MENTAL HEALTH NURSING · STUDY GUIDE

Exam 2 Study Guide

This guide covers chapters 3 and 4. First the law and ethics that press on every psychiatric bedside: the six principles, admission status, confidentiality, capacity, the right to refuse and the rules for restraint. Then the core assessment skills: setting up a safe interview, the mental status exam, ruling out the body, screening cognition and delirium, and asking about suicide directly. Work one chapter at a time. Read the "what to know" paragraphs, study the tables, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts the numbers and rules in one place.

WHAT THIS GUIDE COVERS

- Chapter 3 · autonomy, beneficence, nonmaleficence, justice, veracity and fidelity; dilemmas and moral distress; voluntary admission, emergency holds and involuntary commitment; rights that survive; false imprisonment, battery and assault; HIPAA, psychotherapy notes and 42 CFR Part 2; Tarasoff; consent, competence and capacity; the right to refuse; advance directives; de-escalation and federal restraint rules.
- Chapter 4 · setting up a safe, trauma-informed interview; every domain of the mental status exam; mood versus affect; thought process versus content; the history; medical mimics; MoCA, Mini-Cog and the CAM; suicide screening from ideation to access; means restriction and safety planning; self-injury, aggression, withdrawal and violence screens; delegation, documentation and SBAR.

CHAPTER 3

Legal and Ethical Issues in Mental Health Care

Read it in full: **Chapter 3 in the textbook**. Practice it in the lab: **Status Desk: What Changes, and What Never Does** and **Capacity Bench: Four Abilities, One Decision**.

What to know

Six principles guide every decision. **Autonomy** is the right to decide about one's own body and life, including choices others think unwise. **Beneficence** is acting for the person's good.

Nonmaleficence is avoiding harm, including harm from your own intervention. **Justice** is fair distribution of care, so the quiet person is rounded on as often as the loud one. **Veracity** is truthfulness and **fidelity** is keeping promises. Saying "I will come back at three" and coming back at three is clinical work.

A true **dilemma** is a conflict between two rights, not right versus wrong. The usual collision is autonomy versus beneficence: an ill person refuses the treatment most likely to restore their capacity. The nursing answer is procedural: check that the refusal is informed, check whether capacity for this decision is truly impaired, look for the least restrictive path, escalate (provider, ethics committee, patient advocate), and document the reasoning. **Moral distress** is knowing the right action and being blocked from it; it drives burnout and should be named in debrief.

Most admissions are **voluntary**. A voluntary patient may refuse specific treatments and may request discharge in writing, but release is not automatic: a notice period, commonly 48 to 72 hours, lets the team decide whether involuntary criteria are met. When a voluntary patient says "I want to leave," **notify the provider first**, then explore what changed, then explain the written request procedure. A delay here can turn a lawful admission into false imprisonment.

An **emergency hold**, often 72 hours, applies to a person who, because of a mental disorder, is a danger to self, a danger to others or **gravely disabled** (unable to provide food, clothing, shelter or needed medical care; not poverty or an unusual lifestyle). A hold allows detention and evaluation, not routine forced medication. Longer **involuntary commitment** needs a hearing with due process and proof by **clear and convincing evidence** (Addington v. Texas, 1979). O'Connor v. Donaldson (1975): a state cannot confine a non-dangerous person who can live safely in freedom. Wyatt v. Stickney (1971): a right to adequate treatment.

Involuntary status removes the right to leave and **almost nothing else**. People keep the right to be free of unnecessary restraint, privacy, phone, mail and visitors, information about treatment and the right to refuse it outside narrow circumstances, belongings unless a documented hazard, religious practice, grievances, an attorney and an independent evaluation. Any restriction must be individualized, clinically justified, time-limited, documented and reviewed. **False imprisonment** is unlawful restriction of movement; **battery** is unconsented touching, such as injecting a refused drug outside an emergency; **assault** is the credible threat of it.

HIPAA allows disclosure without authorization for treatment, payment and operations, not to anyone who cares. The commonest breach is confirming to a caller that a person is on the unit. **Psychotherapy notes** kept separately need specific written authorization; **42 CFR Part 2** gives substance use treatment records stricter protection. You may always **listen** to family. Under **Tarasoff** (1976), a serious threat of violence to a reasonably identifiable person creates a duty to protect. The nurse elicits specifics, keeps everyone safe, notifies the provider and supervisor, and documents the words verbatim. All nurses are mandated reporters of suspected abuse or neglect; reasonable suspicion is enough.

