## Nursing Documentation

### *General Info*

**Arrival time to Emergency Department**
04/05/2024 19:23

**Time Zone**
Central (CST)

**Assessment start time**
04/05/2024 19:23

**Time Zone (Document in CST)**
Central (CST)

**Hold Status at Time of Assessment**
None

**Mental Hold Details**
No Mental Health Hold

**Arrival Mode**
Private Vehicle

**Bedside report:**
Patient arrived to the emergency department with spouse.  Patient had reported suicidal ideation.  Patient has been cooperative in the emergency department.  He has received no medications.  He is not on psychiatric medications and no outpatient therapy at this time. Spouse remains at bedside.

**Is patient prescribed psychiatric medication?**
No

**Medications: Non-verified, Medications are per patient or nursing report**
None

**Medication Compliance Details**
Not Applicable

**Report**
Patient states he has been stressed by work and conflict with spouse.  States that he started to have suicidal thoughts and told his spouse about this thoughts and she brought him to the emergency department.

**Precipitating Events / Stressors**
1. Conflict with Spouse after recent move to a new state

2. Stressed by work; recently got a promotion but he has conflict with new spouse

**Psychiatric Diagnosis**
Denies current or past diagnosis

**Psychiatric Dx Details**
Denies

**Was collateral obtained**
No

## Review of Symptoms

**Self-Harm**
Denies

**Homicide**
No Thought/Plan/Intent

**Violence**
No Violence Thought/Plan/Intent

**Abuse Issues**
Denies abuse

**Psychological Trauma**
Have you experienced a traumatic event?

**Have you experienced a traumatic event?**
Yes

**Traumatic event**
Car Accident 3 Years ago and passenger passed away

**Diagnosed with PTSD related to this event**
No

**Related to that event, in the past month, have you...**
Had nightmares about the event(s) or thought about the event(s) when you did not want to?
Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
Been constantly on guard, watchful, or easily startled?

