

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

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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

NCLEX IV (8): Physiological Integrity/Physiological Adaptation

Anatomy and Physiology
Normal Structures

The brain is a complex organ that controls thought, memory, emotion, touch, motor skills, vision, breathing, temperature, hunger and every process that regulates our body. The brain is made up of the cerebrum, brainstem, and cerebellum. The brain has four lobes: Frontal, parietal, occipital, and temporal. The frontal lobe and the prefrontal cortex is responsible for decision making, motivation, problem-solving, planning and attention. The parietal is responsible for touch processing information, spatial awareness, and attention. The occipital lobe is responsible for our vision and interpreting things we see. The temporal lobe is responsible for sensory input (visual and auditory) into derived meanings for retention of visual memory and language comprehension. The brain also houses the limbic system which controls our emotions, learning, and memories. Within the limbic system is the Hypothalamus (which plays a role in controlling behaviors, as well as hunger, thirst, and sleep), the Amygdala (responsible for anger, fear, anxiety, etc.), and The Hippocampus (which is responsible for storing memories and learning).

In addition to the structures of the brain, there are neurotransmitters in the brain. These neurotransmitters transmit and carry signals / target cells. Dopamine is responsible for mood regulation, movement, and pleasure. Serotonin is responsible for a positive mood, digestion, and nausea. Norepinephrine is responsible for the fight or flight response. It can control stress, alertness, arousal, attention, and sleep.

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

Major depressive disorder, characterized by depressed mood, anhedonia, impaired cognitive function, and disturbed sleep processes for at least a 2 week period. There is usually no hx of manic behavior (could be a Bipolar diagnosis). MDD can occur due to environmental factors such as sexual, physical, or emotional abuse during childhood. MDD is also associated with alterations in the hippocampus (smaller in people with MDD). This would make it harder to retain information learned and form short term memories. Activity in the Amygdala is higher, causing more fear, anxiety, and anger. Dopamine, norepinephrine, and serotonin neurotransmitter levels are found to be decreased in people with MDD

To Be Completed Before the Simulation**Anticipated Patient Problem:** Risk for Suicide**Goal 1:** The client will verbalize suicidal thoughts to nurse/provider 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 thoughts of suicide /plan q12hr+PRN	Implement suicide precautions (remove wires, paper scrubs, no strings, 1:1 sitter) in my time of care
Assess mood/affect q12hr+PRN	Encourage client to express feelings and perception of problems q12hr
Assess client's willingness to discuss factors contributing to depression qshift	Establish trust and rapport by providing 1:1 time and attention, being genuine and honest at beginning of my shift and PRN
Assess support system at beginning of my shift	Encourage client to Join support groups q12hr
Assess client's current coping skills at beginning of shift.	educate client about new productive coping skills (walking, talking with family or friends, reading, sports, etc.) q12hr
Assess for signs and symptoms of depression qshift	Administer antidepressant as ordered PRN

Goal 2: The client will refrain from self-harm during my time of care

To Be Completed Before the Simulation**Anticipated Patient Problem: Ineffective coping**

Goal 1: The client will identify 1 unhealthy coping skill and 1 healthy coping skill during my time of care

Goal 2: The client will identify 1 support person to reach out when having difficulty coping 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 client's current coping skills PRN	Educate client about healthy coping skills (walking, reading, talking with a friend, deep breathing, etc.). qshift
Assess support system q12hr	Encourage client to make a list of people to reach out to when having difficulty coping qshift
Assess for substance use PRN	Provide resources to help client decrease substance use(AA/NA, nicotine patches, etc.) qshift
Assess nutritional status q4hr	Encourage client to eat small and frequent meals during my time of care
Assess for presence or symptoms of anxiety q12hr+PRN	Establish trust and rapport by using active listening and avoiding offering false reassurance during my time of care
assess knowledge of resources available for coping skills (support groups and therapy) q12hr	Educate on importance of starting outpatient therapy qshift

To Be Completed During the Simulation:

<p>Actual Patient Problem: Risk for Suicide</p> <p>Goal: Ben will verbalize to a nurse/provider if he is having suicidal thoughts or feelings of wanting to self-harm Met: <input checked="" type="checkbox"/> Unmet: <input type="checkbox"/></p> <p>Goal: Ben will identify 2 people or places he can seek for support to reach out to in crisis before D/C Met: <input checked="" type="checkbox"/> Unmet: <input type="checkbox"/></p> <p>Actual Patient Problem: Ineffective Coping</p> <p>Goal: Ben will verbalize at least one coping skill that helped him before D/C Met: <input checked="" type="checkbox"/> Unmet: <input type="checkbox"/></p> <p>Goal: Ben will identify and verbalize signs of worsening anxiety/ depression (sleep disturbances, lack of appetite, loss of interest) during my time of care Met: <input checked="" type="checkbox"/> Unmet: <input type="checkbox"/></p>

Additional Patient Problems:

(3) Anxiety, (4) Imbalanced nutrition: less than body requirements, (5) Ineffective health self-management, (6) Readiness for enhanced health management

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
1,5	Day 1 0800	Jordan called the mental health clinic because he was concerned about his brother Ben because of his depression and drinking	Day 1 0810	Alex encouraged Ben to talk about what was going on. Alex told him that is was a great first step to admitting that he needs help	Day 1 0815	Ben stated “There is nothing enjoyable anymore” speech is stuttering, mood is depressed, affect is flat. Appears sad, disheveled, hair not kept.
1,2,3,4,5	Day 1 0817	Ben lacked eye contact, stated “my partner Claire died six months ago”. Also stated “I lost my job and I feel like I have no control over my life anymore”. Started crying	Day 1 0818	Alex asked open ended questions. Encouraged Ben to express what he is feeling and going through	Day 1 0820	Ben stated drinking helps him relax and he has not drank beer for 3 days. Stated he used to cope by talking walks with his partner. Also stated “I just find myself so lonely and anxious now. Ben admits to having been dx with an anxiety disorder, has not been taking

						medication, and has not been sleeping or eating well.
1,2,4,5	Day 1 0830	Lost 12.5% weight in a month, wanted to give his motorcycle to Jordan's son. Ben has a gun collection at home and stated, "I just don't think life is worth living for".	Day 1 0835	Passed information to the nurse practitioner and thanked Ben for coming in. Nurse Practitioner asked if they had any questions or concerns	Day 1 0840	Ben still not making eye contact and observed a flat affect.
1,4	Day 1 0845	Alex stated that Ben "I have no control over my life.	Day 1 0850	Jamie and Alex identified some cues and started to determine his suicide risk, did an assessment to assess risk of suicide and feelings of depression	Day 1 0900	Stuttering, looked at the ground, flat affect. Stated" I'm getting sick of all these questions
1,2	Day 2 0810	Jamie notified that Ben is going to be transferred to an acute facility.	Day 2 0820	Educated Ben that his time spent in the acute facility will depend on his progress and treatment plan.	Day 2 0825	Alex called the acute facility and gave report about Ben.
1,2,4	Day 2 0900	Ben arrived to acute facility. Appears tired, disheveled, not maintaining eye contact.	Day 2 0910	Nurse Jessie Provided information about his treatment plan. Educated him that he will attend group, psychotherapy, and CBT. Educated on healthy coping skills (Exercise, relaxation techniques), and to develop a safety plan.	Day 2 0915	Ben asked about a crisis safety plan
1,2,4	Day 2 0930	Ben appeared happy to see Jordan. Became upset when nurse was checking clothes. Started crying	Day 2 0935	Nurse checked his belongings and removed objects that caused a risk. The Nurse implemented suicide precautions.	Day 2 0938	Ben appeared annoyed. The nurse told him that he will have a 1:1 sitter and asked him to remove necklace.

