

- 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

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>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	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>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>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>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>

	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 one prompt 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 within each column of the activity.

Mental Status Exam

Client Name	B.D	Date	4-12-24			
OBSERVATIONS						
Appearance	<input type="checkbox"/> Neat	<input checked="" 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 checked="" type="checkbox"/> Euthymic	<input type="checkbox"/> Anxious	<input type="checkbox"/> Angry	<input type="checkbox"/> Depressed	<input type="checkbox"/> Euphoric	<input type="checkbox"/> Irritable	<input type="checkbox"/> Other
Comments:						
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 checked="" type="checkbox"/> Normal	<input 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 checked="" type="checkbox"/> None	<input type="checkbox"/> Derealization	<input type="checkbox"/> Depersonalization			
Comments:						
THOUGHTS						
Suicidality	<input type="checkbox"/> None	<input checked="" 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:						
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 type="checkbox"/> Good	<input checked="" type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:		
JUDGMENT	<input type="checkbox"/> Good	<input checked="" type="checkbox"/> Fair	<input type="checkbox"/> Poor	Comments:		

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 + 2 + 3
=Total Score: 8

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



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



Mental Health Assessment Tools

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:

- the use of prescribed or over the counter drugs in excess of the directions and
- 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	Questions	Response	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs?	Yes	No
5.	Are you always able to stop using drugs when you 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 drugs?	Yes	No
9.	Has drug abuse created problems between you and your spouse or your parents?	Yes	No
10.	Have you lost friends because of your use of drugs?	Yes	No
11.	Have you neglected your family because of your use of drugs?	Yes	No
12.	Have you been in trouble at work because of drug abuse?	Yes	No
13.	Have you lost a job because of drug abuse?	Yes	No
14.	Have you gotten into fights when under the influence of drugs?	Yes	No
15.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
16.	Have you been arrested for possession of illegal drugs?	Yes	No
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	Yes	No
19.	Have you gone to anyone for help for a drug problem?	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:

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

Scoring:

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

Clinical Utility of instrument:

- The CAGE is very useful bedside clinical assessment tool.
- 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 writtem 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., Albuisson, E. & Deteix, P. (2001) *American Journal of Psychiatry*, 158(1), 96-99.

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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

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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.

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MINI MENTAL STATE EXAMINATION

Patient _____ Examiner: _____ Date: _____

Max
Score Score

- 5 () **ORIENTATION**
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.
- 3 () **REGISTRATION**
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: _____
- 5 () **ATTENTION AND CALCULATION**
Spell “world” backwards. Give 1 point for each letter that is in the right place (e.g., **DLROW** = 5, **DLORW** = 3).

Alternatively, 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).
- 3 () **RECALL**
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)

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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:

30	()	Alert	Drowsy	Stupor	Coma
		30	20	10	0

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Reading:

CLOSE YOUR EYES

Writing:

Construction:

