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? During the mental status examination, I noticed that sometimes TS lacked depth in reality. When he was speaking about his family, I found discrepancies. He stated that he had six children, all twins. So, I asked if that meant he had 12 children. He responded, saying that was impossible and that there were only six girls, all twins. I also found that he has an unhealthy attachment to his eldest brother and often attacks the women he is involved with. He states he blacks out because they make him angry. His brother's current mate is not the only woman he has attacked. He said that he stabbed his brother's ex-wife.	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. Again, upon speaking to TS, I found that he has an unhealthy attachment to his brother, and his brother's relationships are a source of contention. I also found that he is very juvenile. He immediately took a liking to my peer and followed her around. He would tell her she dropped something to get her to bend over. He thought she was 18 and a relationship between the two was appropriate.	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? With TS, I found that asking a mixture of open and closed-ended questions was appropriate based on his mental and intellectual delays. Reminding him where we were was also essential to bring him back to reality. I reminded him that following WB was inappropriate as she tried to do her job. I would also like to explore the relationships TS has within his family to see if his diagnosis is genetic or is affected by nurture.	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 to go in with an open mind. Despite knowing the diagnosis and that he was a registered sex offender, I should have gone in without judgment. I should have been more open to conversation but aware of his diagnosis. I also should practice more therapeutic approaches.

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 this particular assessment because it is clear that TS has some codependency issues when it comes to his older brother and his romantic relationships. By admission this is the only instances that the client blacks out.	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. The only things that stood out to me were TS having some codependency issues and growing an unhealthy attachment to my peer WB. These abnormal findings would lead the client down a path of destruction rather than healing therapeutic approaches if not addressed. To get the client for society, I recommend that he see a therapist to manage his behaviors outside of a mental health facility.	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? As a nursing student, I would bring my findings to his care team. This way, they can be aware of what the client is doing. I redirected the client when he grew an unhealthy attachment to my peer. When discussing the relationship with his brother, I changed the subject when I found the patient growing uncomfortable. As a nurse, I feel I would behave in the same way. However, I would like to see the family dynamics to expand on my findings to see if his brother's relationships are genuinely a trigger for my client.	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 I should always keep my eyes and ears open to what the patient is telling me and what he is showing me. Had I not been paying attention, his behaviors would have escalated, placing staff and students in a dangerous situation. In this situation, I need more therapeutic approaches to reach my client better. Sometimes, I felt lost in trying to lead the patient in questions.

Mental Status Exam

Client Name	TS	Date	09/01/2023

OBSERVATIONS

Appearance	☒ Neat	☐ Disheveled	☐ Inappropriate	☐ Bizarre	☐ Other
Speech	☐ Normal	☐ Tangential	☐ Pressured	☐ Impoverished	☒ Other has speech delay
Eye Contact	☒ Normal	☐ Intense	☐ Avoidant	☒ Other does fleet	
Motor Activity	☐ Normal	☐ Restless	☐ Tics	☐ Slowed	☒ Other
Affect	☐ Full	☐ Constricted	☐ Flat	☐ Labile	☒ Other congruent

Comments: TS was making toilet paper flowers

MOOD

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

Comments:

COGNITION

TS was kind and helpful to peers

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

Comments: By talking to TS it is clear that there is a mental and intellectual delay.

PERCEPTION

Hallucinations	☒ None	☐ Auditory	☐ Visual	☐ Other
Other	☐ None	☒ Derealization	☒ Depersonalization	

Comments: TS seems to believe he has a wife and children. When asked, he states he has six children, all twins.

THOUGHTS

Suicidality	☒ None	☐ Ideation	☐ Plan	☐ Intent	☐ Self-Harm
Homicidality	☒ None	☐ Aggressive	☐ Intent	☐ Plan	
Delusions	☐ None	☐ Grandiose	☐ Paranoid	☐ Religious	☒ Other

Comments: TS speaks in great detail of having six daughters

BEHAVIOR

☒ Cooperative	☐ Guarded	☐ Hyperactive	☐ Agitated	☐ Paranoid
☐ Stereotyped	☐ Aggressive	☐ Bizarre	☐ Withdrawn	☒ Other

Comments: TS took a liking to one of my classmates (WB) making her feel uncomortable.

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

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 + 2 + 8 + 6

=Total Score: 16

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**
☐	☐	☒	☐

NIMH TOOLKIT

asQ 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? TS stated he attempted suicide by cutting and hanging. He did so after he stated he was Falsely accused of sexual assault of a minor younger than 11.

When? Within the last year

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