Assessments and Reflection in Mental Health Nursing

A Learning Activity Focused on Clinical Judgement

- Each student has four clinical days at the Pavilion.
- One of these days will require the student to complete a care plan.
- The other three days will require the student to engage in the clinical and complete this assessments and reflection learning activity.
- Please see the rubric for information on grading. The rubric is completion based. The purpose of this activity is to help you practice your assessment skills, critical thinking, and clinical judgement.
- Failure to complete the clinical assessment and reflection activities will affect your overall course grade and could result in clinical failure.
- This learning activity should be completed at the clinical site. This is not meant to be homework. The only part of this activity that may need to be completed at home is uploading your completed documents to the Edvance360 dropbox.

1. **The student should select a client to assess. The student should learn about that client from staff or the client's chart prior to completing the assessment, so they have baseline knowledge of their client.**
2. **The student should complete a mental status examination on the client. (The mental status exam is provided in this packet on page 5).**
3. **The student should utilize therapeutic communication throughout their interactions with the client.**
4. **The student should select 1 additional assessment to complete on their client based upon their current understanding of the client's needs. (Additional assessments are located in this packet on pages 6 through 15).**
5. **The student should complete one reflection assignment for each assessment they completed.**

Reflection Assignment

Noticing	Interpreting	Responding	Reflecting
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?	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.	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?	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.
During the mental status exam, I noticed the patient was cooperative throughout the assessment but tended to fidget with her hands a lot while speaking with me. I did not have any abnormal assessments but based off her answers to my questions even though she is not currently having suicidal ideations, I felt it may still be beneficial to complete a suicide risk assessment since suicidal ideations were what brought her into the facility.	One thing that stood out to me that I could just be overthinking is her fidgeting during the assessment, while she was cooperative and answered all questions willingly it was hard to know if I had truly established enough trust with the patient for her to feel comfortable talking to me about how she is feeling. She did express to me that she has a hard family life and that there have been other instances of family members self-harming or attempting suicide.	Based upon the information obtained from the patient, I felt it was best to complete a PHQ-9 and a suicidal risk assessment. As a nursing student, I can be a fresh new insight into what the patient is experiencing and be a listening ear for them and then use information obtained to help the nursing staff better care for the patient. I looked at the patient's chart and kindly asked if she would be willing to speak with me, while assessing I used therapeutic communication techniques such as active listening, eye contact, and the use of open-ended questions. As a nurse, I would be able to further build my trust with the patient since I would see her more. As a nurse I could use my assessment to further my patient's care plan and advocate for her care with my fellow physicians and nursing staff.	I learned that you never truly know what someone is going through and just how essential mental health services are to not only our youth but our whole community. I was a little nervous attending the first clinical so next time when doing an assessment, I will try to establish a trusting nursing-patient relationship with the patient so there is less anxiety and the conversation will be less uncomfortable. I feel like it would be beneficial to have seen a nurse do an assessment on a patient before we did one on our own. My feelings towards mental health have always been that it is a much-needed field and I give major thanks to all healthcare members who work in mental health because I personally do not think I could handle working in the mental health field. Hearing my patient tell me about her home life and what brought her into the facility broke my heart.

Mental Status Exam

Client Name	Anabelle	Date	1-27-2023

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: Patient states she is anxious about going back home and taking medications. She states she is angry that she had the suicidal thoughts that brought her here.

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: Patient states she arrived here due to having suicidal ideation, but is no longer having those thoughts nor has a plan.

BEHAVIOR

☒ Cooperative ☐ Guarded ☐ Hyperactive ☐ Agitated ☐ Paranoid
☐ Stereotyped ☐ Aggressive ☐ Bizarre ☐ Withdrawn ☒ Other

Comments: Patient was cooperative during the assessment but was very fidgety with her hands.

INSIGHT ☒ Good ☐ Fair ☐ Poor Comments:

JUDGMENT ☒ Good ☐ Fair ☐ Poor Comments:

(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0 ✓	1	2	3
2. Feeling down, depressed, or hopeless	0 ✓	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1 ✓	2	3
4. Feeling tired or having little energy	0	1 ✓	2	3
5. Poor appetite or overeating	0 ✓	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0 ✓	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ✓	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	✓	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0 ✓	1	2	3

FOR OFFICE CODING 0 + 3 + 0 + 0

=Total Score: 3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☒	☐	☐

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? _____

   _____

   _____

   When? _____

   _____

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: _____

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