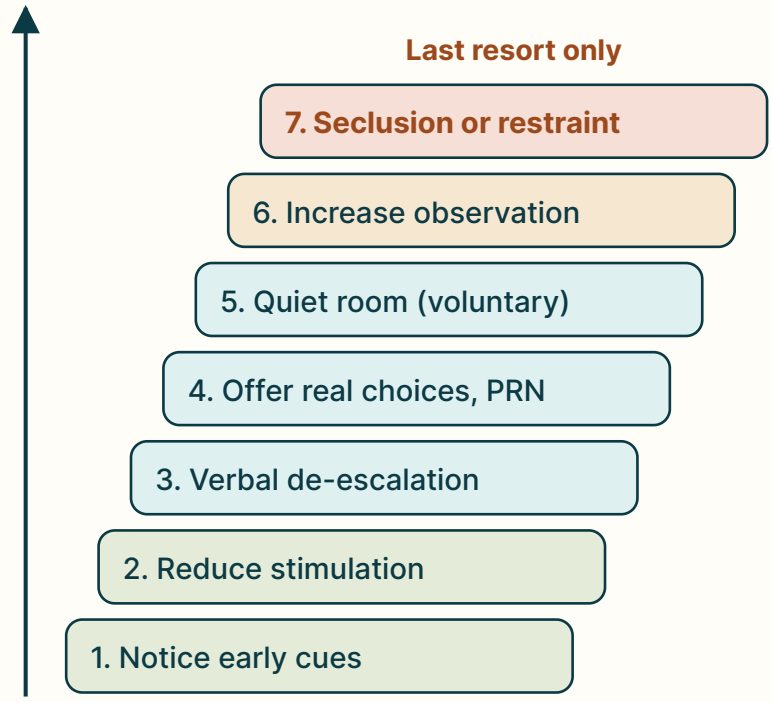
Informed consent is the provider's duty; the nurse witnesses, confirms understanding and voluntariness, and calls the provider back if the person does not understand. **Competence** is a legal status decided by a court and presumed in adults. **Capacity** is a clinical judgment about one decision at one time, tested by four abilities: **understanding, appreciation, reasoning and expressing a choice**. Appreciation is the one most often impaired in psychosis. An unwise choice is not an incapable one, and agreement needs the same test as refusal. Involuntary status does not equal incapacity.

Adults with capacity may refuse psychotropic medication even when detained. The exception is a true **behavioral emergency**, and the right returns when it ends. A **psychiatric advance directive** lets a person's well voice govern a future episode. Without one, a proxy or surrogate decides by substituted judgment, then best interests; guardianship is the last resort. Restraint and seclusion are last resorts under federal rules: an order from a licensed provider, never PRN or standing; a face-to-face evaluation within one hour; limits of 4 hours for adults, 2 hours for ages 9 to 17 and 1 hour under 9, renewable to 24 hours; continuous monitoring; never prone; release as soon as criteria are met; debrief.

LOCK THESE IN

- Autonomy, beneficence, nonmaleficence, justice, veracity, fidelity.
- Voluntary patient wants out: notify the provider first, then explore, then inform.
- Hold criteria: danger to self, danger to others, grave disability. Commitment: clear and convincing evidence.
- Involuntary status removes the right to leave, almost nothing else.
- Tarasoff: serious threat plus identifiable victim. The nurse escalates; the nurse does not decide alone.
- Capacity: understanding, appreciation, reasoning, choice. Decision-specific and time-specific.
- Restraint: no PRN or standing orders; 1 hour face-to-face; 4, 2 and 1 hour limits; 24 hour cap.
- Never "calm down," never prone, never as punishment or a staffing fix.

Least restrictive first: the escalation ladder



If restraint is used

Order	Licensed provider; never PRN or standing
Face to face	Within 1 hour, even if already released
Order limits	Adults 18+: 4 h Ages 9 to 17: 2 h Under 9: 1 h Renew to 24 h, then in-person re-evaluation
Monitoring	Continuous
Release	As soon as criteria met
After	Debrief patient and staff

Climb only as far as safety needs. Each rung must fail before the next is used. Restraint has strict federal limits on orders, timing, monitoring and debriefing, and it is never punishment or a staffing fix.

