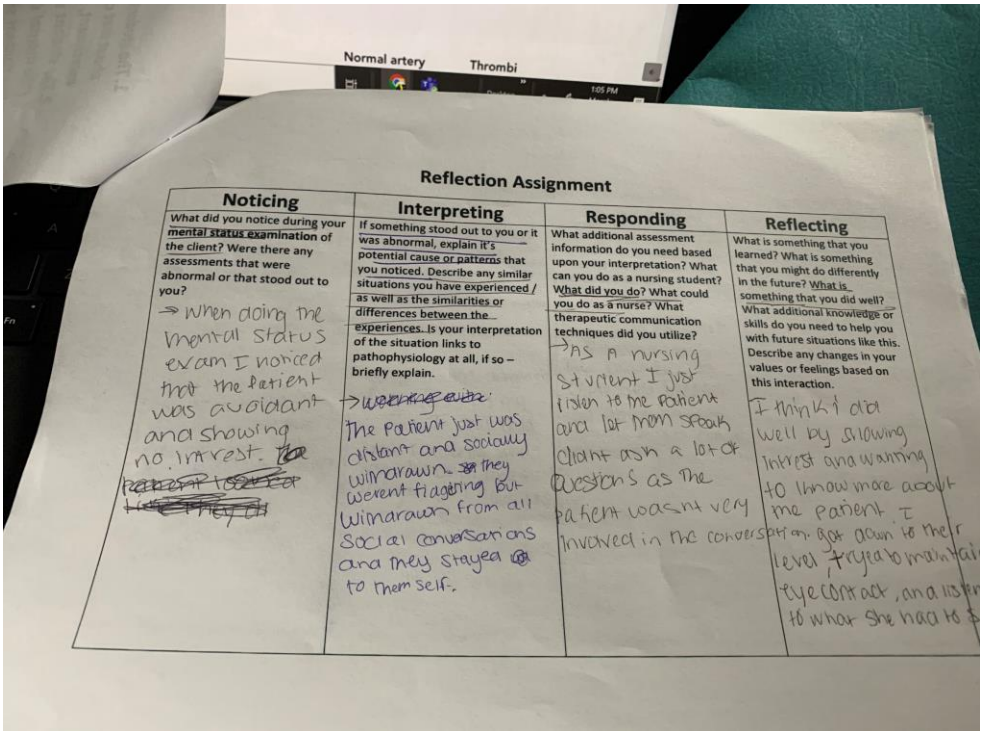
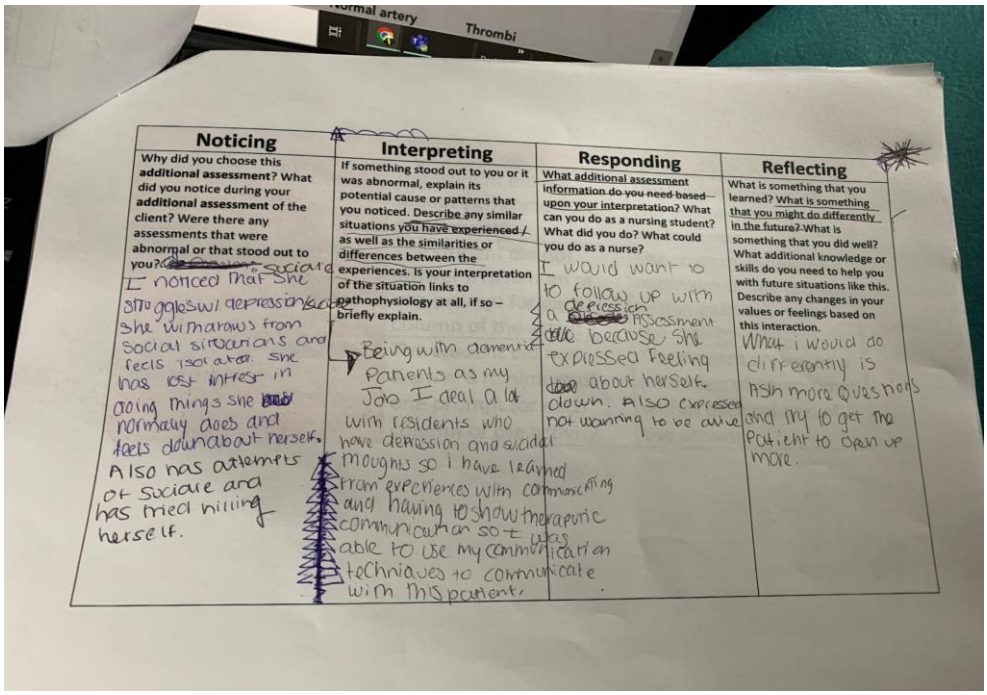

Normal artery
Thrombi
Reflection Assignment
Noticing
What did you notice during your mental status examination of the client? Were there any assessments that were abnormal or that stood out to you?
→ When doing the mental status exam I noticed that the patient was avoidant and showing no interest.
Interpreting
If something stood out to you or it was abnormal, explain it's potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so – briefly explain.
→
The patient just was distant and socially withdrawn. they weren't fidgeting but withdrawn from all social conversations and they stayed to themself.
Responding
What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse? What therapeutic communication techniques did you utilize?
→ As a nursing student I just listen to the patient and let them speak. I didn't ask a lot of questions as the patient wasn't very involved in the conversation.
Reflecting
What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction.
I think I did well by showing interest and wanting to know more about the patient. I got down to their level, tried to maintain eye contact, and listen to what she had to


