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 MSE, I noticed that DW was anxious and roaming around the hall. He kept saying that he was "sorry to inconvenience me." He also kept referring to " Autumn" and " Leaves" as people and feelings. DW thought that he forgot his mother's birthday and became destressed when I was doing my assessment.	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. What stood out to me the most was the bizarre behavior. DW would not make eye contact with me and wanted to stand closest to the window. He pointed out the leaves and how they could communicate with us if only we listened.	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? There were no additional assessments that needed to be performed. However, I would have liked to look deeper into the chart to see his entire history. Based on records, the client was seen back-to-back on three instances before being admitted to the inpatient unit.	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 would search the chart for more information. I learned that he is a father and that his children are very important to him. The patient was HIV positive and willingly admitted to having sex with multiple people unprotected despite his status. I would have liked to educate him on the importance of being transparent and safe with his status. I was good at not treating the patient differently despite his status and his current psychosis. I was able to set boundaries with him and bring him back to reality.

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? Because the patient stated that he burned his wrist to feel numb I thought the PSQ-9 was an appropriate assessment. In some instances, I assumed he was faking to have food and shelter. The client believed he wore out his welcome with his grandmother.	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 abnormal behavior I noticed was the patient talking to "the fall/autumn" and " the leaves." He also stood off to the side, staring straight ahead. He also didn't stay long in group settings. In some instances, I felt as if he was overplaying his psychosis to have shelter and food.	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 could provide education on shelters, food sources, and healthy sexual education.	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 will work on my biases and do more research to find therapeutic approaches to dealing with psychosis. I was however happy to calm another patient down and to get him to eat and drink something on the unit. He was also able to get at least 2-3 hours of sleep after being disruptive and combative all night.

Mental Status Exam

Client Name	DW	Date	09/21/2023

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: Repetitive thoughts: the client is hyper focused on fall,

MOOD

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

Comments: Flat and disassociated from reality.

COGNITION

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

Comments: Client is aware that he is in the hospital but referred to the hospital as "Provena Covenant" which was the original name prior to being bought out by OSF.

PERCEPTION

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

Comments: The client is in psychosis and is currently hyper focused on fall, says that the leaves and crayons are talking to him.

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: Client would stare off into the corner instead of making eye contact with WB & I. Kept repeating thoughts about leaves

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

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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 + 3 + 8 + 3

=Total Score: 14

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**
☐	☒	☐	☐

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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? Two weeks ago, the client harmed himself by burning. DW stated that he wanted to feel something. The feeling that he was trying to achieve was numb. The client said he was tired of people taking advantage of his kind heart. DW feels he is constantly "over loving" and "over giving."

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