**Had nightmares about the event(s) or thought about the event(s) when you did not want to?**
Yes

**Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?**
Yes

**Been constantly on guard, watchful, or easily startled?**
Yes

**Felt numb or detached from people, activities, or your surroundings?**
No

**Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?**
No

**Changes in sleep patterns**
no

**(Anhedonia) Lack of interested in activity**
No

**Feelings of guilt**
No

**Changes in energy**
No

**Change in concentration**
No

**Psychomotor agitation or retardation**
Denies

**Changes in Appetite**
Denies

## History

**History of cardiac issues**
No

**History of seizures**
No

**History of stroke**
No

**Pregnant or Breast Feeding**
No

**Non-Psychiatric medications**
None

**Allergies**
NKDA

**Primary Care Provider**
Dr. Test

**Do you have a psychiatrist**
No

**Psychiatrist/Medication prescriber**
None

**Do you have a counselor or therapist**
No

**Counselor/Therapist's name**
None

**Last seen counselor/therapist**
Not Applicable

**Next appointment with counselor/therapist**
Not Applicable

**Do you have Case Managemnt / ACT Worker or attend Group Therapy**
No

**Have you ever been to mental health inpatient or residential treatment?**
No

**Last inpatient hospitalization**
None

**Approximate # of inpatient visits**
0

**In the last 30 days, have you used any of the following substances**
Denies Substance Use

**Current Withdrawal**
Denies withdrawal symptoms

**History of Seizures**
No

**History of Delirium tremens (DT)**
No

**Addiction Treatment History with approximate timeline of treatment**
Denies

## Family & Social

**Adult/Minor**
Adult
If Adult, are you able to make your own medical decisions?

**If Adult, are you able to make your own medical decisions?**
Yes

**Patient lives with**
Spouse/Significant other

**Marital Status**
Married

**Are there known completed suicides in your family**
no

**Are there known suicide attempts in your family**
no

**Is there known mental illness in your family**
no

**Employment**
Full Time

**Other employment status**
Farmer

**Education**
High school

**Military Status**
N/A

**Do you have any pending legal charges?**
No

**If potential for placement, do you have any past charges of sexual assault or aggravated assault?**
No

***Columbia***

**Can patient complete the Columbia assessment?**
Yes

**1) Wish to be dead ->>- Have you wished you were dead or wished you could go to sleep and not wake up?**
Yes

**2) Current suicidal thoughts ->>- Have you actually had any thoughts of killing yourself?**
Yes

**3) Suicidal thoughts w/ Method (w/no specific Plan or Intent or act) ->>- Have you been thinking about how you might do this?**
No

**4) Suicidal Intent without Specific Plan ->>- Have you had these thoughts and had some intention of acting on them?**
No

**5) Suicidal Intent w/ Plan** *Have you started to work out or worked out the details of how to kill yourself? Did you intend to carry out this plan?*
No

**6) Have you ever done anything, started to do anything, or prepared to do anything to end your life? (In the last 30 days)**
No

**C-SSRS Suicidal Behavior - Lifetime**
No

**Access to firearms**
No

**Access to medications**
No

**Access to Means in Suicidal Plan**
N/A - No suicidal plan

**Means safety counseling completed**
No

**Activating events**
Recent losses or other significant negative event(s) (legal, financial, relationship, etc.)

**RN Cssrs Treatment History**
Not receiving treatment

**Internal**
Identifies reasons for living

**How many times have you had these thoughts?**
(1) Less than once a week

**When you have the thoughts how long do they last?**
(1) Fleeting - few seconds or minutes

**Could/can you stop thinking about killing yourself or wanting to die if you want to?**
(1) Easily able to control thoughts

**Are there things - anyone or anything (e.g., family, religion, pain of death) - that stopped you from wanting to die or acting on thoughts of suicide?**
(1) Deterrents definitely stopped you from attempting suicide

**What sort of reasons did you have for thinking about wanting to die or killing yourself?**
(5) Completely to end or stop the pain (you couldn't go on living with the pain or how you were feeling)

**Risk stratification**
Moderate

***MSE***

**Thought Process**
Coherent

**Suicidal Ideation**
No

**Homicidal Ideation**
No

**Behavior**
Cooperative

**Appearance**
Well Nourished

**Eye Contact**
Good eye contact

**Speech**
Clear, Non-Pressured

**Psychomotor Activity**
Normal

**Mood**
Neutral Mood

**Affect**
Congruent

**Sensorium**
Alert

**Orientation**
Oriented x3

**Memory**
Grossly Intact

**Fund of Knowledge**
Age Appropriate

**Intelligence**
Average

**Insight**
Good insight

**Judgement**
Good judgement

**Developmental and Cognitive assessment**
Patient is able to participate in the assessment

## *Safety Plan*

**Can patient complete the Safety Plan?**
Yes

**Warning Signs**
Conflict with others, isolating more often

**Coping Skills**
Going for a walk, talking to a friend, watching Friends Episodes

**Reasons for Living**
Plans for the Future, Spiritual Reasons

**Social Support System**
Sister, Friend John, Pastor

**Crisis and Professional Service**
Call My Doctor
Call/Text Crisis Hotline: 988

**Safety Plan Collaboration**
Individual agrees to remain clean and sober until crisis passes
Individual agrees to call and talk to mental health provider, hotline, 911, or other responsible person in case of crisis
Individual agrees to accept responsibility of this safety plan

**Safeguard Your Home Following these simple steps can help protect you or your family member when experiencing a mental health crisis**
Firearms: Ask a trusted family member or friend to keep firearms until the situation improves.
Medications: Store all medications in a lock box or locked medicine cabinet. Dispose of unused medications at your local pharmacy.

## Finish

**Assessment completed**
Yes

**Assessment Type**
Assessment Evaluation

**Assessment Provided By**
Healthcare Professional
Individual/Patient

**Assessment completed time**
04/05/2024 19:33