ATI Real Life Student Packet
N201 Nursing Care of Special Populations
2023

Student Name: _Mary Helen Walten_

ATI Scenario: _Major Depressive Disorder_

To Be Completed Before the Simulation

Blue boxes should be completed using textbook information. What do you expect to find? This information should be collected before you start the ATI simulation

Medical Diagnosis: _MDD_

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

<u>Anatomy and Physiology</u>
<u>Normal Structures</u>

<u>Limbic system</u> - hippocampus, amygdala and
- responsible for making memories
- emotional response to events

Hypothalamus - mood regulation + hormonal
Stress response

Prefrontal cortex - responsible for executive
functioning, concentration, motivation, goals

Amygdala - process fear + anxiety

<u>hippocampus</u> - memory formation

NCLEX IV (7): Reduction of Risk

<u>Pathophysiology of Disease</u>

- Effects how you think/behave causing feelings of sadness and loss of interest in things you used to enjoy
- may be genetically linked
- ↓ serotonin, norepinephrine + dopamine
- Symptoms last >2 weeks
- Anhedonia
- insomnia/hypersomnia
- weight changes
- fatigue/energy loss
- decreased concentration/guilt
- thoughts of death or suicide
- may be prevelant in older adults
- need to be evaluated for suicide

To Be Completed Before the Simulation

Anticipated Patient Problem: R/f suicide behavior

Goal 1: Pt will not self harm & will remain safe during my time of care

Goal 2: pt will state they want to live during my shift

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframes	Multidisciplinary Team Intervention (Prework) What will you do if your assessment is abnormal?
Suicide risk evaluation PRN	Initiate suicide precautions
Perform mental status exam upon admission + PRN	establish 1:1 sitter
Determine if depression is 1° or 2° to another condition upon admission	encourage client to share feelings / story
Identify support system PRN	encourage client to enlist help of family & friends for long term recovery
Identify triggering events PRN or upon admission	Encourage client to come up with alternative activities to occupy time
Evaluate understanding of disorder and knowledge of progression + presentation	Encourage client & family to ask questions to enhance understanding

NUR__: Instance of Specialty Population

To Be Completed Before the Simulation

Anticipated Patient Trajectory

Relevant Assessments	Multidisciplinary Team Interventions
(eSWORK) What are someone pertain to your patient's problems? Include time, frame.	(eSWORK) What will students do to cure assessment in the activity.

NUR__: Instance of Specialty Population

To Be Completed Before the Simulation

Anticipated Patient Trajectory

To Be Completed Before the Simulation

Anticipated Patient Problem: Self - neglect

Goal 1: Pt will be able to maintain independence w/ self bathing + self care during my shift

Goal 2: pt will be able to verbalize importance of self care and management during my shift

Relevant Assessments (Prework) What assessments pertain to your patient's problem? Include timeframes	Multidisciplinary Team Intervention (Prework) What will you do if your assessment is abnormal?
Assess barriers to self care q shift	Encourage completion of 3 tasks prior to taking a rest
Assess ability to prepare meals q shift	encourage use of pre made food to increase likelyhood of eating to maintain weight
Assess personal hygine routine q shift	encourage daily bathing
Assess preference for clothing or hygine items q shift	encourage family/friends to provide items
Assess routine for day to day activity q shift	provide limited choices for daily activities
Assess thoughts about self-care q shift	Encourage expression of thoughts/feelings

To Be Completed During the Simulation:

Actual Patient Problem: R/f Suicide	
Goal: BR will not self harm during my time of care.	Met: X Unmet:☐
Goal: BR will state develop a crisis safety plan during my time of care.	Met: X Unmet:☐
Actual Patient Problem: Ineffective coping	
Goal: BR will sate alternative coping methods than alcohol during my shift.	Met: X Unmet:☐
Goal: BR will be able to identify support people during my time of care.	Met: X Unmet:☐

Additional Patient Problems: Anxiety, Readiness for enhanced learning

Below will be your notes, add more lines as needed. **Relevant Assessments:** Indicate pertinent assessment findings. **Multidisciplinary Team Intervention:** What interventions were done in response to your abnormal assessments? **Reassessment/Evaluation:** What was your patient's response to the intervention?

