

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

| Interpretin | Responding | Reflectin |
|--|---|---|
| <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. In your interpretation of the situation links to priority 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 thought reaction.</p> |

| <p>Noticing</p> | <p>Reflecting</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 do 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</p> |

| <p>Noticing</p> |
|---|
| <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> |

Noticing

Why did you choose this additional assessment? What did you notice during your

- o
- o
- o

assessments that were abnormal or that stood out to you?

o

o something stood out as abnormal, explain

o

potential cause or patterns that you noticed. Describe any similar

o

situations you have experienced / as well as the similarities or experiences. Is your interpretation of the situation links to

pathophysiology at all, if so briefly explain.

| | 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 two prompts 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 for each column of the activity. |

Mental Status Exam

| | |
|--|--|
| Client Name XX | Date 09/08/23 |
| OBSERVATIONS | |
| Appearance | X Neat Disheveled Inappropriate Bizarre Other |
| Speech | X Normal Tangential Pressured Impoverished Other |
| Eye Contact | X Normal Intense Avoidant Other |
| Motor Activity | X Normal Restless Tics Slowed Other |
| Affect | X Full Constricted Flat Labile Other |
| <p>Comments: The patient looks his age, 39. He is male, white, with a thin body build. The patient was sitting in the chair, comfortable, with good eye contact. His dress was appropriate for the place. He had a uniform. He had a cooperative and friendly manner and was attentive to the examiner. The affect was full.</p> | |
| MOOD | |
| <p>X Euthymic Anxious Angry X Depressed Euphoric Irritable Other</p> | |
| <p>Comments The patient's mood was neither extremely happy nor somber. His complaint was chronic depression. On the scale 0-10, he said the level of his depression was 8.</p> | |
| COGNITION | |
| Orientation Impairment | X None Place Object Person Time |
| Memory Impairment | X None Short-Term Long-Term Other |

| | | | | | |
|--|--|--|--|------------------------------------|------------------------------------|
| Attention | <input checked="" type="checkbox"/> Normal | <input type="checkbox"/> Distracted | <input type="checkbox"/> Other | | |
| Comments The patient is oriented in time, person, and object. Patient recognizes that he is in the hospital but could not say the full name of the hospital. | | | | | |
| 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: The patient denied having hallucinations, tactile, auditory, or visual at the time of exam or in the past. Patient denied any thoughts of persecution. | | | | | |
| 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 did not have suicidal thoughts during the exam. He had some suicidal thoughts long time ago. Patient denies signs of paranoia or any other delusions. | | | | | |
| BEHAVIOR | | | | | |
| <input checked="" type="checkbox"/> Cooperative <input type="checkbox"/> Guarded <input type="checkbox"/> Hyperactive Agitated Paranoid Stereotyped c] <input type="checkbox"/> Aggressive <input type="checkbox"/> Bizarre <input type="checkbox"/> Withdrawn <input type="checkbox"/> Other | | | | | |
| Comments: The patient was cooperative during the assessment. He answered all questions. He denied being angry or irritable in the past. | | | | | |
| INSIGHT | <input checked="" type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | | |
| Comments: Patient is aware of his illness. | | | | | |
| JUDGMENT | <input checked="" type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | | |
| Comments: Going through a given situation, the patient made decisions wisely. He understood clearly what was wrong and what was the right thing to do. | | | | | |

PATIENT HEALTHQUESTIONNAIRE-9 (PH Q -9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "V" to indicate your answer)

| | Not at all | Severa l days | More than half the days | Nearl y ever y day |
|---|---------------|---------------------|----------------------------------|--------------------------------|
| 1. Little interest or pleasure in doing things | | 1 | 2 | 3 X |
| 2. Feeling down, depressed, or hopeless | | 1 | 2 | 3X |
| 3. Trouble falling or staying asleep, or sleeping too much | | 1X | 2 | 3 |
| 4. Feeling tired or having little energy | | 1 | 2X | 3 |
| 5. Poor appetite or overeating | | 1X | 2 | 3 |
| 6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down | | 1 | 2 | 3X |
| 7. Trouble concentrating on things, such as reading the newspaper or watching television | 0X | 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 | 0X | 1 | 2 | 3 |
| 9. Thoughts that you would be better off dead or of hurting yourself in some way | | 1 | 2 | 3X |

FOR OFFICE CODING²

0 + _____ + _____ + _____

—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 | Somewhat | Very | Extremely |
|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.



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?

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:

Patient answered No.

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) e 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.

The physician is informed of these answers, and all this information has been charted in the patient's health record.

