

Assessments and Reflection in Mental Health Nursing

A Learning Activity Focused on Clinical Judgement

- Each student has four clinical days at the Pavilion.
- One of these days will require the student to complete a care plan.
- The other three days will require the student to engage in the clinical and complete this assessments and reflection learning activity.
- Please see the rubric for information on grading. The rubric is completion based. The purpose of this activity is to help you practice your assessment skills, critical thinking, and clinical judgement.
- Failure to complete the clinical assessment and reflection activities will affect your overall course grade and could result in clinical failure.
- This learning activity should be completed at the clinical site. This is not meant to be homework. The only part of this activity that may need to be completed at home is uploading your completed documents to the Edvance360 dropbox.

- 1. The student should select a client to assess. The student should learn about that client from staff or the client's chart prior to completing the assessment, so they have baseline knowledge of their client.**
- 2. The student should complete a mental status examination on the client. (The mental status exam is provided in this packet on page 5).**
- 3. The student should utilize therapeutic communication throughout their interactions with the client.**
- 4. The student should select 1 additional assessment to complete on their client based upon their current understanding of the client's needs. (Additional assessments are located in this packet on pages 6 through 15).**
- 5. The student should complete one reflection assignment for each assessment they completed.**

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>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>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>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>During the mental status exam, I noticed the patient was cooperative throughout the assessment but tended to stare off and avoid eye contact at times while speaking with me. I did not have any abnormal assessments but based off her answers to my questions even though she is not currently having suicidal ideations, I felt it may still be beneficial to complete a suicide risk assessment since suicidal ideations were what brought her into the facility but I had already used that tool so I utilized another form in place of the suicide assessment</p>	<p>One thing that stood out to me that I could just be overthinking is her avoiding eye contact at times during the assessment, while she was cooperative and answered all questions willingly it was hard to know if she was answering honestly due to being nervous.</p>	<p>Based upon the information obtained from the patient even though it was normal, I felt it was best to complete a suicidal risk assessment. However, since I already used that tool, I completed a mini-mental status exam in regard to this assignment. As a nursing student, I can be a fresh new insight into what the patient is experiencing and be a listening ear for them and then use information obtained to help the nursing staff better care for the patient. I looked at the patient's chart and kindly asked if she would be willing to speak with me, while assessing I used therapeutic communication techniques such as active listening, eye contact, and the use of open-ended questions. As a nurse, I would be able to further build my trust with the patient since I would see her more. As a nurse I could use my assessment to further my patient's care plan and advocate for her care with my fellow physicians and nursing staff.</p>	<p>I learned that you never truly know what someone is going through and just how essential mental health services are to not only our youth but our whole community. My feelings towards mental health have always been that it is a much-needed field and I give major thanks to all healthcare members who work in mental health because I personally do not think I could handle working in the mental health field. Hearing my patient tell me about her home life and what brought her into the facility broke my heart.</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>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 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>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>I chose this assessment due to having already completed the other assessment tools once and to establish her alertness due to her avoiding eye contact at times. I noticed how attentive she truly is but she may just get nervous speaking with new people.</p>	<p>During the assessment the patient had no abnormal findings but seemed to be anxious as she would periodically avoid eye contact or look off in space before responding to a question. It made me wonder if she was not fully opening up to me about her feelings yet.</p>	<p>I feel that the patient would benefit from a follow up mini mental status exam to monitor her alertness as well as implementing a suicide risk assessment. As a nursing student I can present my findings to her care team and explain to them her demeanor during the assessment and address any concerns that I may have. Following my assessment, I thanked the patient for taking the time to talk to me today and then I spoke with her nurse on the unit. As a nurse I would be able to further my concerns to her Physician and advocate for my patients wants and needs in her care.</p>	<p>I learned the importance of the use of therapeutic communication techniques when speaking with the patient, I feel that it helped her relax and be more open during our conversation. In the future, I would try to take the patient to a more secluded area to were just her and I are free to talk instead of in the group room. I feel that I did a good job on making her feel comfortable to open up to me about her situation, I wish I would have had more time to establish that nurse-client therapeutic relationship so she was more comfortable if we were to have another interaction. During this assessment I was able to further understand the importance and need of mental health care services especially in our adolescent population. It was hard for me this semester not to get sad after speaking with the patient and hearing about what they have endured or been admitted for.</p>

	0 points	10 points
Assessments (2)	The student did not submit two completed assessments	The student submitted two completed assessments
Reflection 1 – Mental Status Exam	The student did not answer a minimum of one prompt for each column of the activity.	The student answered a minimum of one prompt within each column of the activity.
Reflection 2 – Additional Assessment	The student did not answer a minimum of one prompt for each column of the activity.	The student answered a minimum of one prompt within each column of the activity.