Patient Problem	Time	Relevant Assessments	Time	Multidisciplinary Team Intervention	Time	Reassessment/ Evaluation
1,2	Day 1 Intake 11:30	Lost wife 6 months ago (Claire) and lost job (police officer) 2 months ago. "I am spiraling out of control" Hx of anxiety disorder and a family history of suicide. Has access to guns and has been giving away possessions. "I don't want to be a burden anymore." Complains of insomnia and is not taking venlafaxine as prescribed. Lost 12.5% of body weight. Has been using ETOH to cope with loss. Drinks 6 pack every day but has not had a drink in 3 days. CSSRS score completed and is at risk of suicide	Day 1 11:50	Refer to inpatient facility for treatment of major depressive disorder with suicide precautions.	Day 1 12:00	Ben agrees to transport to inpatient facility.
1,2	Day 1 Inpatient 1300	Reviewed expectations and the crisis safety plan. "when can my brother come?"	13:22	Called Jordan and explained that he could bring clothes to his borther	13:30	Restated understanding that the crisis plan is a working document and will be used in transition back to day to day life

1	13:30	"What kind of things can I not have?"	13:35	Explained reasoning for removing objects to keep patients safe during there treatment. This includes pictures, necklaces, pens and drawstring clothing	13:40	Was agreeable to surrendering items to security..
3	13:45	Administered 50mg PO as prescribed for MDD and noted mild anxiety.	13:50	Administered 2mg lorazepam PO	14:50	"I feel better and less anxious"
4	Day 5 11:30	"I didn't realize there were other options than medication. I have tried St. John's wort for sleep. Can you tell me more"	11:50	Explained about light therapy, exercise and continuing group and outpatient therapy in conjunction with individualized therapy sessions. Also emphasized not to take St. John's wort with current med regimen	12:10	"Thanks for sharing those options with me."
4	12:30	"I have been doing yoga and walking 1 mile a day. Have also bee riding my motor cycle with friends and listening to music. I plan to look for a job next week."	12:45	Encouraged continuation of alternative activities as well as maintaining his crisis support plan and keep it with him at all times.	12:55	"" I feel like I am getting back to my old self and I am working on building my self confidence. I am working towards a better me"

Module Report

Tutorial: Real Life RN Mental Health 4.0

Module: Major Depressive Disorder

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Individual Name: **Mary Helen Waltjen**

Institution: **Margaret H Rollins SON at Beebe Medical Center**

Program Type: **Diploma**

Standard Use Time and Score

	Date/Time	Time Use	Score
Major Depressive Disorder	10/18/2023 1:49:40 PM	1 hr 30 min	Satisfactory

Reasoning Scenario Details
Major Depressive Disorder - Use on 10/18/2023 1:01:49 PM

Reasoning Scenario Performance Related to Outcomes:
*See Score Explanation and Interpretation below for additional details.

Body Function	Strong	Satisfactory	Needs Improvement
Cognition and Sensation	88.9%	5.6%	5.6%
Excretion	100%		

NCLEX RN	Strong	Satisfactory	Needs Improvement
RN Safety and Infection Control	100%		
RN Health Promotion and Maintenance	100%		
RN Psychosocial Integrity	92.3%		7.7%
RN Pharmacological and Parenteral Therapies	75%	25%	

QSEN	Strong	Satisfactory	Needs Improvement
Safety	100%		
Patient-Centered Care	100%		
Evidence Based Practice	77.8%	11.1%	11.1%

Thinking Skills	Strong	Satisfactory	Needs Improvement
Clinical Application	100%		
Clinical Judgment	88.9%	5.6%	5.6%

Decision Log:

Optimal Decision	
Scenario	Nurse Alex speaks with Ben and Jordan about coming to the clinic.
Question	Nurse Alex recommends that Ben come to the clinic. Based on the conversation with Jordan and Ben, which of the following findings supports Nurse Alex's recommendation for Ben and Jordan to come to the clinic?
Selected Option	Ben's current mood
Rationale	Nurse Alex should recognize that Ben is manifesting signs of anhedonia, which is the inability to experience happiness in life. Ben states that he doesn't enjoy anything in life anymore.

Optimal Decision	
Scenario	Nurse Alex assesses Ben to collect subjective and objective data.
Question	Nurse Alex is reviewing assessment findings along with Ben's electronic medical record (EMR). Nurse Alex should identify that which of the following findings is an indication that Ben is experiencing major depressive disorder?
Selected Option	Ben's weight trend
Rationale	Ben reports a 25 lb weight loss over 6 weeks. Nurse Alex should evaluate Ben's weight trend and identify that a weight loss or gain of 12.5% of the body weight in 1 month is significant and is a manifestation of major depressive disorder.

Optimal Decision	
Scenario	Nurse Alex identifies priority assessment findings.
Question	After completing Ben's assessment, which of the following assessment findings should Nurse Alex identify as the priority?
Selected Option	Ben giving away his possessions
Rationale	Ben giving away his motorcycle and his guns are nonverbal behavior clues of a risk for suicide, which is a client safety priority. Nurse Alex should identify safety as a priority for clients who have major depressive disorder and may be at risk for suicide.

Scenario	Nurse Practitioner Jamie is talking with Ben and Jordan about risk factors for suicide that Ben is manifesting.

Question	Nurse Alex is reviewing Ben's assessment and EMR. Nurse Alex should identify that Ben is at increased risk for suicide based on which of the following findings? (Select all that apply.)
Selected Ordering	Anxiety disorder Access to lethal means of suicide Increased alcohol use
Rationale	Ben has several known risk factors for suicidal behavior, including his alcohol intake of a 6-pack per day.

Optimal Decision	
Scenario	Nurse Alex is self-reflecting on Ben's covert and overt statements made during assessment.
Question	Nurse Alex is recalling the statements Ben has made during the assessment. Which of the following statements made by Ben should Nurse Alex identify as an overt statement?
Selected Option	"I don't think life is worth living anymore.""
Rationale	Ben's statement, "I don't think life is worth living anymore," is an overt statement that requires further assessment by Nurse Alex. Overt statements such as this can be an open indication the client is providing the nurse with a clue as to their risk of suicide.

Optimal Decision	
Scenario	Nurse Alex administers a suicide screening tool.
Question	Nurse Alex is planning to assess Ben's suicide risk. Nurse Alex should plan to assess for which of the following?
Selected Option	Preparatory behaviors
Rationale	Nurse Alex should plan to assess Ben for preparatory behaviors related to suicide intent or plan by using a suicide risk assessment tool. An example of this tool is the Columbia-Suicide Severity Rating Scale. It is intended to help establish a client's immediate risk of suicide and appropriate treatment regimen.

Optimal Decision	
Scenario	Nurse Alex analyzes the results of the C-SSRS.
Question	Nurse Alex is analyzing Ben's responses to the Columbia-Suicide Severity Rating Scale (C-SSRS) within his chart. Which of the following conclusions can Nurse Alex make regarding Ben's answers?
Selected Option	Ben is experiencing suicidal ideation with intent.
Rationale	The C-SSRS is designed so that questions 1 and 2 determine if the client is experiencing suicidal ideation. Ben's responses to both those questions were yes, which demonstrates he is experiencing suicidal ideation. Because Ben responded yes to these questions, Nurse Alex needed to ask questions regarding Ben's intent on suicide. Ben has described a method of ending his life (use of his gun) and a partial plan worked out (chose a gun and has it loaded). He also states that he intends to go through with the suicide soon. All of this indicates Ben has suicidal ideation and intent.

Optimal Decision	
Scenario	Nurse Alex is assessing suicide lethality.
Question	Nurse Alex is reviewing Ben's assessment in the electronic medical record. Which of the following statements by Ben is an indicator of suicide lethality?
Selected Option	"I collect rifles and handguns."
Rationale	Ben stating that he collects rifles and handguns is an indication of suicide lethality. The lethality of a suicide plan indicates how quickly a person would die by that method.

Optimal Decision	
Scenario	Nurse Jessie is reviewing the client's EMR.
Question	Nurse Jessie is reviewing Ben's EMR. Which of the following findings should Nurse Jessie identify as being risk factors for major depressive disorder? (Select all that apply.)
Selected Ordering	Ben's employment status. The death of Ben's spouse Ben's alcohol use Ben's family history
Rationale	Nurse Jessie should identify that Ben's family history (uncle who has major depressive disorder) is a risk factor for major depressive disorder.

Optimal Decision	
Scenario	Nurses Jessie, Ben, and Jordan look through Ben's personal belongings.
Question	Nurse Jessie is currently examining the personal belongings that Jordan brought for Ben to the acute care facility. Which of the following items should Jesse allow Ben to keep in his possession? (Select all that apply.)
Selected Ordering	SocksUnderwear
Rationale	Underwear does not pose a safety risk, and Ben should be allowed to keep these.

Optimal Decision	
Scenario	Nurse Jessie is developing a plan of care that will include suicide precautions.
Question	Nurse Jessie is developing a plan of care for Ben. One of the planned interventions is suicide precautions. Which of the following actions should Jessie plan to take?
Selected Option	Document Ben's behavior every 15 min.
Rationale	Nurse Jessie should plan to document Ben's behavior every 15 to 30 min. Research has shown that clients are at highest risk for suicide during the first few days of facility admission and during times of staff changes.

Optimal Decision	
Scenario	Nurse Jessie addresses the spiritual necklace that Ben is wearing.

Question	During assessment, Nurse Jessie discovers Ben is wearing a necklace that holds spiritual significance. Which of the following actions should Nurse Jessie take?
Selected Option	Ask Ben to remove the necklace and offer chaplain services.
Rationale	Nurse Jessie should ask Ben to remove the necklace to ensure client safety. The nurse should also recognize that the necklace that Ben is wearing has significant spiritual meaning and, therefore, should offer the service of a professional chaplain to speak with Ben to ensure his spiritual needs are being met.

Optimal Decision	
Scenario	Nurse Jessie is planning Ben's care.
Question	Nurse Jessie is planning care for Ben. Which of the following provider prescriptions should Jessie anticipate?
Selected Option	Administer a selective serotonin reuptake inhibitor (SSRI).
Rationale	Nurse Jessie should anticipate the provider to prescribe a selective serotonin reuptake inhibitor (SSRI) to treat Ben's major depressive disorder. Jessie should closely monitor Ben as he begins his medication regimen. Jessie should also provide teaching about the benefits and risks of antidepressant therapy.

Optimal Decision	
Scenario	Nurse Jessie is reviewing medication information for lorazepam.
Question	Nurse Jessie is reviewing information related to the administration of lorazepam. Which of the following information should Nurse Jessie plan to include in the teaching?
Selected Option	Advise Ben to decrease lorazepam gradually.
Rationale	Nurse Jessie should instruct Ben that abrupt withdrawal can cause nausea, vomiting, muscle and abdominal cramps, and tremors.

Scenario	Nurse Jessie evaluates the effectiveness of lorazepam.
Question	Nurse Jessie has administered lorazepam to Ben. Nurse Jessie should assess for which of the following to determine if the medication has been effective?
Selected Option	Central nervous system changes
Rationale	Nurse Jessie should recognize that lorazepam can cause central nervous system adverse effects such as dizziness, drowsiness, lethargy, headache, slurred speech, confusion, and forgetfulness. However, when assessing for the effectiveness of the medication, the nurse should expect to see a decrease in the client's level of anxiety, which is a cognitive change.

Optimal Decision	
Scenario	Nurse Morgan identifies priority assessment findings regarding sertraline.
Question	Nurse Morgan has assessed Ben and is reviewing the electronic medical record. Nurse Morgan should identify that which of the following findings is the priority to report to the provider?

Selected Option	Electrolyte imbalance
Rationale	When using the urgent versus nonurgent client care framework, the nurse determines that the priority finding is hyponatremia. Hyponatremia poses increased medical concerns for Ben. The nurse should teach Ben dietary changes that will correct the deficiency. If hyponatremia is not corrected it can cause various organ alterations.

Optimal Decision	
Scenario	Nurse Morgan provides education for nonpharmacological treatment for major depressive disorder.
Question	Nurse Morgan is discussing nonpharmacological treatments for major depressive disorder with Ben. Which of the following statements should Nurse Morgan make?
Selected Option	"St. John's Wort should be avoided with your prescribed medication."
Rationale	Nurse Morgan should recognize that St. John's Wort has the potential for adverse reactions, such as serotonin syndrome, when taken with SSRIs, such as sertraline.