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

DRUG USE QUESTIONNAIRE (DAST-20)

Name: _____

DOB _____ Date: _____

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is "Yes" or "No", Then, circle the appropriate response beside the question. Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right,

In the statements "drug abuse" refers to:

- o the use of prescribed or over the counter drugs in excess of the directions and
- o any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g. marijuana/ hash), solvents, tranquilizers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed) hallucinogens (e.g. LSD) or narcotics (e.g. heroin). Remember that the questions do not include alcoholic beverages.

| No | uestions | Res onse | |
|-----|--|----------|----|
| | | Yes | No |
| 1. | Have you used drugs other than those required for medical reasons? | Yes | No |
| 2. | Have ou abused rescri tion dru s? | Yes | No |
| 3. | Do ou abuse more than one dru at a time? | Yes | No |
| 4. | Can ou et throu h the week without usin dru s? | Yes | No |
| 5. | Are ou alwa s able to sto usin dru s when ou want to? | Yes | No |
| 6. | Have you had "blackouts" or "flashbacks" as a result of drug use? | Yes | No |
| 7. | Do you ever feel bad or guilty about your drug use? | Yes | No |
| 8. | Does your spouse (or parents) ever complain about your involvement with dru s? | Yes | No |
| 9. | Has drug abuse created problems between you and your spouse or our arents? | Yes | NO |
| 10. | Have ou lost friends because of our use of dru s? | Yes | No |
| 11. | Have ou ne lected your family because of your use of dru s? | Yes | No |
| 12. | Have you been in trouble at work because of dru abuse? | Yes | No |
| 13. | Have ou lost a ob because of drug abuse? | Yes | No |
| 14. | Have ou otten into fi hts when under the influence of dru s? | Yes | No |
| 15. | Have ou en a ed in ille al activities in order to obtain dru s? | Yes | No |
| 16. | Have ou been arrested for ossession of illegal drugs? | Yes | No |
| 17. | Have you ever experienced withdrawal symptoms (felt sick) when ou stopped taking drugs? | Yes | No |
| 18. | Have you had medical problems as a result of your drug use (e.g. memo loss he atitis convulsions bleeding etc.)? | Yes | No |
| 19. | Have you gone to anyone for help for a drug roblem? | Yes | No |

| | | | |
|-----|---|-----|----|
| 20. | Have you been involved in a treatment program specifically related to drug use? | Yes | No |
|-----|---|-----|----|

SCORE:

DAST Scoring: Each "Yes" response 1 point, except questions 4 & 5,
For questions 4 & 5 only, a "No" response 1 point,

A score of 6 points or more = substance abuse problem (abuse/dependence).

CAGE QUESTIONNAIRE

Brief description: The CAGE is a very brief, relatively non-confrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present.

Target population: Adults & adolescents over 16 years. Additionally useful in the general medical population being examined in a primary care setting.

Administrative issues: o Number of items: 4 o Time: less than 1 minute o Administered by: professional or technician o Training required: no o Comments: easy to learn, easy to remember, easy to replicate

Scoring:

- o Time required to score: instantaneous o Scored by: tester

Clinical Utility of instrument:

- o The CAGE is very useful bedside clinical assessment tool.
- o It has become the favourite of family practice physicians, general interns and is also very popular in nursing.

Author: The CAGE Questionnaire was developed by John Ewing.

References:

Aertgeerts, B. , Buntinex, F. , Fevery, J. & Ansons, S. (2000) Is there a difference between CAGE interviews and written CAGE interviews. *Alcoholism: Clinical and Experimental Research*, 24(5), 733-736.

Ewing, J.A. (1984) Detecting alcoholism: The CAGE questionnaire, *JAMA: Journal of the American Medical Association*, 252, 1905-1907.

Mayfield, D. , McLeod, G. & Hall, P. (1974) The CAGE questionnaire: validation of a new alcoholism instrument, *American Journal of Psychiatry*, 131, 1121-1123.

Reynaud, M., Schwan, R. , Loiseaux-Meunier, M.N., Albuissou, E. & Deteix, P. (2001) *American Journal of Psychiatry*, 158(1), 96-99.

CAGE QUESTIONNAIRE

1. Have you ever felt you ought to CUT down on your drinking?
YES/NO
2. Have people ANNOYED you by criticising your drinking? YES/NO
3. Have you ever felt GUILTY about your drinking? YES/NO
4. Have you ever had a drink in the MORNING to alleviate withdrawal
symptoms, or get rid of a hangover (Eye-opener)? YES/NO

SCORING

Two or more positive responses = probable alcohol problem

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

| | | | |
|-------|-------|-----------------|-------------|
| _____ | | Examiner: _____ | Date: _____ |
| Max | | | |
| Score | Score | | |

ORIENTATION

- 5 What is the (year), (season), (date), (month), (day).
- 5 Where are we: (country), (county), (what part of the town/city near the sea, eastern suburbs), (which building), (floor) e.g.

REGISTRATION

- 3 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: ____

ATTENTION AND CALCULATION

- 5 Spell "world" backwards. Give 1 point for each letter that is in the right place (e.g., DLROW = 5, DLORW = 3).

Alter-nativeLy, 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).

RECALL

- 3 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 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 Ask the individual to repeat the following "No ifs and or buts" (1 point). Allow only one trial.
- 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 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 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 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.

_____ Total Score

ASSESS level of consciousness along a continuum:

| | Alert | Drowsy | Stupor | Coma |
|----|----------|--------|--------|------|
| 30 | <hr/> 30 | 20 | 10 | |

CLOSE YOUR EYES

Reading:

Writing:

Construction:

