypertension	
[ ] Diabetes	[ ] Liver	
[ ] GERD	[ ] Renal	
[ ] Head Trauma	[ ] Thyroid	
	[ ] Other: _____	

***C. Assessment of Pain: [ ] No report of pain at this time** **If the patient reports pain, complete as indicated.**

Current or History of Pain (*Please Specify*): _____

FLACC Pain Scale: **If the patient is non-verbal and unable to provide information about pain, Please complete the FLACC Scale (Face, Legs, Activity, Cry and Consolability to assess pain.**

Severity: ☐(*1-10*): _____ *OR*

Location: _____ ☐ FLACC Score: _____ **Onset**: _____

Duration: ☐ Acute Pain (*Few seconds to less than 6 months*) ☐ Chronic Pain (*Greater than 6 months*)

Type of Pain (*Circle all that apply*):	**Quality of Pain:** (*Circle all that apply*):
• Cutaneous (*Sensation*)	• Sharp
• Somatic (*Tendons, Ligaments, Bones, Blood Vessels, Nerves*)	• Dull
• Visceral (*Organs*)	• Diffuse
• Referred	• Shifting
• Neuropathic (*Functional pain*)	• Burning

Aggravating Factors (*Circumstances which cause pain to return or escalate*): _____

_____

Alleviating Factors (*Techniques or circumstances that reduce or relieve the pain*): _____

_____

Effect on Level of Functioning (*Sleep, Changes in Mood, Appetite, Work, Exercise, ADL's, Relations*): _____

_____

Current Treatments	**Effectiveness** (*Relief, Some Benefit, Not Effective):*
• Drug Therapy (*please specify*): _____	_____
_____	_____
• Acupuncture • Biofeedback	_____
• Relaxation/Meditation/Imagery • Heat/Cold	_____
• Other: _____	

Patient Name: _____ MPI#: _____ *Print or Addressograph Imprint*

Does pain appear to be associated with substance withdrawal?: ☐ Yes ☐ No ☐ N/A
Does pain appear to be associated with a co-occurring medical issue?: ☐ Yes ☐ No ☐ N/A

If yes, please specify: _____

Please ensure that any identified pain issues are in the Plan of Care with Nursing interventions that include patient education.

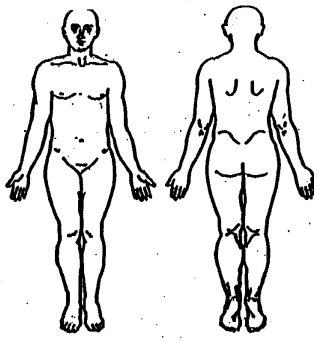
Refer patient to the ACS Clinician for treatment of pain.

D. OBSERVATIONS – Identifying Marks/Injuries *Check all applicable observations and indicate on figure location*

[ ] None Observed
[ ] Bruises
[ ] Cuts
[ ] Decubiti
[ ] Discolorations
[ ] Open Wounds
[ ] Piercings *(note object & location)*
[ ] Rashes
[ ] Scars
[ ] Sutures
[ ] Tattoos
[ ] Track Marks
[ ] Other: _____

Comments:

FRONT BACK



E. Nutritional/Metabolic *(within the last year)*

[ ] No impairments noted
[ ] Weight loss (*last year*) approx. amount: _____
[ ] Weight gain (*last year*) approx. amount: _____
[ ] Appearance:
  [ ] underweight
  [ ] over weight
  [ ] malnourished
[ ] Eating habits:
  [ ] loss of appetite
  [ ] slow eater
  [ ] fast eater
  [ ] refusal to eat
[ ] Cultural food preferences: _____
[ ] Other: _____

F. Prosthetic Devices

[ ] Artificial limb(s)
[ ] Contact lenses
[ ] Dentures [ ] full [ ] partial
[ ] Glasses
[ ] Hearing aid
[ ] None
[ ] Ostomy devices
[ ] Pacemaker
[ ] Other: _____

