Subjective Data:

Chief Complaint:

☐ Scratching, cutting or pinching of skin to the point of bleeding, using fingernails or a sharp object. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

☐ Carving words or symbols into arms, legs, breast, torso, or other body parts. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

☐ Biting oneself to the point of bleeding or leaving marks on the skin. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

☐ Burning of the skin. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

☐ Intentionally preventing wounds from healing. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

☐ Imbedding objects into the skin or body part. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

☐ Ingesting foreign objects or toxic substances. Describe:

Date of incident: ___________________________ Time of Incident: ___________________________

Objective Data: (clinically indicated VS)

BP _______ Pulse _______ Resp. _______ Temp. _______ Wt. _______ O2 Sats. _______ FSBS: _______

Character of wound: ☐ Clean  ☐ Dirty  ☐ Gapping  ☐ Redness/Swelling

☐ Crusted  ☐ Dry  ☐ Weeping  ☐ Imbedded or foreign material present

Drainage: ☐ Yes  ☐ No If “Yes” describe ____________________________________________________________________________

CONTACT HEALTH PROVIDER IMMEDIATELY IF: Health Care Provider must be called if not on site or if after clinic hours.

☐ Wound is severe /deep/ requires sutures  ☐ Laceration to the face, ear, nose, eyelid or over joint  ☐ Bleeding is uncontrolled  ☐ Signs of infection present

☐ Laceration to the abdomen or chest that may penetrate underlying organs  ☐ Dysphagia  ☐ Upper/lower GI bleed  ☐ Acute abdomen pain

☐ Hematuria  ☐ Dysuria  ☐ Vaginal discharge, bleeding, pain, foul odor  ☐ Rectal Bleeding

REFER TO HEALTH CARE PROVIDER IF: If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.

☐ Daily dressing changes are indicated  ☐ Wound edges do not approximate easily with Steri – Strips  ☐ Wound not responding to nursing intervention

☐ Wound has imbedded debris not easily irrigated out  ☐ Last Tetanus/Diphtheria injection more than 5 years

CONTACT MENTAL HEALTH PROFESSIONAL IMMEDIATELY IN ALL CASES OF SELF-HARM QMHP must be called if not on site or if after clinic hours.

QMHP Contacted: ________________________ Time Notified: ________________________

Emergency department notification time: ___________________________ Transport Time: ___________________________ Transported by: _________

Health Care Provider: ___________________________ Time Notified: ___________________________ Orders Received for Treatment:  ☐ Yes  ☐ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions: Self-Injury

(check all that apply)

☐ Check in assessment only for health care provider visit.

☐ Acute emergency situation, imminent danger of self-harm – initiate Suicide Watch per OP 140129.

☐ Stop bleeding with pressure

☐ Wash well with antiseptic soap, sterile water or sterile normal saline, remove all ingrained dirt.

☐ Apply telfa pad, clean dry dressing or butterfly dressing or Steri – Strips

☐ Arrange for dressing change, wound check and suture removal

☐ “Polysporin” ointment twice a day for 10 days PRN and dressing if wound location subject to irritation or dirt.

☐ Acetaminophen 325 mg - 2 tablets p.o. three times a day for 4 days PRN OR ☐ Ibuprofen 200 mg – 2 tablets p.o. three times a day for 4 PRN days.

☐ X-ray per Health Care Providers order.

☐ Education/Intervention: Instructed to keep wound clean and dry, signs and symptoms of infection, condition worsens or fever, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note:

Health Care Provider Signature/Credentials: ___________________________ Date: _____________ Time: _____________

RN/LPN Signature/Credentials: ___________________________ Date: _____________ Time: _____________

Inmate Name (Last, First)  _____ DOC # ________