Normal artery
Thrombi
Noticing
Why did you choose this additional assessment? What did you notice during your additional assessment of the client? Were there any assessments that were abnormal or that stood out to you?
I noticed that she struggles w/ depression & suicidal. She withdraws from social situations and feels isolated. She has lost interest in doing things she normally does and feels down about herself. Also has attempts of suicide and has tried killing herself.
Interpreting
If something stood out to you or it was abnormal, explain its potential cause or patterns that you noticed. Describe any similar situations you have experienced / as well as the similarities or differences between the experiences. Is your interpretation of the situation links to pathophysiology at all, if so – briefly explain.
Being with dementia patients as my job I deal a lot with residents who have depression and suicidal thoughts so I have learned from experiences with communicating and having to show therapeutic communication so I was able to use my communication techniques to communicate with this patient.
Responding
What additional assessment information do you need based upon your interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse?
I would want to to follow up with a depression assessment tool because she expressed feeling down about herself. Also expressed not wanting to be alive
Reflecting
What is something that you learned? What is something that you might do differently in the future? What is something that you did well? What additional knowledge or skills do you need to help you with future situations like this. Describe any changes in your values or feelings based on this interaction.
What I would do differently is ask more questions and try to get the patient to open up more.

Mental Status Exam

Client Name [redacted] Z.F				**Date** 1/16/23	
OBSERVATIONS					
Appearance	☐ Neat	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Other
Speech	☒ Normal	☐ Tangential	☐ Pressured	☐ Impoverished	☐ Other
Eye Contact	☐ Normal	☐ Intense	☒ Avoidant	☐ Other	
Motor Activity	☒ Normal	☐ Restless	☐ Tics	☐ Slowed	☐ Other
Affect	☐ Full	☐ Constricted	☒ Flat	☐ Labile	☐ Other
Comments:					
MOOD					
☒ Euthymic	☐ Anxious	☐ Angry	☒ Depressed	☐ Euphoric	☐ Irritable ☐ Other
Comments: withdrawn, Pale color, Very distant					
COGNITION					
Orientation Impairment	☐ None	☐ Place	☐ Object	☐ Person	☐ Time
Memory Impairment	☒ None	☐ Short-Term	☐ Long-Term	☐ Other	
Attention	☒ Normal	☐ Distracted	☐ Other		
Comments:					
PERCEPTION					
Hallucinations	☒ None	☐ Auditory	☐ Visual	☐ Other	
Other	☒ None	☐ Derealization	☐ Depersonalization		
Comments:					
THOUGHTS					
Suicidality	☐ None	☒ Ideation	☒ Plan	☒ Intent	☒ Self-Harm
Homicidality	☒ None	☐ Aggressive	☐ Intent	☐ Plan	
Delusions	☒ None	☐ Grandiose	☐ Paranoid	☐ Religious	☐ Other
Comments: self harmed, wants to [redacted] not be alive					
BEHAVIOR					
☒ Cooperative	☐ Guarded	☐ Hyperactive	☐ Agitated	☐ Paranoid	
☐ Stereotyped	☐ Aggressive	☐ Bizarre	☐ Withdrawn	☐ Other	
Comments:					
INSIGHT	☐ Good	☒ Fair	☐ Poor	Comments:	
JUDGMENT	☐ Good	☒ Fair	☐ Poor	Comments:	

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient:

1. **In the past few weeks, have you wished you were dead?** ☒ Yes ☐ No
2. **In the past few weeks, have you felt that you or your family would be better off if you were dead?** ☒ Yes ☐ No
3. **In the past week, have you been having thoughts about killing yourself?** ☒ Yes ☐ No
4. **Have you ever tried to kill yourself?** ☒ Yes ☐ No

   If yes, how? self harm, overdosing on pills

   When? happend a week ago

If the patient answers Yes to any of the above, ask the following acuity question:

5. **Are you having thoughts of killing yourself right now?** ☒ Yes ☐ No

   If yes, please describe: "I don't want to be alive right now"

Next steps:

- If patient answers "No" to all questions 1 through 4, screening is complete (not necessary to ask question #5). No intervention is necessary (*Note: Clinical judgment can always override a negative screen).
- If patient answers "Yes" to any of questions 1 through 4, or refuses to answer, they are considered a positive screen. Ask question #5 to assess acuity:

☒ "Yes" to question #5 = **acute positive screen** (imminent risk identified)
- **Patient requires a STAT safety/full mental health evaluation. Patient cannot leave until evaluated for safety.**
- Keep patient in sight. Remove all dangerous objects from room. Alert physician or clinician responsible for patient's care.

☐ "No" to question #5 = **non-acute positive screen** (potential risk identified)
- **Patient requires a brief suicide safety assessment to determine if a full mental health evaluation is needed. Patient cannot leave until evaluated for safety.**
- Alert physician or clinician responsible for patient's care.

Provide resources to all patients

- 24/7 National Suicide Prevention Lifeline 1-800-273-TALK (8255) En Español: 1-888-628-9454
- 24/7 Crisis Text Line: Text "HOME" to 741-741