

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><i>I focused on the client's hygiene because I noticed body odor, wrinkled cloths, and a messy room. She refused help with showering or cleaning but enjoyed drawing and was calm while doing it.</i></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><i>Poor hygiene and clutter may reflect depression, trauma, or low self-worth. Her abuse history and foster placements could make her resist help. Trauma and depression can affect motivation through changes in stress hormones and neurotransmitter.</i></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>I used active listening and reflection while drawing with her to build trust. I respected her refusal but encouraged small step and shared my observations prof. As a nurse, I would set gentle goals and praise progress.</i></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>I learned patience and building rapport; did well in speaking time connecting: want more trauma-informed care skills.</i></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>Alert, oriented, flat affect, poor hygiene, mood slightly in incongruent.</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>Flat affect/self neglect linked to depression and past abuse neurotransmitter imbalance and reduce self-care.</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>I learned I used open-ended questions, active listening, validation, documented observations. As a nurse, could plan hygiene routine.</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>learned therapist presence matters; next time to use structured prompts, proud of calm communication, I want to move adolescent mental health skills.</p>

Mental Status Exam

Client Name Hilda Sills-Allen Date 9-8-25

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 type="checkbox"/> Full	<input type="checkbox"/> Constricted	<input checked="" type="checkbox"/> Flat	<input type="checkbox"/> Labile	<input type="checkbox"/> Other

Comments: Calm but stubborn, prefers messy room

MOOD

Euthymic Anxious Angry Depressed Euphoric Irritable Other

Comments: Says she is "happy" but feels isolated

COGNITION

Orientation Impairment	<input checked="" type="checkbox"/> None	<input checked="" type="checkbox"/> Place	<input type="checkbox"/> Object	<input checked="" type="checkbox"/> Person	<input checked="" 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: participates in drawing and activities, some difficulty sustaining attention.

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: No perceptual disturbances observed.

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: Thought content appropriate during interaction.

BEHAVIOR

<input checked="" type="checkbox"/> Cooperative	<input type="checkbox"/> Guarded	<input type="checkbox"/> Hyperactive	<input type="checkbox"/> Agitated	<input type="checkbox"/> Paranoid
<input checked="" type="checkbox"/> Stereotyped	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Bizarre	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Other

Comments: Guarded, slightly stubborn, resists hygiene care.

INSIGHT Good Fair Poor Comments: understands need for care, but does not cons

JUDGMENT Good Fair Poor Comments: N/A.



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

