

OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS
MENTAL STATUS CHANGE

MSRM 140117.01.36
(R-4/13)

Subjective Data:

Allergies: _____

Chief complaint: _____

Onset: _____ Duration: _____

History:

<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Thyroid disease	<input type="checkbox"/> Heart disease/stroke	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dementia
<input type="checkbox"/> Fever	<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Medication change	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Alcohol/drug use	<input type="checkbox"/> COPD	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Detoxification

Associated symptoms:

<input type="checkbox"/> Weakness	<input type="checkbox"/> Gait disturbance	<input type="checkbox"/> Headache	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Shortness of breath
<input type="checkbox"/> Numbness	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Slurred speech	<input type="checkbox"/> Confusion	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Agitation	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Tremors	<input type="checkbox"/> Paranoid ideations/delusions	<input type="checkbox"/> Nausea/vomiting
<input type="checkbox"/> Depression	<input type="checkbox"/> Suicidal thoughts	<input type="checkbox"/> Muscle twitching	<input type="checkbox"/> Diaphoresis	<input type="checkbox"/> Aches/pains, muscle stiffness
<input type="checkbox"/> Tactile disturbances (pins and needles)				

Objective Data: (clinically indicated VS)

BP _____ Pulse _____ Resp. _____ Temp. _____ Wt. _____ FSBS _____

Mental Status		Neurological		LOC	
Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Oriented to place	<input type="checkbox"/>	<input type="checkbox"/> Pupils reactive to light	<input type="checkbox"/>	<input type="checkbox"/> Alert
<input type="checkbox"/>	<input type="checkbox"/> Oriented to date & time	<input type="checkbox"/>	<input type="checkbox"/> Grip strength equal	<input type="checkbox"/>	<input type="checkbox"/> Arouses to voice
<input type="checkbox"/>	<input type="checkbox"/> Can repeat "ball, flag, tree"	<input type="checkbox"/>	<input type="checkbox"/> Speech normal	<input type="checkbox"/>	<input type="checkbox"/> Arouses to touch
<input type="checkbox"/>	<input type="checkbox"/> Can spell "WORLD" backward	<input type="checkbox"/>	<input type="checkbox"/> Gait normal	<input type="checkbox"/>	<input type="checkbox"/> Comatose
<input type="checkbox"/>	<input type="checkbox"/> Can name a pen and watch	<input type="checkbox"/>	<input type="checkbox"/> Smile symmetrical	<input type="checkbox"/>	<input type="checkbox"/> Cooperative
<input type="checkbox"/>	<input type="checkbox"/> Can repeat "no ifs and or buts"	<input type="checkbox"/>	<input type="checkbox"/> Neck ROM normal	<input type="checkbox"/>	<input type="checkbox"/> Disorganized in speech
<input type="checkbox"/>	<input type="checkbox"/> Can draw a clock set to 2:30			or behavior	
<input type="checkbox"/>	<input type="checkbox"/> Can recall the 3 words "ball, flag, tree"			<input type="checkbox"/>	<input type="checkbox"/> Incoherent

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY FOLLOWING INTERVENTIONS:

Refer to Medical Provider If:

- | | |
|---|---|
| <input type="checkbox"/> Any recent medication change | <input type="checkbox"/> Cause of mental status change is unknown or persists |
| <input type="checkbox"/> Decreased level of consciousness | <input type="checkbox"/> Loss of consciousness was due to trauma |
| <input type="checkbox"/> Any suspicion of drug or alcohol ingestion | <input type="checkbox"/> Any fever |

Emergency department notification time: _____ Transport time: _____

Medical Provider/RN Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

- Alteration in neurological status related to: Acute confusion Altered thought processes Impaired memory

Plan:

Nursing Intervention Routine:

- Maintain airway, breathing and circulation if unresponsive
- Assess FSBS
- Provide non-threatening, low stimulus environment
- Refer to "Seizure Protocol" MSRM 140117.01.40 if offender had seizure
- Refer to "Hypoglycemia Protocol" MSRM 140117.01.23 if blood sugar low
- Refer to "Head Trauma Protocol" MSRM 140117.01.39 if history of head trauma
- Refer to "Detoxification" MSRM 140123.01 if history of drug or alcohol abuse

Progress Note: _____

Offender Education:

- Instructed on treatment provided, follow-up sick call with medical provider if applicable. Offender verbalizes understanding of instructions.

LPN Signature/credentials: _____ **Date:** _____ **Time:** _____

RN/Provider Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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