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 was able to assess the patient in multiple settings. Conversation was different in each setting depending on the environment. The patient's eye contact was normal during school time, however avoidant during group activities. The patient was open for conversation during school time, but stated she was anxious during activity.	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 linked to pathophysiology at all, if so- briefly explain. The patient had a hard time when completing schoolwork during school time. She spent multiple minutes on simple questions that were being asked. During activity, the patient struggled to express her feelings or emotions. This was my first time working with children in a mental health facility, so I do not have previous experiences like this one.	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? Personally, I feel like being able to speak with a case manager or even a parent about the situation with the patient would have been helpful, simply to gain more knowledge on prior history or the situation at hand. As a nursing student, I could ask a case manager or even a nurse to help in this situation by explaining what they might know about the patient and their situation.	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 the interaction. I learned that showing a patient that you are there and willing to listen to them can make a huge impact on the outcome of a conversation. This patient in particular was very shy until I started showing interest in her and her schoolwork. She was eager to learn. In the future, I think I should be more willing to use therapeutic communication to gain information on prior history while also trying to help the patient talk about their feelings. During the interaction, I felt like my thoughts and feelings didn't change, however my eyes were opened to the reality of how many children were on the unit for suicide attempts/ideations.

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 the Suicide Risk Screening Tool for this patient. The reasoning for this patient's stay is due to a suicidal attempt/ideation. The patient had a plan to kill herself with a razor. While using this tool, the patient answered yes to the first four questions, however, didn't have active thoughts of suicide during our conversation.	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 linked to pathophysiology at all, if so- briefly explain. I noticed that in a pediatric unit such as the one I was in, the children feed off of one another. If one child begins to act out, multiple others will follow; especially if discipline or direction from staff isn't implemented. For example, this patient did not have active thoughts of suicide at the time of assessment, but other children were joking about killing themselves. This could have triggered the patient to begin having active thoughts, causing her to act out or become angry or anxious.	What additional assessment information do you need based upon interpretation? What can you do as a nursing student? What did you do? What could you do as a nurse? As a nursing student, I could try to implement therapeutic communication techniques with the other patients, however I did not want to take the attention off of my patient during her assessment. I could have taken the patient out of the group room to allow for a more intimate environment without distractions. As a nurse, I could have implemented discipline among the other patients while using other methods of distraction so none of the patient would have been discussing/joking about suicide.	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. Growing up, suicide is something I was not familiar with or knew much about. Slowly, it is becoming something that more and more children are attempting and being successful at. This is a sad reality that I am still struggling to accept. I had an overwhelming urge to want to help the children on the unit, however I felt like there are so many additional people who have to also become involved in order for things to change for these children.

Mental Status Exam

Client Name	Kaylan L.	Date	2/17/2023

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 was dependent on environment/activity

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

Comments: Slightly Emotionless

COGNITION

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

Comments: unaware of date, dependent on environment

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: Slightly emotionless @ times

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

asQ Ask Suicide-Screening Questions

NIMH TOOLKIT

Suicide Risk Screening Tool

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? Plan to cut self w/ razor

   When? 2/15/2023

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