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.
• Client was cooperative and forthcoming with information during the mental status assessment.	• The additional assessment that I utilized was the Suicide Risk screening tool based on the client's admission diagnosis.		
• Appearance, speech, eye contact, motor activity, and affect were all normal.			
• Client's mood was euthymic yet anxious. She stated, "I'm going home so I am happy." The client plans to get a job and go to college for business.	• One thing that stood out for me regarding this client was while I was doing the Suicide Screening tool. She answered yes to the question, "Have you ever tried to kill yourself?" and when asked how she stated, "I took a bunch of Tylenol crushed up in juice but couldn't follow all the way through because I have a hard time taking pills." She also told me the reason she did it was that she wasn't doing anything with her life besides hanging out with her friends and getting high on marijuana.	• As a nursing student, I can learn more about the client, the reasons she was suicidal, and offer therapeutic communication.	• I learned that just because someone is suicidal before doesn't necessarily mean they will always be consistently suicidal. I also learned that not every suicidal client is the same and can be medically treated the same.
• Client was alert and oriented x4, perception, and thoughts within normal limits for the situation. Client is no longer suicidal.		• I engaged with the client by active listening, restating, and silence.	• Something that I could do differently in the future is dig a little deeper into the chart.
• Client had fair insight and judgment.	• I find this to be a reoccurring statement by many different people.	• Those are some of the therapeutic techniques I used as well as open-ended questions, observation, sharing empathy, and even answering questions she had about being a nursing student.	• I feel like I kept the client calm while she was waiting for her ride and showed her that we do care about her well-being.
			• Nothing really changed for me because working with

mental health clients previously I know that sometimes they just need someone to talk to and a little guidance on how they can get better and progress through their recovery with a little encouragement.

Noticing	Interpreting	Responding	Reflecting
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?	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.	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 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 chose the Suicide Risk screening tool based on the client's admission diagnosis.	• One thing that stood out for me regarding this client was while I was doing the Suicide Screening tool. She answered yes to the question, "Have you ever tried to kill yourself?" and when asked how she stated, "I took a bunch of Tylenol crushed up in juice but couldn't follow all the way through because I have a hard time taking pills." She also told me the reason she did it was that she wasn't doing anything with her life besides hanging out with her friends and getting high on marijuana.	• The only other assessment information that I could have looked into was her discharge plan of care to see what she and the Case Manager discussed for her outpatient care.	• In the future I will continue to use the therapeutic techniques that I have learned thus far and apply them according to the situation.
• I noticed that the client kept looking out the window while I was asking her the questions on the assessment. I could tell that she was anxious not only to get to go home but also due to judgment.		• As a nursing student, I can dig a little deeper into the client's chart or even ask the client about her plan of care outside the clinic.	• I learned that not everyone is comfortable talking about their mental illness even though they are in an inpatient mental health clinic.
		• I asked about her goals and plans to keep her mind busy and away from her suicidal thoughts.	• Not all mental health cases are the same so I will continue to learn different techniques and apply them as I go along within my career.
	• I find this to be a reoccurring statement by many different people.	• As a nurse, I could make sure the client and Case Manager spoke about a plan of care and that the client understands the plan or try to answer any questions/concerns she may have.	

Mental Status Exam

Client Name	A. W_____	Date	2/3/23

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: did look out the window quite a bit

MOOD

☑ Euthymic	☑ Anxious	☐ Angry	☐ Depressed	☐ Euphoric	☐ Irritable	☐ Other

Comments: pt going home so she is happy 😊; plans to get a job & go to college for business nervous

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

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Suicidality	☑ None	☐ Ideation	☑ Plan	☐ Intent ☐ Self-Harm
Homicidality	☑ None	☐ Aggressive	☐ Intent	☐ Plan
Delusions	☑ None	☐ Grandiose	☐ Paranoid	☐ Religious ☐ Other

Comments: no longer suicidal

BEHAVIOR

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

Comments:

INSIGHT
☐ Good ☑ Fair ☐ Poor   Comments:

JUDGMENT
☐ Good ☑ Fair ☐ Poor   Comments:

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? _took a bunch of pills (Tylenol) crushed up in juice but couldn't fully follow through. d/t trouble taking pills._

   When? _1 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: _____

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