

Reflection Assignment

Noticing	Interpreting	Responding	Reflecting
<p>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?</p> <p>While doing the mental status examination of the client, the client appears to be calm and projects as a normal teenager. Upon observation, I noticed that she participates in the group activities and answers questions by the mental health technicians. She interacts with the male group class. What stood out to me is the reason why the client volunteered to be admitted in the facility is because of self-harm in relation to a family problem resulting in her living with her mother and switching to a new school. The client admitted being very active in sports and cheerleading. The reason for the self-harm is the fact that her best friend died, and she could not cope up with the loss. The client denies having SI.</p>	<p>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.</p> <p>The client manifests depression. At the first observation, the client does not seem depressed. Further interview needs to be done as to why the client got admitted in the facility. Reading the client's chart reveals that all the client manifested is the self-harm without SI. The reason on her chart also says because of a loss of her best friend. Prompting the student nurse to further investigate. It is also noted that the female client would rather be in the group of male clients rather than in with the group of female clients. The facility's Mental Health Technicians are okay with that situation. The depression might come from the teen-age battle of finding self-identity causing a teenager to depression.</p>	<p>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?</p> <p>After interviewing the client, I found out that the client is a very vibrant teenager at one point with interest in several sports and cheerleading. Because of her parent's divorce, she moved away from her school to live with her mother. After switching schools, she mentioned that her best friend died and devastated her. That was her trigger to start self-harm. The client mentioned that she volunteered to admit herself as a partial client as it helps her cope up with all the "drama" that is happening at her present school. The client also mentioned that she quit her basketball team because of depression. She is hoping to recover, but her own sister told everyone in their school of her admission to the facility. She opted to keep coming to the facility for that reason.</p>	<p>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.</p> <p>As a father, it is my responsibility to make sure that my daughter will not experience what the client experiences. Divorce might not be that devastating for the adults involved, but it takes a great toll on the children. As in the case of the client, moving to a new town in a new school creates a great deal of anxiety. This could lead to much deeper mental problems, as for the client's case, depression and self-harm. The inability to cope with the loss and the move, made it even harder to manage. The MSE tool helps only in identifying affect. Interviewing the client will reveal deeper reasons and manifestations of what, how, and why the feelings are experienced.</p>

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<p>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?</p> <p>I chose the Suicide Risk Screening Tool and the PHQ-9 because these are the most appropriate tools to ask the client.</p> <p>On the Suicide Risk Screening Tool, the client all NO's. Although she admitted of self-harm, I wish we have a self-harm tool in her situation.</p> <p>The PHQ-9 score of the client is 18. This score puts her on the moderate to high depression. The client also complains of not able to sleep, or sleep over, or eat well.</p>	<p>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.</p> <p>What stood out to me about the client's additional assessment, is that, although the client has been on several medications, the effectiveness of these medications is not taking effect yet. Since the client was prescribed these medications for more than a year now, it could have made her stop self-harm. On a positive note, the client has no SI and may be caused by the medication working.</p>	<p>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?</p> <p>As a nursing student, we need to use our critical thinking skills to get the main cause of why clients manifest these mental health issues.</p> <p>Further investigation is needed all the time regarding our knowledge about mental health. The tools health care team uses are very important in dealing with mental health issues.</p>	<p>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.</p> <p>If there is one thing I learned from the client's situation, is that mental health in children or teenagers are very much vulnerable since personalities are not formed well yet. It is hard to diagnose situations like this since the raging hormones tend to affect the medications that deals with imbalances in the brain. Creating a nurse-client relationship with the client was not easy since the student nurse is older than the client and there are interests that do not align with age differences. However, therapeutic communication was established, and significant subjective data was obtained and processed.</p>

Mental Status Exam

Client Name VM	Date 03/10/2023
OBSERVATIONS	
Appearance	<input checked="" type="checkbox"/> Neat <input type="checkbox"/> Disheveled <input type="checkbox"/> Inappropriate <input type="checkbox"/> Bizarre <input type="checkbox"/> Other
Speech	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Tangential <input type="checkbox"/> Pressured <input type="checkbox"/> Impoverished <input type="checkbox"/> Other
Eye Contact	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Intense <input type="checkbox"/> Avoidant <input type="checkbox"/> Other
Motor Activity	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Restless <input type="checkbox"/> Tics <input type="checkbox"/> Slowed <input type="checkbox"/> Other
Affect	<input checked="" type="checkbox"/> Full <input type="checkbox"/> Constricted <input type="checkbox"/> Flat <input type="checkbox"/> Labile <input type="checkbox"/> Other
Comments: The female client appears calm and eager to be in the male group.	
MOOD	
<input type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other	
Comments: The female client enjoys the company of the male group and interacts with them.	
COGNITION	
Orientation Impairment	<input checked="" type="checkbox"/> None <input type="checkbox"/> Place <input type="checkbox"/> Object <input type="checkbox"/> Person <input type="checkbox"/> Time
Memory Impairment	<input checked="" type="checkbox"/> None <input type="checkbox"/> Short-Term <input type="checkbox"/> Long-Term <input type="checkbox"/> Other
Attention	<input checked="" type="checkbox"/> Normal <input type="checkbox"/> Distracted <input type="checkbox"/> Other
Comments: The client does not have problems answering questions.	
PERCEPTION	
Hallucinations	<input checked="" type="checkbox"/> None <input type="checkbox"/> Auditory <input type="checkbox"/> Visual <input type="checkbox"/> Other
Other	<input checked="" type="checkbox"/> None <input type="checkbox"/> Derealization <input type="checkbox"/> Depersonalization
Comments: The client presented herself to the facility to learn coping mechanisms for depression.	
THOUGHTS	
Suicidality	<input checked="" type="checkbox"/> None <input type="checkbox"/> Ideation <input type="checkbox"/> Plan <input type="checkbox"/> Intent <input type="checkbox"/> Self-Harm
Homicidality	<input checked="" type="checkbox"/> None <input type="checkbox"/> Aggressive <input type="checkbox"/> Intent <input type="checkbox"/> Plan
Delusions	<input checked="" type="checkbox"/> None <input type="checkbox"/> Grandiose <input type="checkbox"/> Paranoid <input type="checkbox"/> Religious <input type="checkbox"/> Other
Comments: The client does not have SI nor any plan except self-harm.	
BEHAVIOR	
<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded <input type="checkbox"/> Hyperactive <input type="checkbox"/> Agitated <input type="checkbox"/> Paranoid
<input type="checkbox"/> Stereotyped	<input type="checkbox"/> Aggressive <input type="checkbox"/> Bizarre <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other
Comments: The client does not have manifest any behavioral issues.	
INSIGHT	<input checked="" type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor Comments: The client has good insight as she volunteered to be admitted even for a partial treatment.
JUDGMENT	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor Comments: The client has fair judgement as she admitted to harm self to cope with personal problems.

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 + 1 + 2 + 15
=Total Score: 18

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
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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