Admission status and rights

Status	How it starts	Right to leave	Right to refuse
Voluntary	Person requests or consents	Yes, by written request; notice period about 48 to 72 h	Yes
Emergency hold	Certification of danger to self, others, or grave disability	No, for the statutory period (often 72 h)	Generally yes, except a true emergency
Involuntary commitment	Court order after a hearing	No, for the ordered period	Usually yes, unless a separate treatment order
Assisted outpatient treatment	Court order for community adherence	Lives in the community	Refusal triggers review, not force

Capacity: the four abilities

Ability	Question that tests it	Impairment looks like
Understanding	"In your own words, what is this medication for?"	Cannot paraphrase even after simple repetition
Appreciation	"What do you think will happen if you do not take it?"	Recites facts but denies they apply to self
Reasoning	"How did you weigh the side effects against the benefits?"	No comparison; conclusion driven by delusion
Expressing a choice	"So what would you like to do?"	Cannot choose, or reverses within one talk

Key cases and rules

Item	What it says
Wyatt v. Stickney (1971)	Right to adequate treatment, not mere custody
O'Connor v. Donaldson (1975)	Cannot confine a non-dangerous person who can survive safely in freedom
Tarasoff (1976)	Duty to protect a reasonably identifiable victim of a serious threat
Addington v. Texas (1979)	Commitment needs clear and convincing evidence
Washington v. Harper (1990); Riggins v. Nevada (1992)	Right to refuse psychotropic medication
42 CFR Part 2	Stricter consent for substance use treatment records
Lithium (from the family call)	Range about 0.6 to 1.2 mEq/L; toxicity above about 1.5

Worked cases

WORKED CASE 1 · THE VOLUNTARY PATIENT WHO WANTS TO LEAVE

Ms. Duarte, 29, admitted voluntarily two days ago, says at 1600, "I am done. I want to leave right now." She hands you a written request.

STEP 1 · IDENTIFY THE STATUS

Voluntary. She may request discharge, but a notice period (about 48 to 72 hours) lets the team evaluate.

STEP 2 · NOTIFY FIRST

Call the provider now. The statutory clock and the evaluation start with the written request.

STEP 3 · EXPLORE

"Something changed this afternoon. What happened?" She describes a frightening new roommate and a jittery feeling since a new medication: possible akathisia.

STEP 4 · INFORM

Explain the written request process and notice period accurately and without threat.

STEP 5 · DOCUMENT

The request, the time, who you notified, and what you explored.

WHAT NOT TO DO

Do not tell her she cannot leave or lock a door with no legal hold. That is false imprisonment.

WORKED CASE 2 · TESTING CAPACITY

Mr. Kim, 41, on an emergency hold for psychosis, refuses an antipsychotic. He can repeat the doctor's explanation word for word. When asked what will happen without it, he says, "Nothing. I am not ill. The pills are for the others." Is capacity impaired, and for which ability?

STEP 1 · UNDERSTANDING

He can paraphrase the information: intact.

STEP 2 · APPRECIATION

He denies that the facts apply to him: **impaired**. This is the ability most often affected in psychosis.

STEP 3 · REASONING AND CHOICE

Weighing is driven by the fixed belief; choice is consistent.

STEP 4 · CONCLUDE

Capacity for this decision is likely impaired, mainly through appreciation. Report to the provider; this is a clinical judgment about this decision only.

STILL TRUE

Being on a hold does not by itself remove capacity, and outside a true emergency he keeps the right to refuse until the legal process says otherwise.

WORKED CASE 3 · A THREAT WITH A NAME

At 2140 Mr. Wade, 37, says, "When I get out, I am going to hurt my brother Leon." What does the nurse do?

STEP 1 · ELICIT SPECIFICS CALMLY

Ask about plan, means and intent without interrogating.

STEP 2 · KEEP EVERYONE SAFE

Keep the environment safe and adjust observation per policy.

STEP 3 · NOTIFY NOW

Tell the provider and supervisor immediately. A serious threat to an identifiable person may trigger the Tarasoff duty to protect.

STEP 4 · DOCUMENT VERBATIM

"When I get out, I am going to hurt my brother Leon," at 2140, plus whom you told and when.

DO NOT

Do not call the brother yourself unless policy and the provider direct it.

WORKED CASE 4 · RESTRAINT TIMING

A trained RN starts restraint for Mr. Tolliver, 34, at 2110 after he lunged at staff. It is now 2155 and no face-to-face evaluation has happened. He is calm and following commands.

STEP 1 · CHECK THE CLOCK

The face-to-face is due within one hour of initiation: by 2210. Only 15 minutes remain.

STEP 2 · CHECK THE ORDER

An order from a licensed provider is required. Adult limit: up to 4 hours, renewable to 24.

STEP 3 · ASSESS RELEASE

Calm, oriented, following commands, circulation intact: release criteria may be met. Release at the earliest moment criteria are met, not at the end of the order.

STEP 4 · ESCALATE IN SBAR

"I need you at the bedside now for the face-to-face evaluation, and I am requesting an order to discontinue restraint."

AFTERWARD

Debrief with the patient and the staff, and document the episode.

TRAPS PEOPLE FALL INTO

- **Thinking involuntary means no rights.** Only the right to leave is removed. Phone, mail, visitors and the right to refuse mostly survive.
- **Treating a hold as permission to medicate.** A hold permits detention and evaluation, not routine forced medication.
- **Calling "unwise" the same as "incapable."** Capacity is about the process of deciding, never the content.
- **Testing capacity only when the patient disagrees.** Agreement needs the same four-ability standard.
- **Mixing up competence and capacity.** A court decides competence; the bedside judges capacity for one decision.
- **Confirming a patient is on the unit to a caller.** That is a breach. You may always listen and take information.
- **Writing restraint as PRN.** Standing and PRN orders are prohibited outright.

- **Skipping the face-to-face because restraint ended.** It is required within one hour even if the restraint already stopped.

Chapter 3 self-test · ten items

1. A nurse tells a client, "I will be back at three," and returns at three. Which principle does this show?

A. Veracity
B. Fidelity
C. Beneficence
D. Autonomy

B. Fidelity Fidelity is keeping commitments. Veracity is truthfulness; the two are often confused.

2. A client admitted voluntarily submits a written request to leave. What is the nurse's first action?

A. Tell the client he cannot leave until morning
B. Explore at length before telling anyone else
C. Notify the provider of the request right away
D. Return his belongings and walk him to the exit

C. Notify the provider of the request right away Notification comes first because the notice clock and evaluation start with the written request. Then explore and inform.

3. Which finding meets the "gravely disabled" criterion for an emergency hold?

A. Cannot obtain food or shelter because of the disorder
B. Lives in a car by choice and works part time each week
C. Lacks the money to pay rent after losing a job last month
D. Has an unusual lifestyle that the family dislikes

A. Cannot obtain food or shelter because of the disorder Grave disability is inability to meet basic needs because of a mental disorder, not poverty or an unconventional life.

4. A court is weighing a long-term involuntary order. How strong must the proof be?

A. Probable cause shown by police
B. Preponderance of the evidence
C. Beyond a reasonable doubt
D. Clear and convincing evidence

D. Clear and convincing evidence Addington v. Texas (1979) set this middle standard, higher than preponderance and lower than reasonable doubt.

5. Which right is removed by involuntary commitment?

A. The right to refuse most treatments
B. The right to leave the facility
C. The right to send and receive mail
D. The right to contact an attorney

B. The right to leave the facility Involuntary status removes the right to leave and almost nothing else.

6. A caller says, "This is his mother. Is Marcus there?" Which reply is best?

A. "I cannot confirm who is here; I can hear you are worried."
B. "HIPAA does not allow me to talk, so please call back."
C. "You will need to ask him yourself when he gets out."
D. "Yes, he came in last night, and he is doing fine."

A. "I cannot confirm who is here; I can hear you are worried." Neither confirm nor deny, validate the fear, and offer what you can, including taking information.

7. A client says he will kill his former coworker, Ray. What is the nurse's role?

A. Wait to see whether he repeats it tomorrow
B. Keep the statement private to protect trust
C. Phone Ray directly to warn him of the danger
D. Notify the provider now and chart his exact words

D. Notify the provider now and chart his exact words The nurse elicits specifics, keeps everyone safe, notifies at once and documents verbatim. The duty-to-protect decision is not the nurse's alone.

8. A client recites every risk of stopping medication but insists, "None of that applies to me." Which ability is impaired?

A. Expressing a choice
B. Understanding
C. Appreciation
D. Reasoning

C. Appreciation Appreciation is applying the facts to one's own situation, and it is the ability most often impaired in psychosis.

9. Which restraint order is acceptable?

A. A 24-hour order written on admission for an adult
B. A PRN order to restrain if the client becomes agitated
C. A standing order covering all clients on the unit
D. A four-hour order for an adult from a licensed provider

D. A four-hour order for an adult from a licensed provider Restraint needs a time-limited individual order. PRN and standing orders are prohibited, and adult orders run up to 4 hours.

