# 1103.0 Outpatient Mental Health Nursing Assessments

## 1103.1 Policy Approval Clearance Record

| | | |
|---|---|---|
| ☐ Rural Services Policy<br>☒ Mental Health Policy<br>☐ Developmental Services Policy | This policy supersedes:<br>RS #3.2001 | Number of pages in Policy: 2 |
| Review by Representative from the Office of the Attorney General: n/a | Date:<br>n/a | Date Policy Effective:<br>12/01/11 |
| Rural Services Director Approval<br>Signature: *Barbara Legier* | Date:<br>12/6/11 6/6/12 REV | Policy Lead:<br>Sally Mitchell, RN, DON |

## 1103.2 Statement of Purpose

**1103.2.1** **Policy Statement:** Rural Services Mental Health will identify basic health care assessment standards for individuals receiving services and provide nursing oversight to facilitate access by individuals served.

**1103.2.2** **Purpose:** To provide the Mental Health nurse with a standardized format and procedures to complete nursing assessments so that individuals served by the agency are assessed and basic health care needs identified.

## 1103.3 Authority

NRS 433.144, 433.164, 433.459, 433.471, 433.484, 433.494, 449.0175, 449.037, 639.074
NAC 449.037, 449.361, 449.3624, 449.74339, 449.74345, 449.74349
Medicaid Chapter 400
MHDS Policies SP-3.2, PP-MM-02
Rural Services Policies 3.1009, 3.2001, 3.2002, 3.2008, 3.2012, 3.2015

## 1103.4 Unique Definitions and Acronyms

**1103.4.1** **Please refer to the Standard Definitions Policy for definitions**.

**1103.4.2** **Nursing Health Assessment (nursing assessment):** is part of the nursing process which includes establishment of a nursing diagnosis, treatment planning, implementation, and evaluation of the effectiveness of the plan.

**1103.4.3** **Nurse:** a licensed Registered Nurse, practicing under the provisions of the Nevada State Board of Nursing, to engage in the practice of professional nursing.

## 1103.5 Procedures

**1103.5.1** The nurse will complete the following documentation in the AVATAR electronic record within one work day. Nursing Assessments will be completed as follows:

**1103.5.2** **Nursing Assessments:** The nurse will complete client assessments at the time of the initial client nursing appointment at the Mental Health Center, under Nursing Assessment. For efficiency, the nursing assessment will be completed first, followed by the psychiatrist appointment, whenever possible. All screens in the nursing assessment are to be completed. If no data is available for a particular screen, insert 999. A pain assessment must be completed whenever the client has indicated he/she has pain, which will include a pain scale from 1 to 10. A nutritional assessment must be completed when the nurse identifies potential nutritional issues. Nursing assessments will be completed thereafter, for ongoing clients, to evaluate the client's response to care, treatment, and services; to respond to a significant change in status and/or diagnosis/condition but no less that every 2 years. A client who has been discharged from any of our mental health centers but re-admits to our service delivery system at a later date, regardless of the length of time from

the date of discharge, is considered a new client for each re-admission, requiring a new nursing assessment.

**1103.5.3** **Health Review:** The nurse will perform a quarterly Health Review (every 90 days) and document in AVATAR within one work day of seeing the client.

**1103.5.4** **Ambulatory Progress Note:** A DAP note must be completed in AVATAR every time an assessment is completed and/or for each client contact. The body of the progress must contain the name of the nurse and the nurse's credentials (e.g., RN) and must be entered within one work day.

**1103.5.5** **Medication Assessment:** The nurse will complete a minimum initial and annual medication assessment, and as needed in the case of any medication change.

**1103.5.6** **Abnormal Involuntary Movement Scale (AIMS):** The first AIMS test will happen with the initial nursing assessment to establish a client's baseline. The nurse will complete a semi-annual AIMS test for all clients that are on psychotropic medications and on an as needed basis for any change in client's presentation or report of increased medication side effects.

**1103.5.7** **Documentation**

**A. AVATAR/DSNOW Documentation (electronic):**

| Applicable Screen | Data Required |
|---|---|
| Nursing Assessment | Within one work day |
| Health Review | Within one work day |
| Progress Notes | Within one work day |
| Medication Assessment | Within one work day |
| Abnormal Involuntary Movement Scale | Within one work day |

**1103.5.9** **Supervisory Responsibilities:** Supervisors will provide in-service training to ensure all staff understands the requirements of this policy and its procedures. Supervisors will revisit this policy periodically, but no less than annually to identify recommendations for improvement.

