

Module Report

Tutorial: Real Life RN Mental Health 4.0

Module: Major Depressive Disorder



Individual Name: Lucy Siranides

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	10/17/2023 9:20:14 PM	54 min	Satisfactory

Reasoning Scenario Details

Major Depressive Disorder - Use on 10/17/2023 8:48:09 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	94.4%		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	100%		
RN Pharmacological and Parenteral Therapies	100%		

QSEN	Strong	Satisfactory	Needs Improvement
Safety	100%		
Patient-Centered Care	100%		
Evidence Based Practice	88.9%		11.1%

Thinking Skills	Strong	Satisfactory	Needs Improvement
Clinical Application	100%		
Clinical Judgment	94.4%		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.

Optimal Decision	
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 Family history of suicide
Rationale	Ben has several known risk factors for suicidal behavior, including a family history of suicide.

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.

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	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.
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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.

Optimal Decision	
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	Cognitive changes
Rationale	Nurse Jessie should recognize that decreased feelings of anxiety is a cognitive finding used to evaluate the effectiveness of lorazepam.

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.
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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.
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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.

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

Student Name: Lucy Siranides

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: Major Depressive Disorder (MDD)

NCLEX IV (8): **Physiological Integrity/Physiological Adaptation**

Anatomy and Physiology

Normal Structures

- Monoamine Neurotransmitters –
- Monoamine auto-receptors provide feedback regulation in neurotransmitter release, and monoamine transporters clear the released neurotransmitters to control synaptic signaling
 - **Serotonin, 5-hydroxytryptamine (5-HT)** → mood, sleep regulation, hunger, pain perception, aggression, and libido
 - **Norepinephrine (NE)** → mood, attention and arousal, fight or flight in response to stress
 - **Dopamine (DA)** → fine muscle movement, integration of emotions and thoughts, decision making, stimulates hypothalamus to release hormones
- ***Y-Aminobutyric Acid (GABA)*** → reduces anxiety, aggression, pain perception, anticonvulsant and muscle-relaxing properties
- **Acetylcholine** → plays a role in learning and memory, regulates mood, mania, sexual aggression, stimulates the parasympathetic nervous system
- Structures of the Brain –
 - **The Limbic System** → (Amygdala, hypothalamus, hippocampus) regulates activities such as emotions, physical and sexual drives, and the stress response (as well as processing, learning, and memory)
 - **Frontal Lobe** → formulate or select goals; initiate, plan, terminate actions; decision making; insight; motivation; social judgment; voluntary motor ability starts in frontal lobe
 - **Parietal Lobe** → receive and identify sensory information; concept formation and abstraction; proprioception and body awareness; reading, mathematics; right and left orientation
 - **Temporal Lobe** → language comprehension; stores sounds into memory (language, speech); connects

NCLEX IV (7): **Reduction of Risk**

Pathophysiology of Disease

- MDD is a medical illness that affects how you feel, think, and behave, causing persistent feelings of sadness and loss of interest in previously enjoyed activities
- Symptoms present for at least 2 weeks
- Causes of the disorder are a combination of genetic, vulnerability, biochemical and physical changes in the brain, environmental factors, traumatic events, and other psychological and physiological factors
- Genetic: individuals who have a first-degree family member w/ depression are **two to four times** more likely to become depressed
 - However, genetic factors must interact w/ environmental and neurobiological preconditions for depression to respond to environmental stressor as being a significant risk factor
- One theory states that depression is thought to involve changes in receptor-neurotransmitter relationships in the following areas of the brain: limbic system (emotional alterations), hypothalamus (mood regulation), prefrontal cortex (decreased mood, problems concentrating), hippocampus (memory impairments; feelings of worthlessness, hopelessness, and guilt), amygdala (anxiety and reduced motivation)
 - **Serotonin, 5-hydroxytryptamine (5-HT)** → serotonin-circuit dysfunction can result in poor impulse control, low sex drive, decreased appetite, disturbed regulation of body temperature, and irritability
 - **Norepinephrine (NE)** → account for symptoms of **anergia** (reduction in or lack of energy), **anhedonia** (an inability to find meaning or pleasure in existence), decreased concentration, and diminished libido
 - **Dopamine (DA)** → play a role in the reward and incentive behavior processes, emotional expression, and learning processes that are disrupted in depression
 - **Glutamate, Y-Aminobutyric Acid (GABA), and Acetylcholine** → play a role in the etiology of depression