10. A 15-year-old is placed in restraint. What is the longest single order allowed?

A. 2 hours
B. 8 hours
C. 1 hour
D. 4 hours

A. 2 hours Limits are 4 hours for 18 and older, 2 hours for ages 9 to 17 and 1 hour under 9.

CHAPTER 4

Assessment: The Mental Status Exam and Risk Screening

Read it in full: **Chapter 4 in the textbook**. Practice it in the lab: **Build the Mental Status Exam, Finding by Finding** and **Asking Directly: The Suicide Screen, Rung by Rung**.

What to know

In mental health nursing the interview is your instrument. The **mental status exam** (MSE) is the psychiatric head-to-toe: a structured, repeatable description of how a person presents **right now**. It is cross-sectional, so it is repeated every shift and time-stamped. Keep **observed** data (pacing, tearfulness, long pauses) apart from **reported** data (the person's words in quotation marks). "Patient is anxious" is an inference; "wrung hands, respirations 24, stated 'I feel like something terrible is about to happen'" is the finding.

Set up first. Both of you need a clear path to the door. Sit at an angle and at eye level. Remove cords, pens on lanyards and sharp items, use a breakaway lanyard and tell a colleague where you are. If the person is intoxicated, shouting or recently assaultive, bring a second staff member or defer the non-urgent parts. Privacy is part of safety. Trauma-informed interviewing means explaining before acting, asking before touching, offering choices, and never demanding the details of an assault. If the person dissociates, stop and ground them.

The MSE runs through **appearance**; **behavior and motor activity** (psychomotor agitation or retardation, akathisia, acute dystonia, tardive dyskinesia, parkinsonism, catatonia); **speech** by form (pressured, poverty, latency, slurred); **mood**; **affect**; **thought process**; **thought content**; **perception**; **cognition**; and **insight and judgment**. Catatonia (stupor, mutism, negativism, posturing, waxy flexibility, echolalia, echopraxia) carries medical risk and is escalated.

Mood is what they say: subjective, sustained, in quotation marks. **Affect is what you see**: quality, range (full, restricted, blunted, flat), stability (labile) and congruence. "I am fine" through tears is incongruent and needs a follow-up question. **Thought process** is how ideas flow: linear, circumstantial (gets there), tangential (never returns), loose associations, flight of ideas (mania), thought blocking. **Thought content** is what they think: delusions (fixed, false, not explained by culture or faith), obsessions, and always suicidal and homicidal ideation, quoted verbatim.

Ask about hallucinations plainly and ask what the voices say and whether they command. Auditory hallucinations fit primary psychosis; prominent **visual** ones point to delirium, substances or a neurocognitive disorder; tactile ones to stimulants or alcohol withdrawal; olfactory ones to temporal lobe seizure. Fluctuating attention is the key cognitive finding of delirium. Insight is full, partial or absent; absent insight can be **anosognosia**, not stubbornness. Judgment is best judged from real recent behavior.

Rule out the body. New or abruptly changed psychiatric symptoms, new psychosis after about age 40, visual hallucinations, fluctuating consciousness, focal signs or abnormal vital signs need a medical workup first. Always check a **capillary glucose**. Classic mimics: hypoglycemia, hypoxia, infection (often afebrile in older adults), thyroid disease, sodium and calcium disorders, B12 deficiency, withdrawal, anticholinergics and steroids, and autoimmune encephalitis. Alcohol withdrawal can reach delirium tremens at about 48 to 96 hours.

Screens are triage tools. The **MoCA** is scored out of 30 with a cut-off around 26 and adds one point for 12 or fewer years of education. The **CAM** is positive with (1) acute onset or fluctuating course **and** (2) inattention, plus either (3) disorganized thinking or (4) altered consciousness. Hypoactive delirium is the most missed and is often mislabeled depression. Put glasses and hearing aids on before testing, and never treat a low score as proof of incapacity.

Ask about suicide directly; asking does not plant the idea. Climb the ladder: **ideation, plan, intent, access to means**, then preparatory acts and protective factors. A prior attempt is the strongest historical predictor; hopelessness predicts more than sadness; the weeks after discharge and the early weeks of antidepressant treatment carry raised risk. Tools such as the C-SSRS and ASQ structure the talk but do not predict. Restrict means, build a six-step **safety plan**, and never use a no-suicide contract. Ask about intent separately after every episode of self-injury. Close every finding with an observation level, a means action and an SBAR.

