Mental Status Exam

Client Name A.			**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: comfortable					
MOOD					
☑ Euthymic	☐ Anxious	☐ Angry	☐ Depressed	☐ Euphoric	☑ Irritable ☐ Other
Comments: During group tends to pick on other girl.					
COGNITION					
Orientation Impairment	☑ None	☐ Place	☐ Object	☐ Person	☐ Time
Memory Impairment	☑ None	☐ Short-Term	☐ Long-Term	☐ Other	
Attention	☑ Normal	☐ Distracted	☑ Other		
Comments: During group was reading book through it but engaged.					
PERCEPTION					
Hallucinations	☑ None	☐ Auditory	☐ Visual	☐ Other	
Other	☑ None	☐ Derealization	☐ Depersonalization		
Comments: N/A					
THOUGHTS					
Suicidality	☑ None	☐ Ideation	☐ Plan	☐ Intent	☐ Self-Harm
Homicidality	☑ None	☐ Aggressive	☐ Intent	☐ Plan	
Delusions	☑ None	☐ Grandiose	☐ Paranoid	☐ Religious	☐ Other
Comments: N/A					
BEHAVIOR					
☑ Cooperative	☐ Guarded	☐ Hyperactive	☐ Agitated	☐ Paranoid	
☐ Stereotyped	☐ Aggressive	☐ Bizarre	☐ Withdrawn	☑ Other	
Comments: During group was leader and controls group					
INSIGHT	☑ Good	☐ Fair	☐ Poor	Comments: N/A	
JUDGMENT	☑ Good	☐ Fair	☐ Poor	Comments: N/A	

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? I notice that my client seemed comfortable during my mental status examination. During group she was engaging and was very open. She did seem irritable during group. One of the other girls seemed to be staring at her according to her. And later on in the day, she got increasely irritable, she got into more than one altercation.	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 increase irritable attitude could have been related to dying social battery. It could be possible that after a long period of time of being around the group all morning, she becomes tired and exhausted and becomes irritable. I've had times where I am overwhelmed by others after spending long period of time with them.	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? Base upon my interpretation, I need to assess the client's mental anxiety and comfortability. As a nursing student I can ask what is comfortable for the client and what are their boundaries. As a nurse I could advocate for the client to have decreased time with group to recharge social battery. I utilized active listening, kept an open-mind when communicating	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 learned that everyone is different and process situations different as well. In the future I will not be as hesitant as I was in the beginning to talk to clients. I enjoyed how the clients were comfortable more quickly to open up. I need to work more on my therapeutic communication

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

A.

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

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? I chose this assessment because the client has history of suicide idealization. I noticed that during the assessment the client felt comfortable and gave answers quickly. The client did give piercing eye contact. The client did go through the assessment as if they were checking off a box.	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. The client mostly likely seemed in a hurry when performing this assessment because I caught them on the way back to group. The client could be used to the Suicide RISK questionnaire, giving me quick answer responses.	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 need to assess the client's mental in terms of depression. I would ask the client if they ever find themselves in episodes of depression. The client seemed like they have their moments of feeling down and sad, which could be reflecting to her background and experiences.	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'd change the way I approached the assessment. I would rather have the client and myself sitting down while I do the assessment to practice more therapeutic communication.