Your Hospital's Logo Here

PSYCHIATRY FLOW SHEET

PATIENT IDENTIFICATION

Assessments will be done on each shift. Progress Notes should explain / describe any "YES" responses. Direct quotes are helpful. PHYSICAL CONCERNS should also be addressed in the Progress Notes. Report actions taken.

LEGEND: Y = YES N = NO Place code letters in the response column for ** items.

DATE: TIME:	Night	Day	Eve.
1 ANXIETY STATEMENT: worried / fearful / panicked			
2 TENSION: tense / quite nervous / agitated			
3 DEPRESSIVE MOOD: blue / depressed / despairing			
4 HELPLESSNESS / HOPELESSNESS: doubtful / gloomy / sure of failure			
5 GUILT FEELINGS: regret / remorse / delusional guilt			
6 SOMATIC CONCERN: present / preoccupied with / delusional			
7 HOSTILITY: grumpy / angry / assaultive			
8 SUSPICIOUSNESS: guarded / mistrustful / paranoid			
9 UNCOOPERATIVENESS: gripes / resists / refuses			
10 DISTRACTABILITY: trouble focusing / excess response to things around him or her / no activity pursued more than the moment			
11 ELATED MOOD: unaccountably happy / seems high / euphoric			
12 MOTOR HYPERACTIVITY: energetic / pressured / frenetic			
13 DISORIENTATION: bewildered / confused / disoriented			
14 DISORGANIZED SPEECH: rambling / loose / fragmented			
15 GRANDIOSE STATEMENTS: vague / specific / delusional			
16 UNUSUAL IDEAS: odd / bizarre / delusional			
17 HALLUCINATORY STATEMENTS: acknowledges / describes / involved in			
18 HALLUCINATORY BEHAVIOR: subtle / clear evidence / acts on			
19 SOCIAL WITHDRAWAL: distant / avoids / no contact			
20 BLUNTED AFFECT: decreased / consistently reduced / toneless			
21 MOTOR RETARDATION: sluggish / necessary movement only / catatonic			

PART OF THE MEDICAL RECORD

LEGEND: Y = YES N = NO Place code letters in the response column for ** items.

PATIENT:	Night	Day	Eve.
22 MANNERISMS & POSTURING: odd / bizarre / dominates behavior			
23 LOSS OF FUNCTION: needs minimal supervision / requires some supervision / needs assistance or protection of hospital			
24 **ACTIVITY: BR = Bed Rest, UAL = Up Ad Lib, S = Sleep			
25 **SAFETY PRECAUTIONS: Q15 = Q 15 minute checks, VC = visional constant, F = falls, CO = constant observation, S = seclusion, R = restraint, RS = room search			
26 **PERSONAL CARE: I = independent, A = assist, P = prompt			

AN RN MUST DOCUMENT ANY POSITIVE FINDINGS IN #27 - #37 IN THE PROGRESS NOTES

	Night	Day	Eve.
27 GASTROINTESTINAL: diarrhea / constipation / vomiting / nausea			
% of meals eaten / NPO			
BM			
28 GENITOURINARY: dysuria / frequency / urgency / hesitancy / PG			
29 CARDIAC: peripheral edema / SOB / Elevated BP / chest pain			
30 RESPIRATORY: cough / hyperventilation / wheezing			
31 SKIN INTEGRITY: decubitis / rash / lesion / abrasion / contusion			
32 ENDOCRINE: unstable blood sugar			
33 INFECTIOUS DISEASE COMPLICATIONS: hepatitis / HIV / STD's / TB			
34 PAIN			

PAIN SCALES:

WONG-BAKER: *(Faces)* 0 1 2 3 4 5

0-10 VISUAL: *(Numerical)* 0 1 2 3 4 5 6 7 8 9 10

VERBAL: No Hurt — Hurts Little Bit — Hurts Little More — Hurts Even More — Hurts Whole Lot — Worst Pain

WONG-BAKER FACES PAIN SCALE from Wong DL, Hockenberry-Eaton M, Wilson D, Winkelstein ML, Ahmann E, DiVito-Thomas PA, Whaley & Wong: Nursing Care of Infants & Children, 6th ed, St. Louis, MO: Mosby-Year Book Inc., 1999; 1153. Copyrighted by Mosby-Year Book, Inc. Reprinted with Permission.

NON-COGNITIVE: *(FLACC Scale)*
1. Sum of FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY Scores = FLACC Score
2. Evaluate FLACC Score using the 0-10 VISUAL (NUMERIC) Scale

_____ = FACE Score
0 = No particular expression or smile
1 = Occasional grimace or frown, withdrawn, disinterested
2 = Frequent to constant frown, clenched jaw, quivering chin

_____ = LEGS Score
0 = Normal position, or relaxed
1 = Uneasy, restless, tense
2 = Kicking, or legs drawn up

_____ = ACTIVITY Score
0 = Lying quietly, normal position, moves easily
1 = Squirming, shifting back & forth, tense
2 = Arched, rigid, or jerking

_____ = CRY Score
0 = No crying (asleep or awake)
1 = Moans or whimpers, occasional complaint
2 = Crying steadily, screams or sobs, frequent complaints

_____ = CONSOLABILITY Score
0 = Content, relaxed
1 = Reassured by touching, hugging, talking to; distractable
2 = Difficult to console or comfort

SEDATION SCALE:
S = Normal Sleep, easy to arouse, oriented when awakened, appropriate cognitive behavior
1 = Wide awake - alert (or at baseline), oriented, initiates conversation
2 = Drowsy, easy to arouse, but oriented and demonstrates appropriate cognitive behavior when awake
3 = Drowsy, somewhat difficult to arouse, but oriented when awake
4 = Difficult to arouse, confused, not oriented
5 = Unarousable

INTERVENTION:
1 = Discuss pain management plan w/ MD
2 = Pharmacological (see Med Kardex)
3 = Non-Pharmacological
- ☐ Position Changed ☐ Imagery
- ☐ Relaxation Technique ☐ Music
- ☐ Education ☐ Splinting
- ☐ Other: ______________________

PART OF THE MEDICAL RECORD

LEGEND:	Y = YES	N = NO	Place code letters in the response column for ** items.

PATIENT:		Night	Day	Eve.
35 LEARNING: Assess once in 24 hours until learning profile (Part A, B & C) is established				
A. Readiness: Answers questions				
Asks questions				
Willingness to participate in learning activities				
Verbalizes need to learn				
Denies need to learn				
B. Learning Style preferences: D = doing; S = seeing; L = listening				
C. Barriers: [1] language, [2] literacy, [3] cognitive deficits, [4] sensory deficits, [5] acceptance of diagnosis, [6] severity of illness, [7] sedation				
36 SUICIDALITY: Do a Suicide / Self Harm Assessment				
37 HOMOCIDALITY: Low / Medium / High **(based on Plan, Lethality, History)**				

INITIALS	STAFF SIGNATURE	INITIALS	STAFF SIGNATURE

NURSING PROGRESS NOTES:

DATE	TIME	

PART OF THE MEDICAL RECORD

PATIENT:

NURSING PROGRESS NOTES:

DATE	TIME	

PART OF THE MEDICAL RECORD