Mental Status Exam

Client Name	11 year old F, name beginning with the letter A	Date	4-12-2023
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:			
MOOD			
<input checked="" type="checkbox"/> Euthymic	<input 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 patient was in a very cheerful and cooperative mood			
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 checked="" type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization
Comments:			
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 patient denied any suicidal ideations but was admitted due to suicidal ideation			
BEHAVIOR			
<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated
<input type="checkbox"/> Stereotyped	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Withdrawn
	<input type="checkbox"/> Other		
Comments:			
INSIGHT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
	Comments:		
JUDGMENT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
	Comments:		

MINI-MENTAL STATE EXAMINATION (MMSE)

The Mini-Mental State Examination is a 30-point questionnaire used to detect cognitive impairment, assess its severity and to monitor cognitive changes over time.

Name of website: **Mini-Mental State Examination**

URL: www.minimental.com

Country: USA

Authors:

Mini-Mental™ State Examination (MMSE™) by Marshal F. Folstein, MD, Susan E. Folstein, MD, Paul R. McHugh, MD. Copyright ©_ 1975, 1998, 2001 by MiniMental, LLC. Mental Status Reporting Software (MSRS) Checklist™ by Mark A. Ruiz, PhD, Richard J. Latshaw, MS.

Brief Description:

Copyright of the MMSE has been enforced so it is not possible to publish further information here. A sample report can be viewed at the website Psychological Assessment Resources (PAR) Inc (www.parinc.com) by typing MMSE into the search box.

WHY

Cognitive impairment is no longer considered a normal and inevitable change of aging. Although older adults are at higher risk than the rest of the population, changes in cognitive function often call for prompt and aggressive action. In older patients, cognitive functioning is especially likely to decline during illness or injury. The nurses' assessment of an older adult's cognitive status is instrumental in identifying early changes in physiological status, ability to learn, and evaluating responses to treatment.

BEST TOOL

The Mini Mental State Examination (MMSE) is a tool that can be used to systematically and thoroughly assess mental status. It is an 11 question measure that tests five areas of cognitive function: orientation, registration, attention and calculation, recall and language. The MMSE takes 5-10 minutes to administer and is therefore practical to use repeatedly and routinely.

TARGET POPULATION

The MMSE is effective as a screening tool for cognitive impairment with older, community dwelling, hospitalized and institutionalized adults. Assessment of an older adults cognitive function is best achieved when it is done routinely, systematically and thoroughly.

VALIDITY/RELIABILITY

Since its creation in 1975, the MMSE has been validated and extensively used in both clinical practice and research.

STRENGTHS AND LIMITATIONS

The MMSE is effective as a screening instrument to separate patients with cognitive impairment from those without it. In addition, when used repeatedly the instrument is able to measure changes in cognitive status that may benefit from intervention. However, the tool is not able to diagnose the cause for changes in cognitive function and should not replace a complete clinical assessment of mental status. In addition, the instrument relies heavily on verbal response and reading and writing. Therefore, patients that are hearing and visually impaired, intubated, have low english literacy, or those with other communication disorders may perform poorly

even when cognitively intact.

MMSE Scoring guide:

- a) 25-30 suggests a normal scoring range
- b) 18-24 suggests a mild to moderate impairment of cognitive functioning
- c) Scores under 17 suggests a severe cognitive impairment

MMSE is a screening tool as opposed to a diagnostic tool.

References:

Anthony JC, LeResche L, Niaz U, VonKorff MR and Folstein MF (1982) Limits of the mini-mental state as a screening test for dementia and delirium among hospital patients. *Psychological Medicine*, 12: 397-408.

Cockrell JR and Folstein MF (1988) Mini Mental State Examination (MMSE), *Psychopharmacology*, 24: 689-692.

Crum RM, Anthony JC, Bassett SS and Folstein MF (1993) Population-based norms for the mini-mental state examination by age and educational level, *JAMA*, 18: 2386-2391.

