

Reflection Assignment

Noticing	Interpreting	Responding	Reflecting
<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>The client was cooperative and happy to participate. The client was truthful with their responses.</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>Nothing in particular stood out to me about the client. The client stated they understood why they were at the facility and stated that even though they have had thoughts of suicide that led them there, they were not currently having suicidal thoughts.</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>I made sure that the client felt comforted with the examination and I asked the questions in a conversation setting without feeling like I was drilling the client with questions. We talked about how they felt and what it meant to them.</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> <p>I learned it is important how you talk to these clients. You must be caring, open-minded, and willing to talk. A lot of clients at this facility enjoyed talking to us students. I valued these conversations and I learned a lot!</p>

Noticing	Interpreting	Responding	Reflecting
<p>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?</p> <p>I chose the PHQ-9 questions because the client was here for depression and suicidal ideation. The client stated they no longer felt suicidal. Even though the client is not suicidal they scored a 4 on the questionnaire.</p>	<p>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.</p> <p>Nothing in particular stood out to me. The client felt good, energetic, and happy today. The client stated some things they think of several days or more than half.</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?</p> <p>This information is important to obtain. The client stated information that was relative to when they were admitted and also relative to this day. I felt no additional information was needed.</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> <p>I learned that how the client responds to questions for the PHQ-9 depends on how they feel in that moment in that day. One answer that varied for my client was that some days they thought they would be better off dead or harming themselves but some days they did not.</p>

Mental Status Exam

Client Name <u>E.K.</u>		Date <u>2-2-24</u>			
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 checked="" type="checkbox"/> Normal	<input type="checkbox"/> Tangential	<input type="checkbox"/> Pressured	<input 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:					
MOOD					
<input type="checkbox"/> Euthymic <input type="checkbox"/> Anxious <input type="checkbox"/> Angry <input type="checkbox"/> Depressed <input checked="" type="checkbox"/> Euphoric <input type="checkbox"/> Irritable <input checked="" type="checkbox"/> Other					
Comments: <u>Client stated they felt in a "good" mood</u>					
COGNITION					
Orientation Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Place	<input type="checkbox"/> Object	<input type="checkbox"/> Person	<input type="checkbox"/> Time
Memory Impairment	<input checked="" type="checkbox"/> None	<input type="checkbox"/> Short-Term	<input type="checkbox"/> Long-Term	<input type="checkbox"/> Other	
Attention	<input type="checkbox"/> Normal	<input checked="" 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 type="checkbox"/> None	<input checked="" type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization	<input type="checkbox"/> -out of body	
Comments: <u>gumminess, foggy, surrounding</u> <u>sense of watching movie of your life</u>					
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: <u>powers, missions,</u>					
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 checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:	
JUDGMENT	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:	

IV & snack

thought process

Do you sometimes have thoughts that others & you are self.

parent of circumstances

waited on grandchild would you do

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 + 1 + 0
=Total Score: 4

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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