> **LOCK THESE IN**
>
> - MSE is a snapshot of now; repeat it every shift and time-stamp it.
> - Mood is what they say; affect is what you see.
> - Process is how they think; content is what they think.
> - Visual hallucinations point toward delirium, substances or dementia.
> - Check glucose first; new psychosis after 40 is medical until proven otherwise.
> - CAM: acute onset or fluctuation AND inattention, plus disorganized thinking OR altered consciousness.
> - Suicide ladder: ideation, plan, intent, access, then preparatory acts.
> - Safety plan and means restriction, never a no-suicide contract.

The mental status exam, domain by domain

Observe	Ask and quote	Screen cognition
Appearance	Mood (what they say)	Level of consciousness
Behavior and motor	Thought content	Orientation x 4
Speech	Perception	Attention (serial 7s)
Affect (what you see)	Insight	Recall at 5 minutes
Thought process (flow)	Judgment (recent acts)	Abstraction

Incongruence is a finding

Mood: "I am fine," in quotation marks. Affect: tearful, dysphoric, restricted.
The mismatch gets a direct follow-up question, not just a note.

Describe, do not conclude. The MSE is a snapshot of right now. Chart mood in the person's words and affect in clinical adjectives, and quote every risk statement verbatim.

MSE domains and the words to use

Domain	Observe or ask	Descriptive terms
Appearance	Age, grooming, dress, scars, odor	Dressed in three sweaters in warm weather; healed linear forearm scars
Behavior and motor	Eye contact, movement	Agitation, retardation, akathisia, tardive dyskinesia, catatonic features
Speech	Rate, volume, latency	Pressured, poverty of speech, increased latency, slurred
Mood	"How has your mood been?"	The person's words: "empty," "wired"
Affect	Quality, range, stability, congruence	Dysphoric, restricted, blunted, flat, labile, incongruent
Thought process	Flow of ideas	Linear, circumstantial, tangential, loose, flight of ideas, blocking
Thought content	Delusions, obsessions, SI and HI	Persecutory or grandiose delusion; verbatim risk quotes
Perception	"Do you hear or see things others do not?"	Auditory, visual, tactile, olfactory; command content
Cognition	Orientation, attention, recall	Oriented x 4; inattentive on months backward; 3 of 3 recall
Insight and judgment	Awareness of illness; recent decisions	Partial insight; judgment impaired as shown by a stated act

The suicide screening ladder

Step	Ask it like this	What it changes
Ideation	"Have you had thoughts of killing yourself?"	Full assessment; frequency guides observation
Plan	"Have you thought about how you would do it?"	Specificity and lethality raise acuity; method drives means restriction
Intent	"What has stopped you so far?"	Loss of deterrents means immediate safety measures
Access	"Is there a firearm at home? Where are your medications?"	Directly actionable: secure or remove
Preparatory acts	"Have you written anything or given things away?"	High acuity even if intent is denied
Protective factors	"What has kept you going?"	Levers for the safety plan

Worked cases

WORKED CASE 1 · WRITING THE MSE FROM OBSERVATIONS

At 0800 you meet Ms. Petrova, 52. She sits in three sweaters on a warm day, answers after long pauses, says her mood is "empty," and her face barely moves. She jumps from her son to the weather to a neighbor's dog and never returns to your question. She says, "There is no point anymore."

STEP 1 · APPEARANCE

"Dressed in three sweaters in warm weather."

STEP 2 · SPEECH

"Increased latency before each answer."

STEP 3 · MOOD AND AFFECT

Mood: "empty." Affect: flat or blunted, congruent with stated mood.

STEP 4 · THOUGHT PROCESS

Jumps topics and never returns: **tangential**. (Circumstantial would reach the point eventually.)

STEP 5 · THOUGHT CONTENT

Quote it: "There is no point anymore." That sentence demands a direct suicide screen now.

THEN ACT

Ask, "Are you having thoughts of killing yourself?" and climb the ladder.

WORKED CASE 2 · PSYCHIATRIC OR MEDICAL?

Mr. Haddad, 74, is brought in for "new psychosis." He sees insects on the wall, is oriented one hour and confused the next, and had a urinary catheter placed two days ago. Temperature 37.9 °C.

STEP 1 · SPOT THE RED FLAGS

Age over 40 with new psychosis, visual hallucinations and fluctuating attention all point away from primary psychiatric illness.

STEP 2 · BEDSIDE CHECKS

Capillary glucose, oxygen saturation, full vital signs, urinalysis, medication review.