Comments

G. Activities of Daily Living

1. **Grooming/Personal** *Indicate*
   I = Independent or A = Assisted
   - Bathing _____
   - Dressing _____
   - Eating _____
   - Hair Care _____
   - Hygiene _____
   - Shaving _____
   - Showering _____
   - Toileting _____
   - Other _____

Comments

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

2 **Mobility/Ambulation** [ ] Full [ ] Partial [ ] Non-ambulatory	*Indicate:* **I = Independent or A = Assisted** • Cane _____ • Crutches _____ • Prostheses _____ • Transfer _____ • Walker _____ • Wheelchair _____	Comments

Complete Fall Risk Screening CVH-574

II. INTERPERSONAL CONSIDERATIONS

A. Relations

1. Who are the important people in your life? _____
2. Who do you want involved in your treatment plan meeting? _____

   _____
3. Describe how easy or difficult it is for you to get along with others: _____

   _____

B. Self Concept

1. Describe what you like about yourself: _____

   _____
2. Describe what you would like to change about yourself or traits you'd like to work on: _____

   _____
3. Are there hobbies or interests which give you pleasure? _____

   _____

C. Sexuality

1. Within the last month have you been sexually active? [ ] No [ ] Yes
2. What is your sexual preference? _____
3. Do you use precautions? [ ] No [ ] Yes Describe: _____
4. Have you ever gotten into trouble because of your sexual behavior? [ ] No [ ] Yes Describe: _____

   _____

   _____

D. Spiritual

1. Do you currently practice any religion? [ ] No [ ] Yes Describe: _____
2. How will your spiritual beliefs/practices be affected while in the hospital? _____

   _____

E. Cultural

1. Do you have any specific beliefs regarding the emotional/mental or physical distress you are experiencing?

   [ ] No [ ] Yes Describe: _____
2. Do you or your family have any remedies which you use to address your health problems?

   [ ] No [ ] Yes Describe: _____
3. Are there any cultural or family practices you would like us to know about while you are in the hospital?

   [ ] No [ ] Yes Describe: _____

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III. MENTAL HEALTH ASSESSMENT (*Check all that apply*)

Appearance	Affect/Mood	Thought Content (*Describe*)	Thought Process
[ ] Neat, clean, appropriate [ ] Disheveled [ ] Dirty skin, hair, nails and clothing [ ] Other: _____ _____ _____	[ ] Appropriate [ ] Anxious [ ] Cheerful [ ] Dysphoric [ ] Euphoric [ ] Flat [ ] Labile [ ] Other: _____	[ ] No deficits noted [ ] Delusional [ ] Obsessive [ ] Phobic [ ] Suspicious [ ] Other: _____ _____	[ ] No deficits noted [ ] Blocking [ ] Circumstantial [ ] Looseness of associations [ ] Racing [ ] Tangential [ ] Other: _____ _____

Orientation	Perceptions	Memory	Motor Behavior	Speech
[ ] Oriented [ ] Disoriented (*time, place, person*) [ ] Confused	[ ] Reality based [ ] Hallucinations [ ] Illusions	[ ] Recent memory in tact [ ] Remote memory intact [ ] Deficits in recent memory [ ] Unable to assess due to other impairments	[ ] No deficits noted [ ] Agitated [ ] Pacing [ ] Psychomotor retardation [ ] Repetitive movements	[ ] No impairments noted [ ] Monosyllabic [ ] Mute [ ] Pressured [ ] Rapid [ ] Slow [ ] Slurred [ ] Stuttering [ ] Other: _____ _____

IV. RISK ASSESSMENT

A. SELF-HARM AND SUICIDE RISK (*Check the appropriate answer (Y/N) and comment on patients' answers or record patients' response to specific questions.)* **COMMENTS/PATIENT RESPONSE "Provide Quotes"**

