NH DEPARTMENT OF CORRECTIONS POLICY AND PROCEDURE DIRECTIVE	CHAPTER Health Services STATEMENT NUMBER 6.6
SUBJECT: **NURSING ASSESSMENT**	EFFECTIVE DATE 09/15/02 REVIEW DATE 12/15/03 SUPERCEDES PPD# 6.6 DATED 12/15/00
ISSUING OFFICER: *Phil Stanley, Commissioner*	DIRECTOR'S INITIALS ____ APPENDIX ATTACHED: YES ____ NO ____
REFERENCE NO: See reference section on last page of PPD.	

I. PURPOSE:
To provide a resident data base from which a preliminary treatment plan can be formulated.

II. APPLICABILITY:
To all registered nurses of the Secure Psychiatric Unit.

III. POLICY:
It is the policy of the Secure Psychiatric Unit that a Nursing Assessment as outlined below be performed for each resident by a registered nurse upon admission to the unit. All findings shall be recorded on a printed form approved by the health authority.

IV. PROCEDURES:

A. Upon admission to the unit, the registered nurse shall perform a nursing assessment for each resident that includes at least the following information which will be recorded on the Nursing Assessment form. (Attachment).

1. Inquiry into:
   a. Current illness and health problems, including dental problems, venereal diseases or other infectious diseases.
   b. Use of alcohol or other drugs:
      1) Type
      2) Mode of use
      3) Amounts used
      4) Frequency used
      5) Date and time last used
      6) History of withdrawal problems including seizures.
   c. Past or present treatment or hospitalization for mental illness, including suicide attempts.
   d. Current treatment for medical or dental problems.
   e. Current medications.
2. Observation of:
   a. General appearance:
      1) Hygiene
      2) Nutritional status
      3) State of consciousness

4) Mental status
5) Conduct
6) Tremors
7) Diaphoresis

b. Presence of deformities and ease of movement

c. Condition of skin:

1) Evidence of trauma
2) Bruises
3) Lesions
4) Rashes
5) Infestations
6) Needle marks

3. Identification of:

a. Medical problems with appropriate referrals on an emergency, urgent or routine basis.

b. Nursing diagnosis.

4. Disposition until medically cleared:

a. Infirmary

b. E Ward

1) General population
2) General population with restrictions

5. Formulation of a Nursing/Preliminary Treatment Plan.

B. Should the medical history and physical examination be completed prior to the nursing assessment, the nursing assessment may be cross-referenced to the medical history and physical examination form.

C. If the resident is either unable or unwilling to provide information upon admission, it will be noted on the Nursing Assessment form and in the nursing notes with a contingency plan documented for the collection of data.

D. No resident will be allowed to mix with other residents or take part in community activities prior to a completed health screen and medical communicable disease clearance.

E. Periodic nursing assessments will be performed at least annually or on an as needed basis as residents needs or condition warrants.

REFERENCES:

Standards for the Administration of Correctional Agencies
Second Edition. Standards

Standards for Adult Correctional Institutions
Third Edition. Standards
3-4343 (SPU ONLY)

Standards for Adult Community Residential Services
Fourth Edition. Standards

Standards for Adult Probation and Parole Field Services
Third Edition. Standards

Other

CATTELL/pf
Attachment

Name ________ Age ______ Sex ______
Date/Time of Admission ________
Dr. ________
Marital Status D ________ M ________ S ________
# of Children ________ Ages ________
Religion ________ Language Spoken ________
Referral Source ________
Admitted Via: Ambulance ________ Ambulatory ________
Stretcher ________ Restraints ________
Wheelchair ________

Physical Assessment:

Temp ______ P ______ R ______ BP ______ WT ______
General Appearance: ________
Allergies: ________
Condition of Skin: ________
Recent Physical Exam ________ By Whom ________
Medications Taken Regularly: ________
Physical Problems Including Dental and / or Usual Treatment: ________
Diet: ________
Sleep Pattern: ________
Contacts/Glasses ________ Dentures ________

Elimination Pattern:

Bladder: ________
Bowels: Frequency ________ Laxatives ________
Constipation ________ Diarrhea ________
Chief Complaint / Comments: ________

Attitude in Interview

Cooperative ________
Secure ________
Trustful ________
Seeks support ________
Passive ________
Hostile ________
Suspicious ________
Apathetic ________
Manipulative ________
Unable to comprehend ________
Answers reluctantly ________

Mood & Affect

Inappropriate affect ________
Flat, blunted affect ________
Labile (mood & effect) ________
Elevated mood ________
Depressed ________
Anxious ________
Fearful ________
Cyclothymic ________

Speech

Rapid ________
Slowed ________
Loud ________
Soft ________
Monotonic ________
Mute ________

Intra-Interpersonal

Withdrawal, Isolation ________
Suspiciousness ________
Hostility ________
Obsessions/Compulsions ________
Phobias ________
Sexual difficulties ________
Marital problems ________
Family problems ________
School problems ________
Employment problems ________

Motor Behavior

Hypoactive ________
Hyperactive ________
Abnormal ________

Cognitive

Loose ________
Flight ideas ________
Disoriented ________
Time ________
Place ________
Person ________
Hallucinations ________
Auditory ________
Visual ________
Delusions ________

Danger to Self & Others

Thoughts of suicide ________
Suicidal behavior ________
Other self-destructive behavior ________
Family/Suicide ________
Homicidal thoughts ________
Homicidal behavior ________

Drug & Alcohol

Alcohol ________
Smoking ________
Sedatives ________
Stimulants ________
Narcotics ________
Marijuana ________
Police problems ________

Physical

Increased sleep ________
Decreased sleep ________
Early awaking ________
Decreased weight ________
Increased weight ________
Sumatic complaints ________
Seizures ________

NH DEPARTMENT OF CORRECTIONS
SECURE PSYCHIATRIC UNIT
NURSING DATA BASE / ASSESSMENT

SPU-32
4/95

PATIENT IDENTIFICATION

Name ________
DOB ________ Age ________
DOAdm. ________
No. ________

NURSING ASSESSMENT / PROBLEM IDENTIFICATION / INITIAL PLAN

Admitting Nurse: ______________________

Date: ______________ Time: ______________