

Assessment and Reflection 1

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27 February 2026

## Reflection- Mental Status Exam

### Noticing

My patient was a 38-year-old female admitted for suicidal ideation. Because suicidal ideation was her primary reason for admission, I focused closely on assessing depressive symptoms using the PHQ-9 prior to discharge. The PHQ-9 allowed me to assess depressive symptoms over the last two weeks, including loss of interest, sleep disturbances, low energy, feelings of worthlessness, concentration difficulty, and most importantly, thoughts of being better off dead or self-harm (question 9).

During my assessment, she appeared neat, with normal speech, eye contact, and motor activity. Her affect was full, and her mood was euthymic. She was oriented x4 with no memory or attention impairments. She denied current suicidal or homicidal ideation during my assessment. Her vital signs at 0820 were stable: pulse 84, temperature 96.9 F, respirations 19, oxygen saturation 100%, and blood pressure 134/94. While overall stable, her blood pressure has been slightly elevated during the duration of her stay.

She took pregabalin 100 mg, potassium and sodium phosphates, and apixaban 5 mg, but she refused her psychiatric medications, including aripiprazole 5 mg and divalproex 500 mg. She also refused pantoprazole 40 mg at 0900 because she received that prescription from the night nurse at 0600. I noted several older bruises on both her arms. She was being discharged later that day.

## **Interpreting**

Even though she denied active suicidal thoughts during my interaction, I understand that depression symptoms can fluctuate. The PHQ-9 is valuable because it gives a structured way to measure severity instead of relying only on how the patient presents in the moment.

What stood out to me most is that suicidal ideation does not disappear just because a patient looks calm or is preparing for discharge. If she were to endorse any level of self-harm thoughts on question 9, even “several days,” that would immediately raise concern.

I interpreted her refusal of aripiprazole and divalproex as significant. Both medications are commonly used for mood stabilization and management of psychiatric symptoms. Refusing the medications on the day of discharge raised concern for medication noncompliance after leaving the facility.

Since her focus during admission was suicidal ideation, I understood that stability in the hospital does not mean stability at home. The structured environment likely provided support and monitoring that may not be provided after discharge. Her slightly elevated blood pressure could be related to anxiety, stress, or underlying hypertension, but in the context of psychiatric instability, it made me think about the physiologic effects of stress on the body. Overall, I interpreted this as a patient who appeared clinically stable but still had potential risk factors for relapse.

## **Responding**

Because discharge was planned, I recognized that patient education was critical. I would ensure she understands:

- The purpose of aripiprazole is to stabilize mood and reduce intrusive or harmful thoughts.
- The purpose of divalproex is mood stabilization and prevention of mood swings.

- Risks associated with stopping psychiatric medications abruptly.
- Signs of worsening depression or return of suicidal thoughts.
- When and how to seek immediate help (988, ER, calling provider).

Since she is on apixaban, I would also educate her on bleeding precautions and signs of abnormal bruising, especially since she already had older bruises noted on her arms.

I would reinforce the importance of attending follow-up psychiatric appointments and therapy. I will also encourage the identification of a support person she can contact if she begins to feel overwhelmed. As a nursing student, I would communicate her medication refusal and history of suicidal ideation to the RN and ensure discharge documentation reflects her current mental status and education provided.

### **Reflecting**

This experience showed me how vulnerable discharge can be for a patient admitted with suicidal ideation. A patient can appear calm, have stable vital signs, and deny suicidal thoughts in the moment, but still be at risk once they leave the structured environment. I learned that the PHQ-9 is not just a checklist; it helps guide safe discharge decisions. It made me realize that safety planning and medication education are critical components of suicide prevention.

Stability in a controlled setting does not always translate to safety outside of it. I also recognized how important it is to educate patients thoroughly about medication adherence and crisis resources before discharge. In the future, I want to continue building confidence in having direct and honest conversations about suicide prevention and medication compliance. This interaction reinforced that psychiatric nursing is about thinking ahead and protecting patients during vulnerable transitions.

## \*Mental Status Exam

Client Name <u>M.M.</u>		Date <u>02/23/26</u>	
<b>OBSERVATIONS</b>			
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: <u>Has several older bruises on arms.</u>			
<b>MOOD</b>			
<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:			
<b>COGNITION</b>			
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:			
<b>PERCEPTION</b>			
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:			
<b>THOUGHTS</b>			
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><del>Refused admission</del> admission for ideation suicidality</u>			
<b>BEHAVIOR</b>			
<input type="checkbox"/> Cooperative	<input checked="" 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: <u>Refused behavioral medications</u>			
<b>INSIGHT</b>	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			
<b>JUDGMENT</b>	<input checked="" type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Comments:			

Plans to be discharged 02/23/26 today.

## 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 + 1 + 2 + 3  
=Total Score: \_\_\_\_\_

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 <input type="checkbox"/>	Somewhat difficult <input type="checkbox"/>	Very difficult <input type="checkbox"/>	Extremely difficult <input type="checkbox"/>
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