Folstein MF, Folstein, SE and McHugh PR (1975) Mini-Mental State: A practical method for grading the state of patients for the clinician, *Journal of Psychiatric Research*, 12: 189-198.

Foreman, M.D., Grabowski, R. (1992) Diagnostic dilemma: cognitive impairment in the elderly. *Journal of Gerontological Nursing*, 18, 5-12.

Foreman, M.D., Fletcher, K., Mion, L.C. & Simon, L. (1996) Assessing cognitive function. *Geriatric Nursing*, 17,228-233.

MINI MENTAL STATE EXAMINATION

Patient _____ Examiner: _____ Date: _____

Max
Score Score

- 5 (5) **ORIENTATION**
What is the (year), (season), (date), (month), (day).
- 5 (5) Where are we: (country), (county), (what part of the town/city – near the sea, eastern suburbs), (which building), (floor) e.g.
- 3 (3) **REGISTRATION**
Ask if you can test the individual's memory. Name 3 objects (e.g. apple, table, and penny) taking 1 second to say each one. Then ask the individual to repeat the names of all 3 objects. Give 1 point for each correct answer. After this, repeat the object names until all 3 are learned (up to 6 trials). Number of trials needed: _____
- 5 (5) **ATTENTION AND CALCULATION**
Spell "world" backwards. Give 1 point for each letter that is in the right place (e.g., **DLROW** = 5, **DLORW** = 3).

Alternatively, do serial 7s. Ask the individual to count backwards from 100 in blocks of 7 (i.e. 93, 86, 79, 72). Stop after 5 subtractions. Give one point for each correct answer. If one answer is incorrect (e.g. 92) but the following answer is 7 less than previous answer (i.e. 85), then count the second answer as being correct.

(The tester can ask the client both of the attention and calculation questions, but only use the result from the highest scoring question, allowing for up to a maximum of 5 points).
- 3 (3) **RECALL**
Ask for the 3 objects repeated above. Give 1 point for each correct object.
(Note recall cannot be tested if all 3 objects were not remembered during registration)

MINI MENTAL STATE EXAMINATION

LANGUAGE

- 2 (2) Point to a pencil and ask the individual to name this object (1 point). Do the same thing with a wrist-watch (1 point).
- 1 (1) Ask the individual to repeat the following "No ifs and or buts" (1 point). Allow only one trial.
- 3 (3) Give the individual a piece of blank white paper and ask him or her to follow a 3 stage command: "take a paper in your right hand, fold it in half and put it on the floor" (1 point for each part that is correctly followed).
- 1 (1) Show the individual the "CLOSE YOUR EYES" message on the following page (but not the pentagons yet). Ask him or her to read the message and do what it says (give 1 point if the individual actually closes his or her eyes).
- 1 (1) Ask the individual to write a sentence on a blank piece of paper. The sentence must contain a subject and a verb, and must be sensible. Punctuation and grammar are not important (1 point).
- 1 (1) Show the individual the pentagons on the following page and ask him or her to copy the design exactly as it is (1 point). All 10 angles need to be present and the two shapes must intersect to score 1 point. Tremor and rotation are ignored.

_____ 30 Total Score

ASSESS level of consciousness along a continuum:

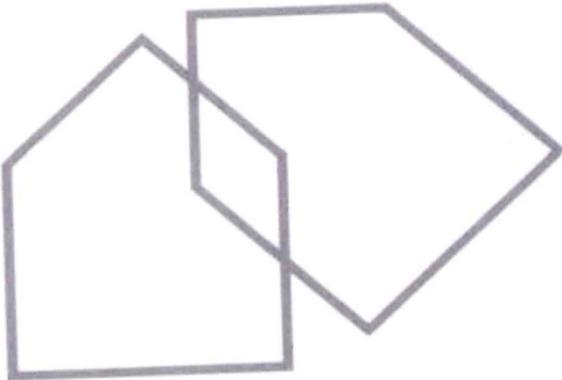
30	(30)	Alert	Drowsy	Stupor	Coma
		30	20	10	0

Reading:

CLOSE YOUR EYES

Writing:

Construction:



mini mental status exam:

(11/0)

- 1. 5
- 2. 5
- 3. 5
- 4. 5
- 5. 5
- 6. 2
- 7. 1
- 8. 3

9. 1

10. The cat jump over the door (1pt)



(1pt)



total : alert