1	How does the future look to you?	
2	What things in your life make you want to go on living?	
3	Whom do you rely on during difficult times?	
4	Has treatment been effective for you in the past year? [ ] Yes [ ] No [ ] N/A *If no*, explain why:	
5	Are there things that you've been feeling guilty about or blaming yourself for? [ ] Yes [ ] No	
6	Do you ever wish you could go to sleep and just not wake up? [ ] Yes [ ] No	
7	Do you feel that life is not worth living? [ ] Yes [ ] No	
8	Do you consider yourself an impulsive person? [ ] Yes [ ] No Why or Why Not?	
9	When people are feeling extremely upset, they sometimes have thoughts of wanting to harm themselves. Do you have any thoughts of wanting to harm/hurt yourself? [ ] Yes [ ] No ***If no, proceed to # 12***	
10	When you begin to have thoughts of harming yourself what do you do?	
11	Patient has a history of acting on these thoughts. [ ] Yes [ ] No *If yes*, please describe:	

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

COMMENTS/PATIENT RESPONSE "Provide Quotes"

12	Have there been times when voices told you to hurt or kill yourself? [ ] Yes [ ] No	
13	Have you ever had thoughts of wanting to kill yourself in the past year? [ ] Yes [ ] No ***If no, proceed to # 27***	
14	Can you tell me about the first time you ever thought about suicide?	
	a. What triggered your thinking about suicide?	
	b. Why did you think suicide was the best option at that time?	
	c. Did you want to die? [ ] Yes [ ] No	
	d. Please tell me exactly what you did.	
	e. Were you injured by the suicide attempt? [ ] Yes [ ] No	
	f. Did you receive medical care? [ ] Yes [ ] No	
	g. Did you take steps to prevent your discovery or rescue? [ ] Yes [ ] No	
	h. How do you feel about surviving?	
	i. Did you learn anything helpful about yourself or others? [ ] Yes [ ] No	
15	Have there been other times in your life when you tried to kill yourself? [ ] Yes [ ] No *If yes*, please describe when, where, why and how.	
16	Have you thought about or tried to take your life in the past year? [ ] Yes [ ] No	
17	Have you thought about or tried to take your life in the past month? [ ] Yes [ ] No	
18	How often do you think about killing yourself? (*Check one*) **Frequency:** [ ] Never [ ] Rarely [ ] Sometimes [ ] Frequently [ ] Daily	
19	When you have these thoughts, how intense or severe are they? (*Circle one*) **Intensity:** Mild 1 2 3 4 5 6 7 8 9 10 Severe	
20	Have you thought about when you would kill yourself? [ ] Yes [ ] No	
21	Have you thought about where you would kill yourself? [ ] Yes [ ] No	
22	Have you thought about how? [ ] Yes [ ] No	
23	Do you have access to the means to end your life? [ ] Yes [ ] No *If yes*, please describe:	
24	Have you made any particular preparations? [ ] Yes [ ] No	
25	Have you rehearsed your suicide in any way? [ ] Yes [ ] No	
26	Why do you want to die?	

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

27	Has anyone in your family attempted suicide? [ ] No [ ] Yes *If yes*, date: _____ (*month/year*) Please identify who, when and circumstances:		
28	Self Harm and Suicide Risk History:	**EVER**	**Past 6 Months**
	• Indication of Self Harm	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Self Mutilating Behaviors	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Suicidal Ideation	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Suicidal Intent	[ ] Yes [ ] No [ ] Unknown	[ ] Yes [ ] No [ ] Unknown
	• Suicide Plan	[ ] Yes [ ] No [ ] Unknown	[ ] Yes [ ] No [ ] Unknown
	• Single Attempt	[ ] Yes [ ] No	[ ] Yes [ ] No
	• Multiple Attempts	[ ] Yes [ ] No	[ ] Yes [ ] No
29	Patient reluctant to discuss information regarding history and may be withholding information. [ ] Yes [ ] No		

Immediately notify the MD if there are any YES responses or new information is obtained regarding the patient's suicidal potential which was not elicited during the MD assessment.