STEP 3 · RUN THE CAM

Acute onset and fluctuation: yes. Inattention: yes. Disorganized thinking: yes. CAM **positive**.

STEP 4 · ESCALATE

"Acute delirium, CAM positive, temperature 37.9, catheter placed two days ago. Requesting medical review and urine culture now."

SUPPORT WHILE YOU WAIT

Orient him, keep glasses and hearing aids on, reduce noise.

WORKED CASE 3 · CLIMBING THE SUICIDE LADDER

Mr. Ortiz, 60, recently widowed, says he has "had enough." Screen him.

STEP 1 · IDEATION

"Have you had thoughts of killing yourself?" "Most days, and they are getting louder."

STEP 2 · PLAN

"I would take my pills. I have saved about sixty."

STEP 3 · INTENT

"What has stopped you so far?" "My dog. But my daughter is taking her next week."

STEP 4 · ACCESS AND PREPARATION

The tablets are at home; he has written a letter to his daughter.

STEP 5 · ACT

Do not leave him alone, start continuous observation, notify the provider, plan means restriction with a support person.

WHY THE LADDER MATTERS

His first answer sounded vague. The plan, the hoarded supply, the disappearing protective factor and the letter only came out because each rung was asked.

WORKED CASE 4 · SELF-INJURY

Kayla, 19, has new superficial cuts on her forearm. She says she cut "to stop feeling numb." She has done this before.

STEP 1 · TREAT THE WOUND

Competent care, no commentary, no disgust and no reward.

STEP 2 · FIND THE FUNCTION

"What was going on right before?" She describes a fight with her partner and then feeling unreal.

STEP 3 · ASK INTENT SEPARATELY

"When you cut, did you want to die?" Ask this every time; NSSI is a risk factor for later suicide.

STEP 4 · PLAN ALTERNATIVES

Distress tolerance skills and a plan for the next trigger.

LANGUAGE

A person who self-injures, never a "cutter," and the behavior is communication, not manipulation.

TRAPS PEOPLE FALL INTO

- **Charting mood as an adjective.** Mood is the person's word in quotation marks. Affect gets the clinical adjectives.
- **Confusing circumstantial with tangential.** Circumstantial gets to the point eventually. Tangential never returns.
- **Calling akathisia anxiety.** Inner restlessness with rocking or pacing after an antipsychotic is a medication effect.
- **Treating a denial as clearance.** People who have decided may deny. Sudden calm after severe depression raises concern.
- **Using a no-suicide contract.** No evidence it works, no legal protection, and it suppresses honest disclosure.
- **Testing cognition without glasses or hearing aids.** Sensory loss, language, pain and sedation all lower scores.
- **Missing hypoactive delirium.** The quiet, slowed form is the most missed and is often called depression.
- **Letting assistive personnel screen.** They observe and report everything; the nurse assesses suicide risk.

Chapter 4 self-test · ten items

1. Which entry describes affect rather than mood?

A. Client states she feels "empty"
B. Client reports feeling hopeless
C. Tearful, with a restricted range
D. Client says, "I am fine, I guess"

C. Tearful, with a restricted range Affect is what the nurse observes. Mood is what the client says, recorded in quotation marks.

2. A client starts to answer, drifts through his childhood and a recipe, and never returns to the question. What is this?

A. Circumstantial thinking
B. Tangential thinking
C. Flight of ideas
D. Thought blocking

B. Tangential thinking Tangential thinking veers off and never returns. Circumstantial thinking reaches the point after detours.

3. A client describes ants crawling under his skin two days after his last drink. What does this most suggest?

A. Temporal lobe seizure
B. Major depression
C. Primary schizophrenia
D. Alcohol withdrawal

D. Alcohol withdrawal Tactile hallucinations suggest stimulant use or alcohol withdrawal. Olfactory ones suggest seizure.

4. Which CAM pattern confirms delirium?

A. Acute onset and inattention plus disorganized thinking
B. Inattention and slowly worsening memory over two years
C. Altered consciousness alone, noted after a long nap
D. Disorganized thinking and a low mood for the whole month

A. Acute onset and inattention plus disorganized thinking CAM needs features 1 and 2 (acute onset or fluctuation, and inattention) plus 3 or 4.

5. What is the first bedside check for a newly agitated, confused client?

A. A head CT scan now
B. Capillary blood glucose
C. A full MoCA screening
D. A urine drug screen

B. Capillary blood glucose Hypoglycemia causes agitation within minutes and resolves quickly with glucose. Check it first.

