	0 Points	10 points
Assessments (2)	The student did not submit two completed assessments	The student submitted two completed assessments
Reflection 1 - Mental Status Exam	The student did not answer a minimum of one prompt for each column of the activity.	The student answered a minimum of one prompt within each column of the activity.
Reflection 2 - Additional Assessment	The student did not answer a minimum of one prompt for each column of the activity.	The student answered a minimum of one prompt within each column of the activity.

Comments: Nice MSE assessment comments. However, I noticed you mentioned there was no plan for suicidal intent at this time, but you documented Suicidal ideation, plan, and self-harm. Was this individual having suicidal ideation on your assessment (intent or plan)? We are assessing for the day to see if this has been resolved. Did you ask if there was passive suicidal ideation (thoughts of death but no intent or plan). I also noticed that you documented homicidal ideation. This could be serious and further evaluation would need to be addressed if the patient was having thoughts of hurting others and had a plan. Hallucinations: only document if they are hearing, seeing, tactile, or other components. It's ok you put in comments that the patient reports history, but denies today.

PHQ-9: Score 22
Assessment: What does this score indicate? Why do we use this tool and what nursing interventions would you do?
If it was outpatient: Severe: Notify provider: Immediate initiation of pharmacotherapy and, if

severe impairment or poor response to therapy, expedited referral to a mental health specialist for psychotherapy and/or collaborative management.
Inpatient: collaborate information to provider/document/nursing interventions in the treatment plan. Monitor for suicide, safety protocols, and redo the PHQ-9 during the stay.

MSE Assessment: Nice job building a trusting relationship. Pathophysiology: did you explore any social needs like shelter, food, financial needs, and if the patient has good support? You did discuss substance use and could be linked to the Pathophysiology of her depression, sadness, and thoughts of suicide. Substances can be a depressant or a stimulant which can lead to symptoms. I like that you pointed out SAFETY due to suicide risk! Great job. Great nursing application: review chart, past psychiatric history, medications, any triggers, and applying what you see/hear to the care provided. The importance of counseling for this individual is imperative along with any psychopharmacologic treatment.