

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>42 years - old female appeared slightly shaky and reported drinking about 42 cups of coffee daily. She was alert and answered questions appropriately. Mild tremors and increased heart rate were noted. During mental exam, she appeared alert oriented x4.</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>Finding likely related to excessive caffeine intake causing central nervous system stimulation. possible caffeine intoxication leading to restlessness and tremors.</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>Assessed Continued to monitor her behavior and encouraged discussion about Caffeine use and its possible effects on mood and concentration. As a nursing student, I would educate her on reducing Caffeine intake gradually.</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>Learn that excessive Caffeine can affect mood and behavior. I did well identifying the possible Cause of shakiness in the future, I'll explore lifestyle habits more thoroughly during Assessment.</p>

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<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 to do mental status exam and suicidal ideation assessment because patient appeared slightly agitated and shaky during the assessment, she was alert oriented x4, answered questions appropriately, and denied any suicidal thoughts or self-harm intentions. Her shakiness and restlessness stood out and were likely related to her excessive caffeine intake.</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>patient's shakiness and restlessness stood out, likely from excessive caffeine. Similar to other patients with stimulants intake, it caused tremors and agitation. Caffeine blocks adenosine stimulation.</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>Based on my interpretation, I need to assess her vitals, sleep patterns, and tremors related to high caffeine intake. I observed her agitation and ask about coffee habits, as a student I can educate on caffeine effects and report findings. Next time, I could assess underlying reasons for excessive intake.</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 asking difficult questions like suicidal thoughts is important for safety. Next time, I will be more confident and direct. I did well by completing the assessment professionally despite being a novice. I need more practice and communication skills for sensitive topics. The experience showed me what uncomfortable questions are necessary for safe nursing care.</p>

Client Name *Emily Coleman*

Date *10-9-2025*

## 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 type="checkbox"/> Normal	<input checked="" 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: *Minor hand tremors noted.*

## MOOD

Euthymic  Anxious  Angry  Depressed  Euphoric  Irritable  Other

Comments: *Appears slightly jittery, likely due to high caffeine intake.*

## COGNITION

Orientation Impairment	<input checked="" type="checkbox"/> None	<input checked="" 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: *Cognition intact.*

## 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: *ATA No perceptual disturbance observed.*

## 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: *Thoughts coherent and logical, no evidence of self-harm.*

## BEHAVIOR

Cooperative  Guarded  Hyperactive  Agitated  Paranoid  
 Stereotyped  Aggressive  Bizarre  Withdrawn  Other

Comments: *pt engaged appropriately but showed minor restlessness and trem*

## INSIGHT

Good  Fair  Poor Comments: *Understands caffeine eff*

## JUDGMENT

Good  Fair  Poor Comments: *Decision making approp*



# 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