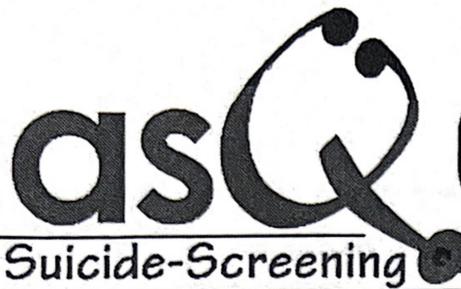


Reflection Assignment

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>- She was very aware of her actions & knew she made a poor decision.</p> <p>- She stated that she has been depressed since was a teenager & has been hospitalized twice.</p> <p>- something that stood out was she said she had been sober from meth for</p> <p>11 yrs but signed her rights over to her boys.</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>- She gave up her rights to her kids because she was addicted to meth & wanted to keep them safe.</p> <p>- I have known many ppl that have either gave up or lost their children due to drug addiction.</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>- ASD suicide risk based on her admission dx.</p> <p>- maintain a safe/calm environment</p> <p>- keep an eye on the pt & initiate safety precautions.</p> <p>- active listening, silence, repeating</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>- something that I learned is even though someone has SI they can still be aware of their actions & feel guilty about wanting to commit suicide.</p>

Noticing	Interpreting	Responding	Reflecting
<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 this because pt was admitted for SI.</p> <p>- She had ideations but didn't follow through.</p> <p>- Pt was very forthcoming about her actions & what led up to her ideations.</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>- She stated she lost her job & was lonely. We all have been through similar situations & what we choose to do w/ them is our own choice.</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>- An additional assessment that could have been done in the PHTQ - 9 based on her w/ depression.</p> <p>- just listen to the pt & keep her calm.</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>- Everyone reacts to life differently & handles life in their own way.</p> <p>- I need to know more ways to help pts to cheer them up & more focused treatment ways.</p>



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



Mental Status Exam

Client Name <u>J.G.</u>		Date <u>3/10/23</u>			
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:					
MOOD					
<input type="checkbox"/> Euthymic <input checked="" type="checkbox"/> Anxious <input type="checkbox"/> Angry <input checked="" type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input type="checkbox"/> Other					
Comments:					
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:					
PERCEPTION					
Hallucinations	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Auditory	<input type="checkbox"/> Visual	<input type="checkbox"/> Other	
Other	<input type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization		
Comments:					
THOUGHTS					
Suicidality	<input type="checkbox"/> None	<input checked="" type="checkbox"/> Ideation	<input checked="" 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: <u>lost job & felt worthless so wanted to walk out in front of a semi-truck</u>					
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 checked="" type="checkbox"/> Withdrawn	<input type="checkbox"/> Other	
Comments:					
INSIGHT	<input type="checkbox"/> Good	<input checked="" type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:	
JUDGMENT	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input checked="" type="checkbox"/> Poor	Comments:	