- w/ limbic system, “the emotional brain,” to allow expression of emotions (sexual, aggressive, fear, etc.)
- **Occipital Lobe** → interprets visual images; visual association; visual memories; involved w/ language formation

- **Cognitive Theory** → predisposed to depression through early life experiences
 - Beck’s cognitive triad:
 - Negative, self-deprecating view of self
 - Pessimistic view of the world
 - Belief that negative reinforcement will continue
 - CBT → what you think = what you do
- **The Stress-Diathesis Model of Depression** → biopsychosocial theory that explains depression from an environmental, interpersonal, and life-events perspective combined w/ biological vulnerability or predisposition
 - Psychosocial stressors and interpersonal events can trigger certain neurophysiological and neurochemical changes in the brain
 - Neurotransmitter depletion may occur and cause permanent neuronal damage, leaving the person vulnerable to depression later in life

To Be Completed Before the Simulation

Anticipated Patient Problem – Impaired Mood Regulation: Depression

Goal 1: ATI will keep a journal expressing thoughts and feelings during my time of care.

Goal 2: ATI will identify negative thoughts and rationally counter them and/or reframe them in a positive manner during my time of care.

<p align="center">Relevant Assessments</p> <p>(Prewrite) What assessments pertain to your patient’s problem? Include timeframes</p>	<p align="center">Multidisciplinary Team Intervention</p> <p>(Prewrite) What will you do if your assessment is abnormal?</p>
<p>Assess feelings and attitudes towards self qshift and PRN.</p>	<p>Administer antidepressants as ordered.</p>
<p>Assess trigger(s) of depression and/or predisposing factors on admission.</p>	<p>Facilitate a safe and supportive environment by through a clean, organized space free of harassment or judgement continuously/qshift.</p>
<p>Assess expectations for themselves, their family, the community, and healthcare workers during my time of care.</p>	<p>Establish a schedule and routine when inpatient and adapt a similar system for when discharged during my time of care.</p>
<p>Assess daily activities from before admission upon admission.</p>	<p>Encourage self-care (i.e., bathing, oral hygiene, getting dressed each day, getting out of bed, etc.) qday or when appropriate.</p>
<p>Assess knowledge of early signs of depression (i.e., sleep disturbances, anhedonia, fatigue, irritability, etc.) prior to discharge.</p>	<p>Educate on signs of depression (i.e., sleep disturbances, anhedonia, fatigue, irritability, etc.) and encourage contacting support system, hotlines, therapist, etc. when signs are recognized prior to discharge.</p>
<p>Assess knowledge and adherence to medication regimen (i.e., of antidepressants, benzodiazepines, anxiolytics, antipsychotics, etc.) during my time of care.</p>	<p>Educate on medication administration, schedule, and any possible side effects (involve family/support system in education) prior to discharge.</p>

To Be Completed Before the Simulation

Anticipated Patient Problem – Risk for Self-Directed Violence

Goal 1: ATI will identify at least two people he/she can seek out for support and emotional guidance when he/she is feeling self-destructive before discharge.

Goal 2: ATI will not inflict any harm to themselves or others during my time of care.

Relevant Assessments	Multidisciplinary Team Intervention
(Prewrite) What assessments pertain to your patient's problem? Include timeframes	(Prewrite) What will you do if your assessment is abnormal?
Assess for ideas of self-mutilation or suicidal ideation/plan qshift and PRN.	Remove any items that may cause harm (i.e., tubing, wires, trash bags, curtains, etc.) and initiate suicide precautions if indicated.
Assess current (or need for) support system on admission and prior to discharge.	Contact the family and arrange for crisis counseling prior to discharge.
Assess history of substance abuse on admission.	Establish rapport through therapeutic communication and convey acceptance qshift.
Assess knowledge of resources available after discharge during my time of care.	Educate the client about crisis intervention services such as suicide hotlines, websites, support groups, and other resources prior to discharge.
Assess for aggressive behavior and expressions of anger qshift and PRN.	Encourage participation in physical activity, art therapy, or listening to music qshift and PRN.
Assess coping mechanisms utilized during times of stress, hopelessness, sadness, etc. on admission and PRN.	Educate on effective coping mechanisms (i.e., walking, running, drawing, journaling, mindfulness, therapy, etc.) prior to discharge and PRN.

To Be Completed During the Simulation:

#1 Actual Patient Problem: Risk for Suicide Behavior
 Goal: B.R. will establish a Crisis Safety Plan with the nurse, including the identification of triggers (i.e., bars, coworkers, holidays), coping strategies (i.e., exercise, deep breathing), and emergency contacts (i.e., Jordan, Bob, Rebecca) prior to discharge. Met: Unmet:
 Goal: B.R. will refrain from abusing substances (i.e., alcohol) and will not keep his lethal weapons in his possession after discharge. Met: Unmet:
 #2 Actual Patient Problem: Impaired Mood Regulation: Depression
 Goal: B.R. will demonstrate compliance with medications (i.e., Lorazepam, Sertraline) and the treatment plan (i.e., attending therapy session) during my time of care. Met: Unmet:
 Goal: B.R. will feel connected with others (i.e., staff members and family) to share thoughts, feelings, and beliefs during my time of care. Met: Unmet:

Additional Patient Problems:

#3 Anxiety
 #4 Imbalanced Nutrition: Less Than Body Requirements
 #5 Risk for Acute Substance Withdrawal Syndrome: Alcohol
 #6 Ineffective Coping
 #7 Complicated Grieving
 #8 Disturbed Sleep Pattern
 #9 Readiness for Enhanced Hope
 #10 Readiness for Enhanced Coping

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, 5, 6, & 7	01/26 1200	Stated "I'm drinking a lot lately. There's nothing about life that's enjoyable anymore, and I need help."	01/26 1202	Recommended meeting at the mental health clinic and established rapport through supportive and therapeutic communication	01/26 1205	Agreed to come into clinic (accompanied by brother, Jordan); hesitant to express feelings, and offered limited information about life
1, 2, 5, 6, & 7	01/26 1245	Stated "My partner Claire died about six months ago," "I lost my job," "I'm spiraling out of control."	01/26 1248	Utilized open-ended questions and statements to gather more information about partner's death, loss of job, and drinking habits	01/26 1252	Stated "My life's just not the same anymore," "And the only thing that helps is drinking."
1, 2, 5, 6, & 7	01/26 1255	Stated "It [drinking] helps me relax," "It helps make the day go by faster."	01/26 1258	Utilized SBIRT questioning (i.e., frequency of drinking, when last drink was)	01/26 1301	Stated "I haven't had a beer in three days. But I was drinking at least a six pack a day. And some days were probably a little more than that."
1, 2, 5, 6, & 7	01/26 1303	Stated "It's been difficult not having a drink. I want to go to the bar."	01/26 1306	Utilized therapeutic communication through acceptance and recognition about	01/26 1310	Stated "My partner Claire and I used to go for long walks. I also did a lot of traveling."

				drinking; focused on coping skills present		Those were happy times.”
2, 3, 6, & 7	01/26 1311	Stated “But I just find myself so lonely and anxious now.” (Jordan) stated “Even before Claire died, you were diagnosed with an anxiety disorder.”; has not been taking medication for anxiety	01/26 1314	Utilized therapeutic communication via the exploring technique to gather information on medications	01/26 1315	(Jordan) stated “The anxiety medication is venlafaxine.” Stated “Tramadol for my back pain.” Relayed that back injury occurred at work and received surgery
1, 2, 3, 4, 6, 7, & 8	01/26 1317	(Jordan) stated “He also hasn’t been sleeping since Claire died. And recently, he’s lost weight and doesn’t have an appetite for anything.” Stated “Just don’t have the energy to fix anything,” “I just don’t want to be a burden.”	01/26 1318	Offered a general lead to speak further about sleep habits and weight	01/26 1319	Stated “I can’t stay asleep,” “Lately, I don’t even try to sleep,” “I lost 25 pounds the last month and a half,” “Just don’t want to eat.” Evidence of insomnia and significant weight loss (12.5% of original weight in one month)
1, 2, 6, & 7	01/26 1319	Expressed feelings of hopelessness; stated “I just don’t think I’m ever going to get better.”	01/26 1320	Restated and clarified the information given about recent events, losses, and emotions	01/26 1320	Depressed affect; infraorbital edema (bags under eyes)
1 & 2	01/26 1320	(Jordan) relayed the intent to give away valued possession such as a motorcycle and a gun collection	01/26 1345	Conducted the Columbia-Suicide Severity Rating Scale (C-SSRS)	01/26 1350	Results of C-SSRS are in the high-risk category; experiencing suicidal ideation w/ intent
1, 9, & 10	01/26 1352	Stated “I’m getting sick of all these questions.”	01/26 1357	Recommended transfer to an acute facility w/ individualized care and therapy sessions; offered answers to any questions	01/26 1359	Agreed to go to acute facility; stated “I’m just ready to get some help.”
1, 9, & 10	01/26 1500	Transferred to inpatient facility	01/26 1505	Explained treatment plan and provided a pamphlet w/ more information; ensured patient care tech present before leaving	01/26 1508	Stated “Ok, sounds good.”
1, 2, 3, 5, 6, & 7	01/26 1515	History of anxiety disorder, access to lethal means of suicide, increased alcohol use, family history of suicide, death of partner	01/26 1520	Removed personal items that may pose a safety risk – razor, shoes w/ laces, pants w/ drawstring, cell phone, picture frame, and pen	01/26 1525	Conveyed understanding of process; stated “Yeah, that’s fine.”
1 & 7	01/26 1530	Necklace holds significant meaning, received from partner, feels comfort and protection from it	01/26 1535	Removed the necklace and offered chaplain services	01/26 1536	Reluctant to remove necklace
2 & 3	01/26 1550	Seemed more nervous than when first arrived at facility; stated “My heart is racing, and I just feel funny.”	01/26 1553	Ordered and then administered Sertraline and Lorazepam 2mg (2x/day) PO; educated on use	01/26 1558	Verbalized understanding of medications; agreed to take Sertraline and Lorazepam

2, 3, 6, 7, 9, & 10	02/21 0900	Participating in partial hospitalization program; stated "I'm better, I'm not back to my old self yet;" attending individual and group therapy sessions; prescribed medications to help with anxiety and depression	02/21 0902	Provided information about partial hospitalization program and details about sessions offered; educated on side effects of Sertraline and Lorazepam	02/21 0908	Experiencing electrolyte imbalance
2 & 8	02/21 0915	Relayed lack of knowledge about nonpharmacological treatments for depression; stated "The only thing I've tried in the past is St. John's Wort to help with my sleep."	02/21 0915	Educated on light therapy, exercise, and to refrain from taking St. John's Wort w/ prescribed medication	02/21 0918	Verbalized understanding of other treatment methods and medication regimen
1, 2, 3, 6, 7, 9, & 10	02/21 0930	Reports having no thoughts of harming self; conveys beliefs that the medications and therapy sessions are beneficial	02/21 0930	Utilized open-ended questions and statements to allow for more thoughts and feelings about what was learned in the program to be shared	02/21 0935	Improvement is felt in self-worth, hygiene, socialization, and coping mechanisms; Hamilton Depression (HAM-D) Rating Scale score 0
1, 2, 3, 4, 5, 6, 7, 8, 9, & 10	02/21 0940	Makes eye contact; has an upbeat voice, pleasant affect, positive demeanor; preforms ADLs independently; has feelings of hopefulness; sets realistic goals; able to problem solve, concentrate, make decisions; sleeps 6hrs/night; reports eating a well-balanced diet	02/21 0950	Transitioned to intensive outpatient program; provided information w/ additional resources; recommended removing all alcohol from home and having Jordan keep the guns locked at his house; developed a Crisis Safety Plan	02/21 1000	Stated "Thank you for the information...And I'm looking forward to finding a support group that will help me maintain my goal of sobriety."