Optimal Decision	
Scenario	Nurse Morgan utilizes therapeutic communication techniques.
Question	Nurse Morgan is talking to Ben about his progress in the partial hospitalization program. Which of the following responses should Nurse Morgan plan to make?
Selected Option	"Tell me more about what you learned in the program."
Rationale	Nurse Morgan recognizes that asking Ben an open-ended question encourages him to share information and responses to situations. Open-ended questions are therapeutic and help to establish a rapport between Nurse Morgan and Ben.

Optimal Decision	
Scenario	Nurse Morgan evaluates Ben for improvement in Major Depressive Disorder.
Question	Based on Nurse Morgan's conversation with Ben and review of the electronic medical records, which of the following findings indicate a positive outcome to Ben's plan of care? (Select all that apply.)
Selected Ordering	Ben's self-worth Ben's coping mechanisms Ben's socialization Ben's hygiene
Rationale	Ben's appearance is much neater. His hair is combed, he is clean shaven, and his clothes are neat and match. Nurse Morgan should recognize, based on assessment findings, that Ben's appearance is an indication that his major depressive disorder is improving.

Individual Report – Score Explanation and Interpretation

Reasoning Scenario Information:

Reasoning Scenario Information provides the date, time and duration of use, along with the score earned for each attempt. A Reasoning Scenario Performance score of Strong, Satisfactory, or Needs Improvement is provided for each attempt. This information is also provided for the Optimal Decision Mode if it has been enabled.

Reasoning Scenario Performance Scores:

Strong	Exhibits optimal reasoning that results in positive outcomes in the care of clients and resolution of problems.
Satisfactory	Exhibits reasoning that results in mildly helpful or neutral outcomes in the care of clients and resolution of problems.
Needs Improvement	Exhibits reasoning that results in harmful or detrimental outcomes in the care of clients and resolution of problems.

Reasoning Scenario Performance Related to Outcomes:

A clinical reasoning performance score related to each outcome is provided. Outcomes associated with student responses are listed in the report. The number across from each outcome indicates the percentage of responses associated with the level of performance of that outcome.

NCLEX® Client Need Categories:

Management of Care	Providing integrated, cost-effective care to clients by coordinating, supervising, and/or collaborating with members of the multi-disciplinary health care team.
Safety and Infection Control	Incorporating preventative safety measures in the provision of client care that provides for the health and well-being of clients, significant others, and members of the health care team.
Health Promotion and Maintenance	Providing and directing nursing care that encourages prevention and early detection of illness, as well as the promotion of health.
Psychosocial Integrity	Promoting mental, emotional, and social well-being of clients and significant others through the provision of nursing care.
Basic Care and Comfort	Promoting comfort while helping clients perform activities of daily living.
Pharmacological and Parenteral Therapies	Providing and directing administration of medication, including parenteral therapy.
Reduction of Risk Potential	Providing nursing care that decreases the risk of clients developing health-related complications.

Physiological Adaptation	Providing and directing nursing care for clients experiencing physical illness.

Quality and Safety Education for Nurses (QSEN)

Safety	The minimization of risk factors that could cause injury or harm while promoting quality care and maintaining a secure environment for clients, self, and others.
Patient-Centered Care	The provision of caring and compassionate, culturally sensitive care that is based on a client's physiological, psychological, sociological, spiritual, and cultural needs, preferences, and values
Evidence Based Practice	The use of current knowledge from research and other credible sources, upon which clinical judgment and client care are based.
Informatics	The use of information technology as a communication and information gathering tool that supports clinical decision making and scientifically based nursing practice.
Quality Improvement	Care related and organizational processes that involve the development and implementation of a plan to improve health care services and better meet the needs of clients.
Teamwork and Collaboration	The delivery of client care in partnership with multidisciplinary members of the health care team, to achieve continuity of care and positive client outcomes.

Body Function

Cardiac Output and Tissue Perfusion	The anatomical structures (heart, blood vessels, and blood) and body functions that support adequate cardiac output and perfusion of body tissues.
Cognition and Sensation	The anatomical structures (brain, central and peripheral nervous systems, eyes and ears) and body functions that support perception, interpretation, and response to internal and external stimuli.
Excretion	The anatomical structures (kidney, ureters, and bladder) and body functions that support filtration and excretion of liquid wastes, regulate fluid and electrolyte and acid-base balance.
Immunity	The anatomic structures (spleen, thymus, bone marrow, and lymphatic system) and body functions related to inflammation, immunity, and cell growth.
Ingestion, Digestion, Absorption and Elimination	The anatomical structures (mouth, esophagus, stomach, gall bladder, liver, small and large bowel, and rectum) and body functions that support ingestion, digestion, and absorption of food and elimination of solid wastes from the body.
Integument	The anatomical structures (skin, hair, and nails) and body functions related to protecting the inner organs from the external environment and injury.
Mobility	The anatomical structures (bones, joints, and muscles) and body functions that support the body and provide its movement.

