

Reflection Assignment

| Noticing | Interpreting | Responding | Reflecting |
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| <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> | <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. Is your interpretation of the situation links to pathophysiology at all, if so – briefly 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 values or feelings based on this interaction.</p> |

Noticing - I noticed during my mental status exam that the patient was hyperactive. I noticed this due to the patient fidgeting and moving around during the exam. Another abnormality I noticed was that the patient reported feeling frustrated. She attested this to having to wait a long time to shower and not receiving the correct breakfast. Another abnormality discovered was the patient had hallucinations. She claims that she has been seeing someone that no one else sees for the past several years. The patient also reports having PTSD due to losing a family member in a car accident. She claims that PTSD affects her when entering a vehicle. The patient also reports suicidal ideations.

Interpreting - As I stated, I noticed hyperactivity within the patient based on her movements. She was fidgeting, which can potentially be caused by anxiety. The frustration I noticed in the patient seemed to be situational/temporary caused by inconveniences she experienced within the unit. The hallucinations the patient has been experiencing can be potentially caused by schizophrenia. The PTSD due to losing a family member in a car accident. Suicidal ideations can be potentially caused by depression or PTSD.

Responding - An additional assessment needed is an ASQ suicide risk screening test. As a nursing student, I can conduct an ASQ suicide risk screening test. As a nurse I would use therapeutic communication to help the patient work through her thoughts and feelings. The therapeutic communication techniques that can be utilized in this situation would be open ending questions, restating, and giving recognition.

Reflection - Something that I have learned is that many different mental health issues may present at different times but be present all at once. I learned this through conducting my assessment with the patient. She was very open to discussing her mental health and gave detailed answers which allowed me to understand more deeply what she was experiencing. Through this encounter, it was clear to me that this patient present with multiple mental health issues. She expressed being hospitalized several times through the years and when different traumas occurred and mental health issues started to present themselves. This made it clear to me that different mental health issues may present at different times but be present all at once. In the future, it would have been beneficial to have more time to speak with this patient. From the way she was so open to talking with me and how she behaved throughout the mental status assessment, it was clear that she needs to talk about her mental health status. I think I used therapeutic communication well. I used open ended questions and restated her feelings after she spoke. I also gave recognition to her thoughts and feelings. Having more knowledge about mental health disorders would be beneficial in the future to help with situations like this. I gained more empathy from having this conversation with the

patient.

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| 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? | 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. | 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 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. |

ASQ suicide-risk screening tool

Noticing - I chose to utilize the ASQ suicide-risk screening tool because based on the information I was given on the patient, it was the best fit as well as the priority assessment. In the additional assessment I conducted, I noticed that the patient is a high risk for suicide. She answered “yes” to all of the questions asked in the screening. These would be considered abnormal and did stand out to me.

Interpreting - The abnormality I noticed was the high risk for suicide. This can be caused by many factors. Based on this patient, I would attest this high risk to PTSD and depression. The patient reported both of these mental health issues during our talk. I have discussed suicidal ideation with someone in my personal life who was feeling this way and some of the feelings they describe are similar to what the patient expressed. The difference is that I was not utilizing a screening tool. My interpretation of the situation is that this patient is high risk for suicide. She reported wishing she was dead, feeling as if people in her life would be better off if she were dead, having thoughts of killing herself, attempting suicide by overdose several times, and thinking about killing herself currently. These results are disconcerting and puts the patient at high risk for suicide.

Responding - Additional assessment information that would be helpful would be conducting a PHQ-9 assessment. As a nursing student I would be able to conduct a PHQ-9 questionnaire. I unfortunately did not have time to complete another additional assessment. I did utilize therapeutic communication with the patient by restating and giving recognition. As a nurse I could ensure that there are no potentially harmful materials in the patient's room. This would be beneficial because she mentioned having the compulsion to commit suicide if there was something available to her.

Reflecting - I learned how much suicidal ideation can be very prevalent in a patient. I had previously encountered patients with passive thought but not active, so this was a learning experience. In the future I would try to spend more time with the patient to conduct further screenings and sit and talk with her more. I did well at utilizing therapeutic communication with the patient by restating and giving recognition. I think this had a positive affect on my interaction with the patient. Additional skills that would be helpful in this situation in the future would be having more experience with patients who were experiencing active thoughts of suicide. I gained more empathy from having this conversation with her.