Paige Hennessy

Mental Health

Professor Irelan

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Reflection Assignment #3

Noticing:

During the mental status examination, I noticed the patient seemed enthusiastic to conversate. The conversation consisted of questions regarding mood and the patient did not struggle to answer any questions asked. The patient had very intense eye contact during our conversation/interview and I noticed that very early into conversation. There were no abnormal findings that stood out to me. The patient said they don't "think" they are experiencing any hallucinations or delusions, I found this answer interesting given that the patient seemed unsure.

Interpreting:

The only aspect that felt abnormal was the patient's response to the question regarding hallucinations and delusions. The patient replied stating "I don't think I do". Instead of completely confirming or denying the presence of hallucinations or delusions. This abnormal finding is potentially related to the patient's diagnosis of schizoaffective, or bipolar disorder. The patient also seems to have slight denial of sign or symptoms related to diagnosis so the patient may be experiencing denial.

Responding:

I think that there may be a need for an additional suicide screening, and more potential interviews to determine his true signs and symptoms and their relation. The patient seemed to be unsure of the signs and symptoms, or potential denial. As a nursing student we can educate the

patient to speak to their provider or nurse about what they are experiencing. We can also offer a listening ear to assist the patient in therapeutic communication. Therapeutic communication is important, we can assist the patient in ways to properly express their feelings and how to monitor their signs and symptoms.

Reflecting:

I learned that a patient may be in true denial about their diagnosis. This patient struggled to determine their signs and symptoms, and this showed during their interview. I think in the future it is important to be truly aware of the patient's history and current status when speaking to them. If the patient is unaware of their illness, miseducated, or in denial then we are healthcare professionals may not be getting accurate or up to date information, which is crucial to assisting them in receiving proper care.

Additional assessment reflection:

Noticing:

I chose the suicide screening assessment tool because this patient has four previous suicide attempts. The patient recently overdosed on medication and was under the influence of alcohol on their arrival to the Emergency Room. I noticed during the conversation the patient seemed uncomfortable answering certain questions regarding their suicide attempts. There was not abnormal findings that specifically stood out to me during this portion of our conversation.

Interpreting:

The patient did seem uncomfortable or awkward during certain questions regarding the suicide screen. This could be related to the patient feeling ashamed or embarrassed to admit their

previous attempts. The patient admitted to previous attempts but when I asked when they took place the patient stated they “could not remember”.

Responding:

I think this additional assessment was crucial to perform due to the patient’s past history and current situation. It is essential to know your patient’s history and their current situation, so additional assessments are extremely useful. As a student nurse I informed the patient that I am here to have a conversation, and they can communicate with me when and how they choose to in a respectful and appropriate way. We need to set our boundaries while also ensuring the patient we are there for them. As a student nurse it is also essential to use therapeutic communication skills to properly communication with your patient.

Reflecting:

I felt very prepared to converse with this patient. I was not surprised to find that the patient felt as though they did not want to discuss their suicide attempts. This can be a common finding in those who feel ashamed or have very few supportive persons. I think I handled the situation appropriately. I allowed the patient to speak how they felt and did not push the patient. I encouraged open communication and therapeutic communication. I think going forward I will continue to encourage communication with patients, even when they are closed off.

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? Patient states they "do not remember"

   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

Mental Status Exam

Client Name	Date

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:

MOOD

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

Comments:

COGNITION

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

Comments:

PERCEPTION

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

Comments:

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:

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