MD Contacted: [ ] No
[ ] Yes: _____ _____ _____AM/PM
Physician Name Date Time

Contacted by: _____ _____
RN Signature Print Name

B. AWOL RISK (*Check all that apply*)	**Comments**
[ ] No evidence at this time [ ] History of AWOL attempts [ ] Expressed desire to go AWOL [ ] Denies need for hospitalization	_____ _____ _____ _____ _____
C. VIOLENCE RISK (*Check all that apply*) [ ] No current evidence or history of violence risk [ ] Fire Setting [ ] Ever [ ] Past 6 months (*Dates*) _____ [ ] Abuse of Animals [ ] Ever [ ] Past 6 months (*Dates*) _____ [ ] Violence (Property or Person) [ ] Ever [ ] Past 6 months (*Dates*) _____ [ ] Homicidal Ideation [ ] Ever [ ] Past 6 months (*Dates*) _____	**Describe Contributing Factors –** Consider precipitants to anger, substance use, delusions of persecution, cognitive impairment, history of seizure. _____ _____ _____ _____ _____ _____ **Describe Motive, Intent, Access To Weapons:** _____ _____ _____

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

D. ASSESSMENT OF VICTIMIZATION - Introduction: These days many people are exposed to violence in some form. Violence is a health risk and can result in physical and emotional problems. It is our routine procedure to ask patients about their exposure to violence. If you are a victim of violence, we can better help you if we know about it.

Instructions: *If the individual answers yes to any of the questions below, ask for details, such as who, how, where and when.*

1. In the past 12 months, has anyone slapped, pushed, grabbed or shoved you? ☐ Yes ☐ No

_____

2. In the past 12 months, has anyone choked, kicked, bit or punched you? ☐ Yes ☐ No

_____

*****3. In the past 12 months, has anyone forced or coerced you to have sex? ☐ Yes ☐ No

_____

*4. In the past 12 months, has anyone threatened you with or actually used a weapon to scare or hurt you? ☐ Yes ☐ No

_____

*5. Do you feel you are currently in danger? ☐ Yes ☐ No

If yes, please explain: _____

6. Victimization Risk Factors (*Check all that apply*):

☐ No risk factors identified

☐ Developmental Disabilities	☐ Impulse Control Deficits	☐ Allegations of Abuse
☐ Cognitive Deficits	☐ Altercations with Peers/Staff	☐ Past Trauma History
☐ Psychosis	☐ Personal Boundaries Impaired	
☐ Elderly	☐ Impaired Judgment	

7. Does the patient appear at risk of victimization while hospitalized? ☐ Yes ☐ No

_____

*** New information revealed as a result of this assessment, particularly when Items 3-5 are positively endorsed, indicates risk of victimization and requires immediate safety measures instituted and MD notification.**

Adapted from the Universal Violence Prevention Screening Protocol, Dutton, MA, Mitchell, B, Haywood, Y. (2003)

E. PAST HISTORY OF SECLUSION & RESTRAINT

1. What are some of the things that make you angry? _____

_____

2. How do you generally respond or behave when you get angry? _____

_____

3. Have you ever been physically restrained or placed in seclusion? [ ] No [ ] Yes – Date of last incident: _____

Describe when, where, what happened, and reaction to restraint: _____

_____

_____

4. The CVH Seclusion and Restraint policy was reviewed with the patient. [ ] Yes [ ] No Reason: _____

If restraint or seclusion becomes necessary, who would you like staff to notify?

Contact Name _____ Phone Number: _____

Patient has signed a Release of Information to notify person(s) designated [ ] Yes [ ] No - If no, inform Social Worker

Social Worker name: _____ Date and Time of Notification: _____

5. Is there a pre-existing medical condition or disability that places the patient at risk should seclusion/restraint be utilized?

[ ] No [ ] Yes, If yes please describe: _____

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6. Is there history of sexual abuse that places the patient at greater psychological risk during seclusion/restraint?