## 1103.6 Policy Cross Reference

**1103.6.1** **Rural Services Policy 1120.0 – Medication Maintenance**

**1103.6.2** **Rural Services Policy 2.0010 – Abnormal Involuntary Movement Scale AIMS)**

# MHDS Initial Nursing Assessment Report

**Patient Name:** **Gender:** **Date of Birth:**

**Date of Assessment:** **Admission Date:** **PATID:**

**Completed by:** **Episode No.:** **Facility Chart No.:**

## CHIEF COMPLAINT:

**Chief complaint:**

**History of presenting illness:**

## GENERAL PHYSICAL CONDITION:

**Date of this assessment:**

**When was patient's last medical exam?**

**General Physical Condition Comments:**

**Temp:** **Pulse:** **Respiration:**

**Emergency room visits in the past year:**

**BP:**

**Prosthesis needed?**

**Height:** **Weight:**

**Type prosthesis:**

**BMI:** **Girth:**

**State reason if unable to complete any portion of assessment:**

## MEDICAL HX, TX, AND HEALTH HABITS:

**Date of this assessment:**

**Tobacco use/type:**

**Medical History:**

**Amount of tobacco used, how often & duration:**

**Surgical History?**

**Pattern of tobacco use:**

**Has attempted to quit:**

**History of communicable disease:**

**Expressed interest in quitting:**

**Caffeine use/type:**

**Number of hospitalizations:**

**More than 6 cups caffeinated beverages per day?**

**Date of last hospitalization:**

**Other sources of caffeine:**

**History of physical trauma?**

**Trauma comments:**

**Medical treatment/history comments:**

**State reason if unable to complete any portion of assessment:**

## SUBJECTIVE PHYSICAL:

**Date of this assessment:**

***EYES/EARS***

**Is Hearing WNL bilaterally?**

**Hearing impairment?**

**History of ear surgery?**

**Other problems related to the ears?**

**Hearing aid?**

**Comments on hearing:**

**Legal deafness?**

**Hearing special needs:**

***NOSE/THROAT***

**Nose/Throat problems:**

**Nose/Throat comments:**

***ENDOCRINE***

**Endocrine problems:**

**Endocrine related comments:**

*PULMONARY/CARDIOVASCULAR*

Pulmonary/Cardiovascular Problems:

Pulmonary/Cardiovascular comments:

*GI*

GI Problems:

GI comments:

*GU/REPRODUCTIVE*

GU Problems:

GU comments:

Female menstrual status:

LMP:

If hysterectomy, when?

Menopause?

Birth control type:

Female reproductive comments:

Hormone therapy?

Male reproductive:

Male reproductive comments:

*HEAD INJURY*

Head injury(ies)?

Duration of LOC or Coma:

Location of injury(ies):

How did the head injury(ies) occur?

Number of injuries:

Approximately when did the injury(ies) occur?

Head injury related comments:

State reason if unable to complete any portion of assessment:

**OBJECTIVE PHYSICAL:**

Date of this assessment:

Dental:

Skin condition:

Dental health comments:

Skin integrity comments:

Neuromuscular comments:

Neuromuscular:

Neurological comments:

Neurological:

If seizures, when was last?

Number CVA's:

CVA approximately when?

*EYES*

Vision WNL bilaterally?

Legal blindness?

Visual impairment? None indicated

Wears glasses?

Surgery which eye?

Other problems related to the eye?

Vision comments:

*SLEEP*

Sleep/Rest Pattern:

Sleep related comments:

State reason if unable to complete any portion of assessment:

**PHYSICAL MARKS / WOUNDS / INJURIES:**

Date of this assessment:

Current Fracture:

Does patient present with any physical disfigurement, marks, wounds, or injuries?

Ostomy:

Sutures / staples:

Unhealed Burn:

Laceration:

Rash:

Decubitus:

Ulceration:

Additional comments:

Tattoo:

Bruise/abrasion/scar:

State reason if unable to complete any portion of assessment:

## FALL RISK ASSESSMENT:

Date of this assessment:

Have you fallen in the past year?

Do you have problems with your inner ear or balance?

Have you ever fallen while on prescribed medications?

Do you lose your balance due to hip, knee, ankle or foot problems?

Reassessment date:

Have you experienced a fall in the past three months?

Have you ever had a seizure?

Does the patient have an unsteady gait?

Yes to any item indicates that patient is at risk.

Fall Prevention Plan in effect?

Additional fall risk comments:

State reason if unable to complete any portion of assessment:

## PAIN ASSESSMENT:

Date of this assessment:

Is patient experiencing pain?

Is pain chronic and/or acute?

Describe Location, Duration, Onset and Intensity:

Pain level (1-10):

Aggravating Factors:

Effects on Daily Life:

Pain Intervention Plan:

Pain Management Hx:

Current Pain Management Regime:

Effectiveness of Current Pain Management Regime:

Patient's Pain Goal:

Additional Pain Related Comments:

Current Alleviating Factors:

State reason if unable to complete any portion of assessment:

## NUTRITIONAL SCREENING:

Date of this assessment:

Food Allergies/Intolerances?

Cultural/Religious Food Preferences?

Height: Weight: Girth:

Identification of Nutritional Problems:

Referred to Dietitian if 3 or More Nutritional Problems are identified?

Nutritional Comments:

If yes, describe allergies/intolerances:

If yes, describe preferences:

BMI:

Weight Range from BMI Calculation:

Chewing/swallowing difficulty:

State reason if unable to complete any portion of assessment:

## PATIENT FAMILY EDUCATION RECORD:

Date of this assessment:

**Estimated ability to learn:**

**Preferred learning methods:**

**Barriers to learning:**

**Readiness to acquire skills through:**

**Other barriers:**

**Education comments:**

**Educational needs:**

***ADMISSION EDUCATION***

**Education provided:**

**Other Admission Education provided:**

**Education provided to:**

***PSYCHIATRIC EDUCATION***

**Education provided:**

**Other Psychiatric Education provided:**

**Education provided to:**

***ONGOING EDUCATION***

**Education provided:**

**Other Ongoing Education provided:**

**Education provided to:**

***BIOPHYSICAL EDUCATION***

**Education provided:**

**Other Biophysical Education provided:**

**Education provided to:**

**State reason if unable to complete any portion of assessment:**

**PLAN OF CARE:**

**Date of this assessment:**

**Nursing Dx and/or issues to be addressed in the Plan of Care:**

**Discharge Needs:**

**Disposition:**

**Other Issues/Comments Regarding Disposition:**

**State reason if unable to complete any portion of assessment:**