

 <p><b>Connecticut Valley Hospital Nursing Policy and Procedure</b></p>	<p><b>SECTION B: THE NURSING PROCESS CHAPTER 6: ADMISSION, NURSING ASSESSMENT, NURSING REASSESSMENT</b></p> <p><b>POLICY AND PROCEDURE 6.5: NURSING CLINICAL ASSESSMENT OF THE PATIENT (Mental Status Evaluation/MSE)</b></p>
<p>Authorization: Nursing Executive Committee</p>	<p>Date Effective: May 1, 2018 Scope: Connecticut Valley Hospital</p>

**Standard of Practice:**

The registered nurse will individualize the clinical assessment of each patient incorporating Mental Status Evaluation (MSE) guidelines and known safety/risk factors.

**Standard of Care:**

The patient can expect a professional Nursing assessment of his/her ability to function responsibly while off the unit.

**Policy:**

A clinical assessment of each patient in the General Psychiatry, and those demonstrating significant behavioral change in the Addiction Service Division will be conducted by a registered nurse before he/she leaves the unit for a building or grounds pass, scheduled activity, or Temporary Leave/Visit (TL/TV). Patients returning from day and overnight TL privileges will be clinically assessed by the RN upon return to the unit.

**Procedure:**

Assess the patient's clinical status and functioning once per shift if the patient will be leaving the unit for a building or grounds pass, scheduled activity, or Temporary Leave/Visit.

Review inter-shift reports and staff observations.

Consider appearance, orientation, behavior/activity, attitude, speech, mood and affect, perceptions, thought, cognition, judgement, insight, reliability, stressors, coping skills, relationships, spiritual and cultural factors.

Consider known risk factors such as self-harm, violence directed at others and/or property, and potential for substance abuse.

Interview patient.

Document **Nursing** Clinical Assessment on CVH-143.

***Exception: Addiction Services Division.***

Determine patient disposition and document on **the Nursing** Clinical Assessment Flow Sheet (CVH-143):

- Appropriate for off-unit activities
- Inappropriate for off-unit activities
- Level held
- Referred to MD for assessment

***If level is held, see Restriction of Privileges in Division Specific Freedom of Movement procedures.***

Document significant clinical changes in the **Integrated** Progress Notes of the patient's medical record.

Document the assessment of any patient leaving for or returning from TL in the **Integrated** Progress Notes of the patient's medical record.

Review clinical assessments and summarize findings in the RN comprehensive monthly note.