Oxygenation	The anatomical structures (nose, pharynx, larynx, trachea, and lungs) and body functions that support adequate oxygenation of tissues and removal of carbon dioxide.
Regulation and Metabolism	The anatomical structures (pituitary, thyroid, parathyroid, pancreas, and adrenal glands) and body functions that regulate the body's internal environment.
Reproduction	The anatomical structures (breasts, ovaries, fallopian tubes, uterus, vagina, vulva, testicles, prostate, scrotum, and penis) and body functions that support reproductive functions.

Decision Log

Information related to each question answered in a scenario attempt is listed in the report. A brief description of the scenario, question, selected option and rationale for that option are provided for each question answered. The words "Optimal Decision" appear next to the question when the most optimal option was selected.

The rationale for each selected option may be used to guide remediation. A variety of learning resources may be used in the review process, including related ATI Review Modules.

To Be Completed After the Simulation

The orange boxes should be filled out with your simulation patient's actual results, assessments, medications, and recommendations

NCLEX IV (7): Reduction of Risk

Actual Labs/ Diagnostics
Columbia Suicide Severity Rating
Hamilton Depression Rating Scale

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms
- insomnia   -"Don't want to be a burden"
- using alcohol to cope
- weight loss (12.5%)
- giving away possessions
- major personal losses

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
- recent job/personal loss
- anxiety disorder
- Family hx of suicide
- insomnia
- chronic back pain

Therapeutic Procedures
Non-surgical
- Group therapy

Surgical

N/A

NCLEX IV (7): Reduction of Risk

Prevention of Complications
(Any complications associated with the client's disease process? If not what are some complications you anticipate)

- Crisis care plan
- removed all alcohol from house
- removed all guns from home

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management
- Sertraline 50mg PO daily
- Lorazepam 2mg PO BID

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures
- milieu therapy
- yoga
- meditation
- distraction techniques instead of alcohol use
- therapy

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?
- loss of spouse
- loss of job
- insomnia

Client/Family Education

Document 3 teaching topics specific for this client.
- Sertraline side effects
- Other treatments (exercise, light therapy)
- Don't use St. Johns wort w/ Sertraline

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
- nurse   - Therapist   - family support system
- Tech   - Group therapy
- Psychiatrist - Outpatient treatment

Patient Resources
- Group therapy
- inpatient program   - family support
- partial hospitalization program   - support group for sobriety

Reflection Paper

Directions: Write reflection including the following:

1. What was your biggest "take away" from participating in the care of this client?

   It is so important to keep an eye on our loved ones. If we feel like something is wrong, we need to say something and do something. I feel like the fact that Jordan was able to convince his brother that he needed help was that thing that helped save his life.

2. What was something that surprised you in the care of this patient?
   I had not though much about the connection with chronic back pain and the increased risk of suicide. I know now this is an increased risk for suicide now.

3. What is something you would do differently with the care of this client?
   I would have liked to not been as blunt with Ben as the characters were. I know that speaking directly and deliberately is critical in understanding and forming a treatment plan for a client but it almost felt sterile and robotic. I would have softened my personal approach.

4. How will this simulation experience impact your nursing practice?
   I think it put a good perspective on how critical intervention can be for a person in crisis. I know that most people who are in such a vulnerable spot may not respond as quickly as Ben did. I know that we rely heavily on the multiple disciplinary team to make sure the interventions are effective. I also know that not being judgmental is critical to client care.

5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.
   Since Ben is a middle adult, he was able to contribute as a police officer. He was knocked off track when he lost his wife and ultimately his job. We see him rely heavily on his brother and family to help him get back on track. And although he lost his partner, he was able to remember the good time and move forward with alternate coping mechanisms. He was able to get back on track and was starting the job search soon. This is on target for his development.