WHITING FORENSIC HOSPITAL

Nursing Policy and Procedure Manual

SECTION B: THE NURSING PROCESS
CHAPTER 6: ADMISSION, NURSING ASSESSMENT, NURSING REASSESSMENT

POLICY & PROCEDURE 6.5: NURSING CLINICAL ASSESSMENT OF THE PATIENT (Mental Status Evaluation/MSE)

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, Whiting Forensic Hospital demonstrating significant behavioral change 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.

Determine patient disposition and document on **the Nursing** Clinical Assessment Flow Sheet (WFH-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.

Verify that an MSE has been done and is recorded by a physician within forty-eight (48) hours before the patient leaves the Unit for a TL or TV.