MENTAL STATUS ASSESSMENT GUIDELINES

APPEARANCE

Presenting appearance including chronologic age and apparent age (does the person appear older/younger or at stated age), ethnicity, apparent height and weight (thin, cachectic, muscular, frail, overweight, average, stocky, healthy, petite), grooming and hygiene (malodorous, highly perfumed, dirty, unshaven, kemptness, hairstyle, makeup), clothing (what they are wearing, cleanliness and condition of clothes, neatness, appropriateness of garments), physical characteristics (tattoos, scars, missing teeth, bandages, jaundice, amputation, etc.)

BEHAVIOR & MOTOR ACTIVITY

Mannerisms, patterns of movement, speed of movement.
Abnormal mannerisms include echopraxia (involuntarily copies others' movements), catatonia, waxy flexibility (stuperous but takes body position physically imposed by examiner), akathisia (inner driven motor restlessness), lethargic, hyperactive, aggressive, assaultive, compulsive, withdrawn, isolative, manipulative, disruptive, intrusive, socializes, preoccupied, restless, etc.

SUBJECTIVE MOOD

Ask the client about their overall mood for the day. Compare this with the affect displayed during the same time period and record concordance in the affect section.

OBJECTIVE AFFECT

Describe what you see in their facial expressions, body language, laughter, use of humor, tearfulness. Describe appropriateness to circumstances and content of speech. Expansive (contagious- you can't help from smiling yourself), full range or broad (normal), flat (no expression), blunted (few emotions, low intensity), constricted (limited variability), labile (extreme variation), concordance (expressed emotion seems to fit what the client is saying or doing), anxious, irritable, neutral, angry, pleasant, etc.

ATTITUDE

Next, record the client's attitude toward the examiner. Note whether the client appeared interested during the interaction or, perhaps, if the client appeared bored. Record whether the client is hostile and defensive or friendly and cooperative. Note whether the client seems guarded and whether the client seems relaxed with the interview process or seems uncomfortable. Other descriptors include uncooperative, hostile, suspicious, or belligerent. This part of the examination is based solely on observations made by the health care professional.

SPEECH

Document information on all aspects of the client's speech. Include evaluation of quality, quantity, rate, rhythm, and tone. For example, note if the client is speaking at a fast pace or is talking very quietly, almost in a whisper. Other descriptors include clear/normal, pressured, slow, soft, mute, fast, loud, slurred, hyperverbal, pressured, or perseverate.

THOUGHT PROCESSES (How ideas fit together)

Normal thought process is logical, coherent and goal directed. Variations include: tight associations (one thought sensibly leads to another reasonable thought), looseness of association (one thought leads to another somewhat less reasonable or loosely related thought), flight of ideas (rapidly changing topics), racing (rapid thoughts), circumstantial (being vague, i.e., "beating around the bush" - giving irrelevant details but eventually returns to the main idea), tangential (departure from topic with no return), word salad (nonsensical responses), neologism (creating new words), clang association (rhyming words – I want to say the play of the day, ray, stay, may I pay), thought blocking (speech is halted), poverty (limited content), preservation (continues to repeat the same thought or phrase), confabulation (filling in of a memory gap with a detailed fantasy), rumination (obsessive thought over a certain topic).

THOUGHT CONTENT (Topic of thought)

- **Suicidal Ideation** – If the client has suicidal ideation, inquire about any specific plans, evaluate the potential for carrying out the plan and report this immediately to the nurse or instructor.
- **Homicidal Ideation** – Same as above
- **Perception** – Ideas of reference (false idea that outside events have special meaning for oneself), ideas of influence (false belief that outside events can have influence on one's behavior), depersonalization (person feels detached, unreal, physically altered – out of body, body part altered, cut off from other people), derealization (parts of the environment feel unreal, somehow altered), illusions (a wrong perception of a real physical external stimulus).
- **Hallucinations** –Types of hallucinations include: auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things). Ask some of the following questions: "Do you hear voices when no one else is around?" "Can you see things that no one else can see?" "Do you have unexplained sensations such as smells, sounds, or feelings?" If a person has auditory hallucinations, inquire what the voices are telling them and if they recognize the voice. If the voices are commanding them to do something, ask them if they normally obey the voices or are they able to ignore them? Report any harmful command hallucinations to the nurse or instructor.
- **Delusions** – To determine if a client is having delusions, ask some of the following questions, "Do you have any thoughts that other people think are strange?" "Do you have any special powers or abilities?" "Does the television or radio give you special messages?"

COGNITION

Orientation- person, place, time, situation.
Memory - Short term memory is assessed by listing three objects, asking the patient to repeat them to you to insure that they were heard correctly, and then checking recall at 5 minutes.
Concentration- ask the patient to continuously subtract 7 starting from 100 or to spell "world" backwards
Attention Span – observe client on the unit or during conversation and note amount in minutes the client can engage in a task or conversation
Abstraction - Can be assessed by asking the patient to find the similarities between objects (e.g., the similarities between a triangle and a square) or to explain an idiom such as, "the grass isn't always greener on the other side.
Judgment – rate as good, fair or poor and give examples of behaviors or decisions made that relate to the care of their current condition such as boundaries, medication adherence, attending groups, etc.
Insight- an individual's awareness and understanding of their current medical problem.
Rate as good, fair or poor and describe the rationale for the rating.

CULTURAL ASSESSMENT

Assess the patients cultural using your book as a guide for point of identity, time orientation, non-verbal communication pattern. Research and discuss the common health beliefs and practices of the patient's culture including the attitude toward mental illness.

SPIRITUAL ASSESSMENT

Assess the spiritual needs of the client. Are they being met in the hospital setting? Referral needed?

NURSING DIAGNOSIS AND INTERVENTIONS

List the top three priority nursing diagnoses and most important nursing interventions for your client.

LEARNING NEEDS OR TEACHING DONE

Evaluate any learning needs and carry out teaching. Topics include pain management, food/drug interaction, diet, disease process, medications, safety, discharge planning.

EVALUATION OF TEACHING/LEARNING RESPONSE

Evaluation includes: teach-back method, verbalizes understanding or repeat demonstration. Learning response includes, asked questions, difficulty understanding, expressed denial, resistant, lacking motivation.