Brayden P.

Mental Status Exam

Client Name K.D.	Date 04/14/23

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:					

COGNITION

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

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☐ Stereotyped	☐ Aggressive	☐ Bizarre	☑ Withdrawn	☐ Other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:

NIMH TOOLKIT

asQ Suicide Risk Screening Tool

Ask Suicide-Screening Questions

K.D.

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 OD on medications, hang self with belt. Patient has reported she took a handful of meds from cabinet and blacked out.

   When? Within the last year and a half."

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: Patient denies current suicidal ideation, feels safe since admission, and helped with Prozac medication.

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**

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? I noticed that this client was very anxious and seemed bothered by the assessment tools. I had to explain that I did not work for the facility and I didn't know why she was here.	**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 had suicidal ideations, self harm, and plans to indulge in self harm. The client states that "I feel safer here than I do anywhere else.	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 use the ASQ suicide screening tool to assess if she would be a Positive Screen. Therapeutic communication is a must as a nurse and as the student. Talking to the client as a nurse would be establishing a nurse-client relationship and identifying triggers and what helps the client feel better about themselves.	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 learned that the pavillion can be a safer place for those who feel down in their lives, and for those who are struggling. It was nice to see the kids get along when they can. Every client is different so knowing how to provide individualized care is a must for this nursing student.