

Jessica Warren

Noticing

MSE

The client I interviewed has autism. Even with this diagnosis, which commonly comes with communication barriers, Alex was cooperative and answered all questions. Alex did have to be prompted to speak in order for him to communicate with me. I found that if I smiled at him and praised him after answering my question, he appeared to relax.

Additional Assessment

The Suicide Risk Screening tool is the additional assessment I did with Alex. His assessment came back normal, with no risk of self-harm. I did this assessment because of his behaviors at the group home, causing him to be removed from his routine. Alex was cooperative and answered all questions.

Interpreting

MSE

What stood out to me about Alex is that he slept the entire time I was there for the clinical experience unless someone went to get him to get his food or shower. Alex is from a group home with a structured schedule for those living there. I realize Alex needed to go to that unit due to his behavior, but I also wonder if some other intervention could have happened. He has a diagnosis of bipolar 1, so my concern is that placing him somewhere outside of his routine could trigger depression and cause more harm than good for him.

Additional Assessment

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Responding

MSE

I realize there are some staffing challenges on that unit at OSF, but clients like Alex would benefit from someone encouraging them to come out of their rooms and participate in activities they like to do. There were a few areas where this could have been achieved without over stimulating Alex. Communication techniques used were Active Listening, Verbal Communication, Nonverbal Communication, compassion, and trust.

Additional Assessment

The Suicide Risk Screening tool is the additional assessment I did with Alex. His assessment came back normal, with no risk of self-harm. A mood assessment could have been completed as well. I do not know that I would have gotten accurate information from him. His demeanor reminded me of a child.

Reflecting

MSE

I was very open and willing to talk with all the clients on the unit. I was apprehensive because I have never worked on a unit like that, but I have worked with geriatric residents with mental health diagnoses. I need to keep reminding myself that they are on that unit for mental health reasons and keep my guard up more. I approached the clients on the unit like I do the little old lady and older men I care for. Since I have such an open and welcoming attitude, it made those comfortable around me, and they were talking openly to me even though this was my first time around them. I look at this clinical experience in a positive light, and as of right now, I am very comfortable interacting with the clients.

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Mental Status Exam

Client Name <i>Alex</i>	Date <i>9/8/2023</i>
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 type="checkbox"/> Normal <input type="checkbox"/> Tangential <input type="checkbox"/> Pressured <input checked="" 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: <i>Only responded to questions or if was prompted to talk.</i>	
MOOD	
<input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input checked="" type="checkbox"/> Other	
Comments: <i>"OK"</i>	
COGNITION	
Orientation Impairment	<input type="checkbox"/> None <input type="checkbox"/> Place <input type="checkbox"/> Object <input checked="" type="checkbox"/> Person <input type="checkbox"/> Time
Memory Impairment	<input type="checkbox"/> None <input checked="" type="checkbox"/> Short-Term <input checked="" 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:	
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:	
INSIGHT	<input type="checkbox"/> Good <input type="checkbox"/> Fair <input checked="" type="checkbox"/> Poor Comments:
JUDGMENT	<input type="checkbox"/> Good <input checked="" type="checkbox"/> Fair <input type="checkbox"/> Poor Comments:



Suicide Risk Screening Tool

Ask Suicide-Screening Questions

Ask the patient: Alex

- 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