

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

Student Name: Kaitlyn Stahre

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 controls thoughts, memory, emotion, touch, motor skills, and other processes that regulate our body. Together the brain and spinal cord make up the central nervous system. The brain is made up of carbohydrates, salts, blood vessels, nerves, neurons and glial cells. The brain also contains gray and white matter which are two different regions of the CNS. The grey matter is the darker outer portion whereas the white matter is the lighter inner section of the brain. Gray matter is responsible for processing and interpreting information while the white matter transmits information to other parts of the CNS. The brain works by sending and receiving chemical electrical signals throughout the body in which the brain interprets. The brain can be divided into 3 different main parts: the cerebellum, cerebrum, and the brainstem. The cerebrum initiates and coordinates movement and regulates temperature. The brainstem connects the cerebrum to the spinal cord. The cerebellum is located at the back of the head and coordinates voluntary muscle movements to help maintain posture, balance, and equilibrium. The brain also has deeper structures within the brain. The pituitary gland regulates the flow of hormones from the thyroid. The hypothalamus helps regulate body temperature, sleep patterns, hunger, thirst and some aspects of memory/emotion. The amygdala controls the fight or flight response when someone perceives a threat. Lastly the hippocampus supports memory, learning, and perception of space. All together these systems in the brain work together in order to regulate everything through the body which is why it plays a huge factor in someone with Major depression disorder.

NCLEX IV (7): Reduction of Risk

Pathophysiology of Disease

When one has depression the brain functions differently than of someone who does not struggle with depression. With someone who has depression the brain matter contains less grey matter than usual. The sulci and gyri in the brain shrink which can cause a lack of control one has over their emotions, memory, and decision-making abilities. The neurotransmitters dopamine and serotonin are significantly lower in the brain which are what regulate our moods in general. Dopamine plays a role in the happy chemical and pleasure whereas serotonin contributes to the reward center. Therefore, with a decrease in both is what we have seen in someone with depression. There is also a mutation that has been found in the brain to cause depression. This mutation is the 5-HTT gene and can make people less resilient to depression when a crisis hits. With all of these pathophysiological changes in the brain as well as life crisis and traumatic events can cause someone to have major depression disorder.



To Be Completed Before the Simulation

Anticipated Patient Problem: Risk for suicide

Goal 1: Pt will identify stressors/factors that cause them to think of suicide by the end of my time of care.

<p style="text-align: center;">Relevant Assessments</p> <p>(Prewrite) What assessments pertain to your patient's problem? Include timeframes.</p>	<p style="text-align: center;">Multidisciplinary Team Intervention</p> <p>(Prewrite) What will you do if your assessment is abnormal?</p>
<p>Assess history of suicide ideations / attempts prn.</p>	<p>Implement suicide precautions prn.</p>
<p>Assess support system prn.</p>	<p>Educate on the importance of having a support system and provide resources of groups prn.</p>

Assess for suicide ideation plan prn.	Initiate a safety plan with the pt and educate support system of warning signs to look out for prn.
Assess current coping skills prn.	Assist pt with learning coping skills that can help prevent suicide ideation prn.
Assess for feelings of hopelessness/helplessness prn.	Establish rapport and maintain a calm environment prn. Provide group resources and assist with learning coping skills prn.
Asses for alcohol or substance use disorder prn.	Educate on the factors that drugs and alcohol have on depression prn.

Goal 2: The Pt will establish a safety plan and coping strategies when feeling suicide ideation by the end of my time of care.

To Be Completed Before the Simulation

Anticipated Patient Problem: Ineffective coping

Goal 1: Pt will identify their disruptive behaviors and how it prevents them from coping during my time of care.

Relevant Assessments (Prewrite) What assessments pertain to your patient's problem? Include timeframes.	Multidisciplinary Team Intervention (Prewrite) What will you do if your assessment is abnormal?
Assess any stressors in the pts life prn.	Provide stress relieving activities like music therapy prn.
Assess present coping skills prn.	Assist the pt with forming new coping skills prn.
Assess support system and resources prn.	Educate on the importance of support systems and provide resources prn.
Assess pts insight/perception of their disorder prn.	Use therapeutic communication by actively listening and reflecting on what the pt is saying prn. Educate on disorder prn.
Assess pts will and mood about change prn.	Assist the pt in establishing goals for their recovery prn.
Assess nonverbal signs of stress prn.	Implement a calm relaxing environment and establish rapport prn.

Goal 2: Pt will verbalize appropriate coping strategies and resources during my time of care.

To Be Completed During the Simulation:

Actual Patient Problem: Risk for suicide
 Goal: Pt will identify stressors/factors that cause them to think of suicide by the end of my time of care.
 Met: Unmet:

Goal: The Pt will establish a safety plan and coping strategies when feeling suicide ideation by the end of my time of care.
 Met: Unmet:

Actual Patient Problem: Ineffective coping
 Goal: Pt will identify their disruptive behaviors and how it prevents them from coping during my time of care.
 Met: Unmet:

Goal: Pt will verbalize appropriate coping strategies and resources during my time of care.
 Met: Unmet:

Additional Patient Problems: Anxiety

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	0830	Assess pts stressors in life.	0845	Used therapeutic active listening communication.	0900	Pt stated he has been going through a lot, he lost his wife 6 months ago, his job as a cop 2 months ago, and rarely finds enjoyment in things.
2	0910	Assess pts coping skills.	0915	Implemented a calm relaxing environment.	0930	Pt stated he drinks to relax and to make time go by faster. Stated he drinks a 6 pack a day or more but hasn’t drank in 3 days. Stated he used to cope by traveling and going on long walks with his wife.
1,2	0940	Assessed sleeping and eating habits.	0945	Used therapeutic active listening communication.	0955	States he snoozes on and off but doesn’t stay asleep

						and he has lost 25lbs within 6 months because he does not have an appetite.
1,2	1000	Assessed for risk for suicide.	1015	Obtained information by using the CSSRS questionnaire.	1045	Pt scored high risk for risk for suicide. Pt has tried to give his personal belongings away, has means to lethal weapons, has a family history of suicide, and abuses alcohol. States there is nothing to live for anymore.
1,3	1100	Assessed the CSSRS scores with NP.	1230	Transferred ben to acute inpatient care facility, initiated suicide precautions, and looked through belongings to make sure everything was safe.	1245	Pt frustrated with certain belongings being taken away but stated he just wants to feel better.
1,3	1300	Pt seeming anxious/nervous.	1315	Administered sertraline and lorazepam as ordered PO. Educated on to not abruptly stop the use of lorazepam and to avoid St john's wart with sertraline.	1345	Pt states he feels less anxious and understand the safe administration.
1,2,3	5 days later 1000	Pt getting better has spend 5 days inpatient.	1130	Transferred to partial hospitalization.	1230	Pt states he has no thoughts of self-harm. He has been listening to music, doing yoga, meditation, has plans to ride his bike with his friends, and is looking for a job. Pt has also created a safety plan.

Pt no signs of self-harm.

Referred to outpatient.

Pt states he is working

1,2,3

1300

1330

1345

on his self-confidence.

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
N/A

NCLEX II (3): Health Promotion and Maintenance

Signs and Symptoms
-Giving away personal items
-Not being able to sleep throughout the night
-lost 25 lbs. in 6 months and states he has no appetite
-states he lacks finding pleasure in things
-states there is no reason left to live
-states he has guns at the house
-states he drinks to relax him and make the time go by faster.

NCLEX II (3): Health Promotion and Maintenance

Contributing Risk Factors
-Family history of suicide attempt
- alcohol use disorder
-previous diagnosis of anxiety
-lost his partner 6 months ago
-lost his job 2 months ago

NCLEX IV (7): Reduction of Risk

Therapeutic Procedures
Non-surgical
Meditation, light therapy, yoga, walking
Surgical
N/A

Prevention of Complications
(Any complications associated with the client's disease process? If not, what are some complications you anticipate)
-risk for suicide and self-harm
-feelings of loneliness and hopelessness
-feeling low self-worth
-imbalanced nutrition and electrolytes due to not eating
-poor judgment from lack of sleep
-alcohol use disorder and withdrawal

NCLEX IV (6): Pharmacological and Parenteral Therapies

Medication Management
-Venlafaxine
-Lorazepam
- Tramadol

NCLEX IV (5): Basic Care and Comfort

Non-Pharmacologic Care Measures
-Yoga
-Walking 1 mile everyday
-Socializing with friends
- Proper hygiene
-Looking for a job

NCLEX III (4): Psychosocial/Holistic Care Needs

Stressors the client experienced?
-Lost partner 6 months ago
-Lost his job 2 months ago
-Financial stress

Client/Family Education

Document 3 teaching topics specific for this client.
• Educated on not stopping Lorazepam suddenly.
• Educated on not taking St. Johns Wart with Sertraline.
• Educated on the warning signs of suicide ideation and how to create a safety plan.

NCLEX I (1): Safe and Effective Care Environment

Multidisciplinary Team Involvement
(Which other disciplines were involved in caring for this client?)
-NP
-Therapist
-Nurse

Patient Resources

- outpatient therapy.
- group therapy for alcohol disorder.
- safety plan with list of support systems contact information.

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 takeaway from participating in the care of this client is how important support systems are in someone’s life. Ben would most likely not have found help if it wasn’t for his brother who found help for him. You could also tell in the scenario how comfortable ben felt around his brother which is super important for those who have suicide ideation. Having someone the patient is comfortable around is important so they can talk to them about how they are feeling and have that support in the future.
2. What was something that surprised you in the care of this patient?
Something that surprised me was how the patient went from an inpatient to a partial hospitalization program before he was discharged to outpatient services. Most of the time patients are discharged after inpatient to outpatient therapy sessions so I thought it was nice to see they eased Ben out in the safest way possible.
3. What is something you would do differently with the care of this client?
Something I would do differently for this client is give him some resources for meals to help him get back on his feet until he gets a job.
4. How will this simulation experience impact your nursing practice?
This simulation will help impact my experience in my nursing practice because it gives you all the right questions you should be asking your patient with a nice flow. Therefore, I feel this simulation helped me to better increase my assessment of the client.
5. Discuss norms or deviations of growth and development that was experienced during the simulation including developmental stage.
My client was 35 years old. I feel as if he is feeling all the normal things someone his age would feel if they lost their job or partner. Therefore, I feel he is on the negative side of Ericksons psychosocial development because he has no feelings of self-worth right now due to not having a job and losing someone who was significant in his life. However, the client is taking all the steps needed in order to improve his self confidence and get back to feeling the gratitude of life.