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
- DSM-5
 - **Columbia-Suicide Severity Rating Scale (C-SSRS)**
 - **Hamilton Depression (HAM-D) Rating Scale**
 - Beck Depression Inventory (BDI)
 - The Patient Health Questionnaire-9 (PHQ-9)

NCLEX II (3): Health Promotion and Maintenance

- Signs and Symptoms
- **Depressed Mood**
 - **Anhedonia**
 - **Change in weight**
 - **Anxiety**
 - **Insomnia** or hypersomnia
 - Psychomotor agitation or retardation
 - **Fatigue or energy loss**
 - Feelings of worthlessness or guilt
 - Diminished concentration or indecisiveness
 - Recurrent thoughts of death or **suicidal thoughts**

NCLEX II (3): Health Promotion and Maintenance

- Contributing Risk Factors
- History of prior episodes of depression
 - Family history of depressive disorder, especially in first-degree relatives
 - History of suicide attempts or **family history of suicide**
 - Member of the LGBTQ community
 - Female gender
 - **Age 40 years or younger**
 - Postpartum period
 - Chronic medical illness
 - Absence of social support
 - **Negative, stressful life events**, particularly early trauma
 - **Active alcohol or substance use disorder**
 - History of sexual abuse

NCLEX IV (7): Reduction of Risk

- Therapeutic Procedures
- Non-surgical
- **Communication**
 - **Health teaching and health promotion**
 - **Milieu therapy**
 - First-line psychotherapy interventions
 - **Cognitive Behavioral Therapy (CBT)**
 - **Interpersonal psychotherapy (IPT)**
 - Mindfulness-Based Cognitive Therapy
 - **Group therapy**
 - **Medication**
 - Light Therapy
- Surgical
- Electroconvulsive Therapy
 - Transcranial Magnetic Stimulation
 - Vagus Nerve Stimulation

- Prevention of Complications
(Any complications associated with the client’s disease process? If not what are some complications you anticipate)
- **Risk for suicide**
 - Risk for self-injury behaviors
 - **Insomnia**
 - **Weight loss/gain**
 - **Loss of job**
 - **Substance abuse**
 - **Loss of family/friends**

NCLEX IV (6): Pharmacological and Parenteral Therapies

- Medication Management
- **Selective Serotonin Reuptake Inhibitors (SSRIs) (Sertraline)**
 - Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)
 - Atypical Antidepressants
 - Tricyclic antidepressants (TCAs)
 - Monoamine oxidase inhibitors (MAOIs)
 - **Benzodiazepine (Lorazepam 2mg 2x/day)**

NCLEX IV (5): Basic Care and Comfort

- Non-Pharmacologic Care Measures
- Allow client to cry
 - **Encourage independence in the performance of ADLs**
 - **Help the client set goals**
 - Help the client identify areas of his or her life that they can and cannot control
 - **Convey an attitude of acceptance**
 - **Close observation/suicide precautions**
 - **Encourage expression of feelings**
 - **Physical Activity**
 - **Deep breathing**
 - Journaling/art therapy

NCLEX III (4): Psychosocial/Holistic Care Needs

- Stressors the client experienced?
- **Suicidal ideation**
 - **Loss of job → financial burden**
 - **Admitting help is needed**
 - **Feelings of hopelessness, worthlessness, guilt**
 - **Remembering to attend appointments and adhering to medication regimen**
 - Judgement from family or friends
 - **Refraining from substance abuse**
 - **Anxiety**
 - **Weight loss**
 - **Insomnia**

Client/Family Education

- Document 3 teaching topics specific for this client.
- Educate on signs and symptoms of depression relapse (i.e., insomnia, anhedonia)
 - **Educate on medication action and side effects (i.e., SSRIs)**
 - **Educate on healthy coping mechanisms (i.e., exercise, journaling, deep breathing etc.) and refrain from substance abuse**

NCLEX I (1): Safe and Effective Care Environment

- Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
- Psychiatrist
 - Nutritionist
 - Nurse Practitioner
 - Family
 - 1:1 Sitter
 - Pharmacy
 - Case Manager

- Patient Resources
- Therapist
 - Support groups
 - Hotlines
 - Pharmacy

Reflection Paper

Directions: Write reflection including the following:

1. What was your biggest “take away” from participating in the care of this client?
My biggest “take away” from participating in the care of Ben was how important his support system was to him. After suddenly losing his partner, Claire, Ben leaned heavily on his brother, Jordan. When Ben’s emotional and physical state began to worsen, Jordan supported Ben and reached out for help on his behalf. Jordan accompanied Ben to the mental health clinic and was very involved in his care and treatment. During the admission/intake, Jordan offered more information (with Ben’s permission) about his brother in order for the healthcare team to obtain a full view of Ben’s condition and situation. Jordan was sure to visit Ben when he was transferred to the acute inpatient facility and be involved in his safety as Ben improved by ensuring Ben’s gun collection was locked securely at his own home. It is important to remember that not all clients have a strong support system, but to involve those that do in the client’s care for increased successful outcomes.
2. What was something that surprised you in the care of this patient?
Something that surprised me in the care of Ben was how open and honest he was about his feelings despite his struggles with coping. While he was reluctant to voice his emotions and detailed information about his life in the beginning, he quickly opened up to the nurse and began sharing more. Ben was able to take the first step to recovery by asking for help and following through by going to the mental health clinic. He kept up with attending both group and individual therapy sessions and adhered to his medication regimen. The simulation did not portray any regression or relapse during Ben’s treatment which was also surprising to me, each day it seemed that Ben improved.
3. What is something you would do differently with the care of this client?
While all members of Ben’s healthcare team gave him ample information about all aspects of his treatment and resources available to him, I believe it may have been beneficial to explore the nonpharmacological treatments for depression earlier on in his care. On the day that Ben was going to transition from the partial hospitalization program to the intensive outpatient program, the nurse educated on nonpharmacological treatments that could be used in conjunction with his medications. Ben had relayed that he did not realize that exercise could assist him in feeling better and displayed interest in trying to be more active.
4. How will this simulation experience impact your nursing practice?
This simulation will impact my nursing practice as it served as a great example for therapeutic communication with clients who are impacted by mental disorders. While I feel confident speaking with clients, I recognize that my therapeutic communication could always use improvement. In this instance, I feel that the simulation will help me significantly when communicating with all future clients and when I have my clinical rotation at Dover Behavioral Health next week. The healthcare team involved in Ben’s care allowed Ben to share his thoughts and feelings at his own pace and used the appropriate techniques to elicit more information when it was needed. I hope to be able to communicate with my clients as the nurses and psychiatrist did so seamlessly with Ben.
5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.
During the simulation, Ben was 35 years of age and displayed some deviations of growth and development due to his condition of major depressive disorder. For example, typically in middle adulthood work is more crucial and one becomes more occupied with creative and meaningful work and with issues surrounding family. However, Ben had experienced the loss of his partner and his job which contributed to the development of his depression. With these losses, Ben was not able to achieve the life goals established for himself and stated that he did not see the point of living life anymore. In terms of physical development, Ben would be considered to follow normal growth and development for a middle adult.