# Module Report

**Tutorial: Real Life RN Mental Health 4.0**

**Module: Major Depressive Disorder**

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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 | 11/29/2023 11:52:20 AM | 54 min | Satisfactory |

## Reasoning Scenario Details
## Major Depressive Disorder - Use on 11/29/2023 10:58:24 AM

### 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 | 92.3% | | 7.7% |
| RN Pharmacological and Parenteral Therapies | 100% | | |

| QSEN | Strong | Satisfactory | Needs Improvement |
|---|---|---|---|
| Safety | 87.5% | | 12.5% |
| Patient-Centered Care | 100% | | |
| Evidence Based Practice | 100% | | |

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

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| **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** | |
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| **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** | |
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| **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** | Feelings of guilt |
| **Rationale** | Nurse Alex should plan to assess if Ben expresses any feelings of guilt. An example of a tool that can be used is the Hamilton Depression Rating Scale to evaluate a client for major depressive disorder. However, when assessing a client for suicide risk, the priority is to assess for preparatory behaviors. |

| **Optimal Decision** | |
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| **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. |

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| **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 just do not think life is worth living anymore." |
| **Rationale** | Ben stating that life is not worth living anymore is an overt verbal clue that gives insight into suicide intent; however, this statement does not indicate suicide lethality. |

| **Optimal Decision** | |
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| **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** | |
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| **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** | |
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| **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** | |
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| **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 send it home with Jordan. |

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| **Rationale** | Nurse Jessie should ask Ben to remove the necklace and send the necklace home with Jordan. Jessie should recognize that removing the necklace and giving it to Jordan is a safety measure that should be implemented. However, part of the spiritual assessment is identifying Ben's spiritual needs and offering resources, such as chaplain support. |

| **Optimal Decision** | |
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| **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** | |
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| **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** | |
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| **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** | |
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| **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 |

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| **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** | |
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| **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** | |
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| **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** | |
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| **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:

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| **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:

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| **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. |

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

## Quality and Safety Education for Nurses (QSEN)

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| **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

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| **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. |

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| **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.