



## Nursing Service Guidelines Inpatient Behavioral Health

**Title:** ELEMENTS OF THE NURSING ADMISSION ASSESSMENT

**Responsibility:** Trained Inpatient Behavioral Health staff

**Purpose of Guidelines:** To provide guidance and outline the elements of the Behavioral Health Nursing Admission Assessment

**Procedure:**

The Behavioral Health Nursing Admission Assessment includes all relevant areas included in the UTMCM nursing assessment procedure (and additional elements specific to Senior Behavioral Health).

1. Reason for admission (“chief complaint”) stated
2. Psychiatric history
3. Functional screen with triggers for full assessment (addresses vision, hearing, mobility, cognitive abilities/limitations)
4. Pain assessment screening with triggers for full assessment
5. Vital signs
6. Height/Weight
7. Nutritional screening with triggers for full assessment
8. Medications – dosage, frequency, last taken or medication reconciliation form completed
9. Allergies
10. Brief psychosocial history, i.e., treatment providers, patient strengths, patient liabilities, alcohol/drug use, living situation, family and community support
11. Abuse/neglect/domestic violence screen
12. Fall risk assessment
13. Skin assessment
14. Suicide assessment
15. Pneumonia (SBH only) and Flu assessment
16. Violence Risk Assessment
17. Risk to harm assessment (Restraint/Seclusion)
  - a. Identification of tools, methods or techniques to control the individual’s behavior
  - b. Pre-existing medical conditions or physical disabilities/limitations
  - c. Any history of sexual, physical, or mental/emotional abuse
18. Patient/family educational needs, barriers to learning, learning preferences, and readiness
19. Preliminary discharge planning needs
20. Review of systems – physical assessment of patient
21. A summary statement, which identifies problems and includes focus of treatment
22. Date, time, and signature with credentials upon completion

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