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N323
Spring 2024

MSE Reflection

Noticing

During my mental status examination, I noticed that my patient did not immediately have any noticeable markers of schizophrenia. He was well-spoken and expressive, and our conversation was incredibly normal. He was calm with full affect. The only abnormal parts of the exam were perception, insight, and judgment. He has visual and auditory hallucinations. He stated that his visual hallucinations included seeing a facial tattoo on his left cheek and "faces of the voices" in his arms. His auditory hallucinations before admission revolved around harming himself or others, which he denies. At the time of this MSE, he stated, "They are just telling me which cards people have in Uno." He is not currently having any thoughts of harming himself or others. His judgment and insight were both poor.

Interpreting

The potential causes of schizophrenia are not known. However, this patient's episode led to admission due to a lapse in medication management. The patient stopped taking his medication for a short period which caused dissociation and aggravation of his symptoms.

Responding

A suicide risk assessment would be the next assessment to perform. Further questions to evaluate current SI/HI risk and clarifying questions about his hallucinations could be used. I did a suicide risk assessment. I used open questions and summarizing.

Reflecting

I learned that schizophrenia may not always look like it is portrayed in media. It can look very normal, and you may not know you are speaking to someone with schizophrenia. I also learned that hallucinations are often the same hallucination for at least a short time. This patient has had the same visual hallucinations for a long time. In the future, I would prepare questions to further probe into what feelings come up when the hallucinations are present or invading too much. I feel I did well speaking with the patient and gathering information without playing into his delusions. I think it allowed to leave with more empathy towards those with hallucinations.

ASQ Reflection

Noticing

I chose to do the suicide screening assessment due to the patient's history of suicidal ideation, which is what caused him to be hospitalized. He answered no to everything except having thoughts of killing himself within the past week. He states he currently has no SI.

Interpreting
The potential cause of his SI within the past week is increased hallucinations due to not taking his medication.

Responding
As a nursing student, I can recognize signs of crisis. I could offer resources for suicidal ideation. I asked him about prior attempts, to which he denied. As a nurse, I could educate the patient, consult providers about his history, and give medications as needed.

Reflecting
I learned that a patient does not have to be actively suicidal in order to be hospitalized. In the future, I would ask more questions to gather his mental health history.

Mental Status Exam

Client Name	NH	Date	02/23/2024

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:					

Text

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:

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? _____

   _____

   _____

   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