Brayden Percival

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? The client seemed to be emotionless and tired. The client was cooperative, engaging, and respectful during the mental status examination.	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 client stated that his father left him, but was trying to come back into the client's life. The client wants to forgive his father, Without a good male role model, the client struggles to process information / stressful situations.	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? I would also use the PHQ-9 tool to learn more about depression in the client. I can talk with my client and see if he's open to me asking him more questions while using therapeutic communication	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 knew depression was common in young adults, but not at the level I saw today. At first I didn't talk with any of the patients but after awhile I saw how much better it made the kids feel after I showed more interest. I was very supportive practicing better therapeutic communication.

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? The PHQ-9 helps me as a student nurse identify the severity of depression and anxiety the client is experiencing. The client was having a good day, "more optimistic then usual".	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 was open to the situation. He was very concerned about his discharge date. Client has been anxious but cooperative while communicating.	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 then use the Beck Depression Inventory (BDI) to identify the severity of the clients depression. As a nursing student, you want to establish a good client-Nurse relationship and use therapeutic ~~[illegible]~~ communication. As a nurse ~~[illegible]~~ you can teach a client better since theres a direct connection and not an observing one. A nurse can Provide a client teach back, talk with drs. and a wide range of Professions to refer your client to for more help.	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. The clients here deserve a lot more personal attention, some feel neglected. The techs were playing somewhat violent shows for the kids, I personally would choose something more appropriate. I was able to talk with the kids well, they were eager to have new company. I would like to improve on my therapeutic communication.

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? "Cutting for a couple months, had a rough breakup"; "Plan to overdose or cut self".

When? [redacted] 3 months ago / overdose on advil in September 2022

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

Mental Status Exam

Client Name [redacted] A.C.	Date 2/03/23

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: Participating in group talk.

COGNITION

Orientation Impairment	☑ None	☐ Place	☐ Object	☐ Person	☐ Time
Memory Impairment	☑ None	☐ Short-Term	☐ Long-Term	☐ Other	
Attention	☑ Normal	☐ Distracted	☐ Other		

Comments: Understands right & wrong from personal standpoint.

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:					

BEHAVIOR

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

INSIGHT	☑ Good	☐ Fair	☐ Poor	Comments:
JUDGMENT	☑ Good	☐ Fair	☐ Poor	Comments:

PATIENT HEALTH QUESTIONNAIRE-9 (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	(1)	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 + 4 + 6

=Total Score: 13

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
☐	☑	☐	☐