1,2,3	Day 2 0940	Liz stated that prescriptions will meet Ben's needs and will have Mileu therapy.	Day 2 0945	Nurse administered Sertraline 50mg PO daily	Day 2 0950	Nurse reported that Ben seemed more nervous and review information on lorazepam
1,2,3,4	Day 2 1000	Ben fidgeting with fingers, stated "my heart is racing and feels funny".	Day 2 1010	Encouraged to take Lorazepam and to taper down. Administered Lorazepam 2mg PO bid	Day 7 1015	Nurse Morgan talked to Ben; Ben stated, "feels better but not back to old self". Ben joined group therapy
2,6	Day 7 1018	Ben was unaware of nonpharmacologic approaches.	Day 7 1020	Nurse Morgan educated Ben taught about light exercise.	Day 7 1025	Stated "I am taking John's wart".
1,2,6	Day 7 0900	Appeared well groomed, dressed well, made eye contact. Reports no thoughts of self-harm. Reports he has been doing yoga, started to ride motorcycles with friends, listens to music, and plans to start looking for a job soon.	Day 7 0910	Nurse Morgan encouraged Ben to talk about what he had learned in the program.	Day 7 0915	Stated "therapy has helped me interact with others especially with his feelings and emotions". He also stated that does not use EtOH for his coping strategy, stated "I'm working toward building my confidence.
1,2,6	Day 7 0920	Ben is going to intensive outpatient programs.	Day 7 0925	Nurse Morgan provided suicide helpline number and community and local agencies that can help him as well as personal contacts that he can reach when a crisis begins.	Day 7 0930	Reported that he already gave his guns to Jordan and stated that he is looking forward to finding support to maintain goals of sobriety. Reported that outpatient will provide him with more information.

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

- Suicide Risk assessment
- SAFE-T assessment

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms

Poor concentration, impaired judgment, anhedonia, fatigue, slow comprehension, unable to comprehend, lethargic, disheveled

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors

- Anxiety
- Loss of a job
- Death of spouse
- Chronic pain
- Family hx of depression and suicide (uncle)
- Increased alcohol use

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures

Non-surgical

- ECT

Surgical

Prevention of Complications

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

- Suicide (has guns at home)
- Weight loss

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management

- Venlafaxine
- Sertraline
- Lorazepam
- Tramadol – for backpain r/t work injury

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures

- CBT
- Exercise
- Light therapy
- Relaxation techniques
- Group therapy
- Mileu therapy

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?

- Loss of spouse
- Loss of job
- Loss of control (d/t inpatient admission)
- EtOH

Client/Family Education

Document 3 teaching topics specific for this client.

- Different coping mechanism
- importance of safety plan
- how to take lorazepam

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement

(Which other disciplines were involved in caring for this client?)

Mental health facility/ nursing, family, primary care doctor, outpatient therapist, support group

Patient Resources

Outpatient support groups, safety plan, crisis line numbers

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 this client was how important therapeutic communication is and how it really made a difference in caring for this patient. I observed a lot of active listening, offering clarification, restating, and offering information. These all not only allowed Ben to share pertinent information, but it relieved a little bit of his anxiety as he was transferring from the clinic, to the inpatient facility, to the partial treatment center. I also realized how important a support system was. Jordan was crucial in Ben seeking help and remaining positive throughout his treatment.

2. What was something that surprised you in the care of this patient?

What surprised me in the care of this patient was the safety measures that were in place to keep Ben safe. The suicide precautions, the searching of his clothes, and even having him remove his necklace. Even though safety was very important, they did try to offer holistic care by offering chaplain services when they asked Ben to hand over his necklace given to him by his partner Claire.

3. What is something you would do differently with the care of this client?

In this scenario, I heard a lot of great things involving nonpharmacologic interventions related to building support systems and reducing anxiety. I think if I were involved in his care again, I would introduce more positive coping skills. I know some were discussed, but I would covering different breathing techniques, reading, riding a bike, or painting.

4. How will this simulation experience impact your nursing practice?

This simulation really did a great job of showing the extent of MDD in regards to all of the cumulating factors that lead to Ben coming in. His partner passing, him losing his job, drinking EtOH to cope. This taught me that as a nurse, I will need to realize that not everything has one direct link to the source and that therapeutic communication is key to drawing that information out.

5. Discuss norms or deviations of growth and development that was experienced during the simulation, including developmental stage.

For Piaget, I believe Ben fell into the formal operations stage. In the beginning, he wasn't able to think logically, due to the stressors and coping skills worsening his anxiety and his depression. However, by the end he was able to think logically and use deductive reasoning. As for Erikson, Ben would most likely fall into the Generativity vs stagnation. Even with the passing of Claire, he was still trying to get a job, and meet try new things.