   [ ] No [ ] Yes, If yes please describe: _____

F. PERSONAL PREFERENCES

1. What helps when you are not feeling well? (*Check all that apply*)

[ ] Lying down with a cold face cloth	[ ] Wrapping up in a blanket	[ ] Deep breathing
[ ] Additional/extra medication	[ ] A warm or cool drink	[ ] Eating something
[ ] Taking a shower or bath	[ ] Reading	[ ] Writing in a diary/journal/letter
[ ] Exercise	[ ] Drawing	[ ] Playing a game
[ ] Sitting by the nurses station	[ ] Watching TV	[ ] Talking to staff
[ ] Calling your therapist	[ ] Talking with another patient	[ ] Talking with chaplain
[ ] Calling a friend or family	[ ] Pacing the halls	[ ] Listening to music
[ ] Going for a walk	[ ] Other, specify below	

   Elaborate on above choices as needed: _____

2. What are some things that make it more difficult for you when you are already upset? (*Check all that apply*)

[ ] Being touched	[ ] Bedroom door being opened	[ ] People staring at me
[ ] Not having input/choices	[ ] Not being able to express my opinion	[ ] Being criticized
[ ] Being isolated/alone	[ ] Lack of staff availability/attention	[ ] Boredom/lack of activities
[ ] Seeing people in uniform	[ ] Loud noise	[ ] Yelling
[ ] Noise in general	[ ] Particular time of day	[ ] Time of year

   Elaborate on above choices as needed: _____

V. HEALTH TEACHING NEEDS (*Check all that apply*)

A. Patient's Preferred Method of Learning

[ ] One on One Teaching
[ ] Written Information
[ ] Group Discussion
[ ] Other: _____

B. Barriers to Learning

[ ] None	[ ] Speech
[ ] Developmental Disabilities	[ ] Hearing
[ ] Other: _____	

C. Nursing Educational Needs

[ ] Symptom Recognition	[ ] Medication
[ ] Symptom Management	[ ] Self Care
[ ] Psychiatric Illness/Treatment	[ ] Interpersonal Relations
[ ] Medical Condition	[ ] Other: _____

Patient Name: _____ MPI# _____ *Print or Addressograph Imprint*

VI PATIENT STRENGTHS (*Check all that apply*)

[ ] Ability to verbalize needs
[ ] Ability to articulate clearly
[ ] Motivated for treatment
[ ] Ability to collaborate
[ ] Assertive
[ ] Positive Attitude
[ ] Goal Directed
[ ] Values Health and Wellness
[ ] Knowledge regarding own self-care issues
[ ] Uses support system
[ ] Ability to make relationships
[ ] Has Hobbies - Describe: _____
[ ] Identifies Interests – Describe: _____
[ ] Vocational Interests, Describe: _____
[ ] Other: _____

A. Coping Style/Preferences to decrease stress and avoid conflict: _____

VII. SUMMARY OF FINDINGS:

A. Patient expectations of future/continued treatment (*in the patient's own words*): _____

B. Nursing Concerns (*Include risk issues and problems that prevent the patient from being discharged*): _____

C. Chronic Pain (*include type and interventions to manage*): _____

D. Health education needs identified through the Nursing Re-assessment, including specific teaching for Pain Management: _____

E. Services that will be needed post discharge: _____

Registered Nurse Signature:

_____ _____ _____AM/PM
Signature of Assessing Registered Nurse Date Time

Print Name: _____

CVH-574 **CONNECTICUT VALLEY HOSPITAL** Patient Name: _____

New 5/18 **FALL RISK SCREENING**

[ ] Addiction Services Division MPI #: _____ *Print or Addressograph Imprint*

[ ] General Psychiatry Division **Type of Screening:**

☐ Admission (**Date:** _____) ☐ Annual ☐ Change in Patient Condition (*without fall*)