6. A student fears that asking about suicide will put the idea in a client's head. What is accurate?

A. Asking directly does not raise risk; it often eases distress
B. Asking is unsafe with depressed teens and older adults
C. Hinting gently works better than using direct words
D. Asking is safe only after the third or fourth interview

A. Asking directly does not raise risk; it often eases distress Repeated studies show direct asking does not increase ideation or attempts.

7. Which question addresses intent on the suicide ladder?

A. "Where are your medications kept at home?"
B. "Have you had thoughts of killing yourself?"
C. "What has stopped you from acting so far?"
D. "Have you thought about how you would do it?"

C. "What has stopped you from acting so far?" Intent is how much the person wants to act and expects to. The others ask about ideation, access and plan.

8. Kayla shows the nurse new cuts on her thigh. Which question belongs in every such assessment?

A. Whether the client wants attention
B. Why the client keeps doing this
C. Who taught the client to cut
D. Whether there was any intent to die

D. Whether there was any intent to die NSSI and suicidal behavior can occur in the same person. Ask about intent separately every episode.

9. Which item replaces a no-suicide contract?

A. A verbal pledge witnessed by family
B. A signed promise to tell staff first
C. A reduced level of observation
D. A written collaborative safety plan

D. A written collaborative safety plan Safety planning plus means restriction is the standard; contracts have no evidence and falsely reassure.

10. The nurse is making assignments for the evening. What can go to a nursing assistant?

A. Recording vital signs and reporting them
B. Screening a new client for suicide risk
C. Deciding a client's observation level
D. Judging if a self-harm remark matters

A. Recording vital signs and reporting them Assistive personnel report everything; the nurse assesses, screens and decides the observation level.

ONE PAGE

Cram sheet

Everything from chapters 3 and 4 in one place. Cover the right column and see if you can rebuild each row.

Numbers to know

Item	Value	Note
Voluntary notice period	Commonly 48 to 72 h	Notify the provider first
Emergency hold	Often 72 h	5150, Baker Act, Section 12 are local names
Restraint face-to-face	Within 1 h	Even if already released
Restraint order limits	4 h (18+), 2 h (9 to 17), 1 h (under 9)	Renewable to 24 h, then in-person re-evaluation
Range of motion in restraint	Typically every 2 h, one limb at a time	Plus fluids, toileting, skin, circulation
Lithium	0.6 to 1.2 mEq/L; toxic above about 1.5	NSAIDs, thiazides, ACE inhibitors raise it
MoCA	Out of 30; cut-off about 26	+1 point for 12 or fewer years of school
Alcohol withdrawal	Minor 6 to 24 h; seizures 12 to 48 h; hallucinosis 12 to 24 h; DTs about 48 to 96 h	CIWA-Ar
Antidepressant lag	Mood lifts in about 2 to 6 weeks	Energy returns first: watch risk
Mortality gap	10 to 20 years	Mostly ordinary medical causes

Frameworks

Framework	The parts
Six principles	Autonomy, beneficence, nonmaleficence, justice, veracity, fidelity
Dilemma process	Informed? Capacity? Least restrictive path? Escalate. Document reasoning.
Hold criteria	Danger to self, danger to others, grave disability
Capacity	Understanding, appreciation, reasoning, expressing a choice
Surrogate standards	Substituted judgment, then best interests; guardianship last
MSE order	Appearance, behavior, speech, mood, affect, process, content, perception, cognition, insight and judgment
CAM	1 and 2, plus 3 or 4
Suicide ladder	Ideation, plan, intent, access, preparatory acts, protective factors
Safety plan	Warning signs, internal coping, distraction, people to ask, professionals and 988, safer environment

Rules that are not numbers

Topic	The rule
Torts	False imprisonment: restricting movement; battery: touching; assault: the threat.
HIPAA	You may always listen; never confirm presence to a caller.
Tarasoff	Elicit, protect, notify, document verbatim. Do not decide alone.
Right to refuse	Survives detention; only a true emergency overrides it, briefly.
Restraint	Never PRN or standing, never prone, never punishment or convenience.
NMS versus serotonin syndrome	NMS: days, lead-pipe rigidity, low reflexes. Serotonin: hours, clonus, hyperreflexia.
MAOI crisis	Occipital headache plus hypertension: ask about aged cheese, cured meats, tap beer.
Clozapine	Fever or sore throat means check the ANC.

Dr. Garg Learning · CC BY-SA 4.0