Completed by: RN Signature:_____ Print Name:_____ Date:_____

	RATING SCALE				
CATEGORY	**0**	**1**	**2**	**3**	**SCORE**
Substance Abuse History	None	Use more than one year ago	Use in the past year	Use at time of admission	
Age	18 - 49	50 - 59	60 – 70 years	Over 70 years	
Fall History	No falls in last year	Fall in last 12 months	Fall in last 3 months	Fall in last month	
Balance	Independently ambulatory	Non-ambulatory	Independently ambulatory with assistive devices	Ambulatory with assistive devices and staff supervision / assistance	
Mental State	Oriented x 3	Oriented x 2	Oriented x 1	Any of the following: Disoriented, Delirious, Impaired Judgment, Impulsivity	
Vision	Normal	Wears glasses	Blurred vision, cataract, glaucoma	Severe visual disturbance or blindness	
Medications known to increase fall risk - number of taken by patient (*List on back side*)	0	1-2	3-4	More than 4	
Incontinence	Not incontinent	Commode or urinal at bedside	Incontinent with toilet less than 30 feet from bedroom	Incontinent with toilet more than 30 feet from bedroom	
0 – 10 = Low Risk 11 – 17 Medium Risk 18 – 24 = High Risk			**TOTAL SCORE**		

Scoring of 0 – 10: No immediate action necessary.

SCORING OF 11 OR GREATER:

RN 1. Identifies the patient "at risk" of fall; places "Fall Risk" sticker on the spine of the patient's medical record binder

2. Notifies Attending Psychiatrist/ACS Clinician/On-Call Physician of the patient's score on the Fall Risk Screening

Attending Psychiatrist/ACS Clinician/On-Call Physician Notified: _____

by: _____ _____ _____ _____AM/PM

RN Signature Name Printed Date Time

Attending Psychiatrist/ACS Clinician/On-Call Physician:

- Evaluation:-_____

  _____
- Physical Therapy Evaluation ordered
- Occupational Therapy Evaluation ordered (*if indicated*)
- Other orders: _____

Signatures:

_____ _____ _____ _____ AM/PM

Attending Psychiatrist Signature Print Name Date Time

_____ _____ _____ _____ AM/PM

Ambulatory Care Clinician Signature Print Name Date Time

OR

_____ _____ _____ _____ AM/PM

On-Call MD Signature Print Name Date Time

Filing: Admission Screening following Admission H&P

Annual Screening following Annual H&P

Changes in Patient Condition Screening (without fall) chronological order with Physical Health Progress Notes

MEDICATIONS KNOWN TO INCREASE FALL RISK

Some of the medications most commonly used at this facility are listed below. This is not a complete list. Please refer to Lexicomp or Micromedex for information on additional medications. Please review each patient's specific case and co-morbidities when making comparisons with this list.

Analgesics	Acetaminophen with codeine, Fentanyl, Hydrocodone, Morphine sulfate, Oxycodone, Tramadol
Anticholinergics/ Antihistamines	Benztropine, Diphenhydramine
Anticonvulsants	Carbamazepine, Divalproex sodium, Gabapentin, Lamotrigine, Oxcarbazepine, Phenobarbital, Phenytoin, Topiramate
Antidepressants	Amitriptyline, Trazodone
Antidiabetic Agents	Glyburide, Insulin, Metformin, Pioglitazone
Antihypertensives by category	ACE Inhibitors (i.e. enalopril, lisinopril), Angiotensin Beta Blockers (i.e. atenolol, metoprolol, propanolol), Calcium Channel Blockers (i.e. amlodipine, ditiazem, nifedipine, verapamil), Cardiac glycosides (i.e. digoxin), Receptor Blockers (i.e. losaratan), Vasodilators (nitrogylcerine), Misc. (clonidine)
Anxiolytics	Clonazepam, Diazepam, Lorazepam
Diuretics	Furosemide, Hydrochlorothiazide (HCTZ)
Opiate Agonists/ Partial Agonists	Buprenorphine, Methadone
Overactive Bladder and BPH Agents	Oxybutynin, Tamsulosin, Terazosin, Tolterodine
Psychotropics	Aripiprazole, Chlorpromazine, Clozapine, Fluphenazine, Haloperidol, Olanzapine, Quetiapine, Risperdal, Ziprasidone
Sedatives/Hypnotics	Hydroxyzine, Zaleplon, Zolpidem