

Live Person Simulation Scenario  
Psychiatric and Mental Health Nursing  
(Sandra)

I. Scenario Title:

Assessment Interview & Medication Administration for a Client with Clinical Depression & Alcohol Abuse

II. Type of Scenario: Live Actor or Standardized Patient

III. Materials Required:

This is a client interview and medication administration simulation experience. Materials needed are:

- Client interview space, or patient room (standard nursing lab room) with hand-washing facilities
- Intake Forms or client's chart, with History of Present Illness (HPI) & reason for admission
- Client's paper or computer-based MAR (Appendix B)
- VS assessment tools or machine
- Adapted CIWA Assessment Tool (Appendix A)
- Simulated medications listed on MAR (see Appendix B)
- Scissors or hemostats or something sharp in the room within client's reach

IV. Objectives of the Simulation Experience:

This simulation is appropriate for undergraduate psychiatric mental and behavioral health students. It should be placed after students have had theoretical introduction to clinical depression, SI assessment and treatment of acute alcohol withdrawal substitution therapy. Students should:

1. Demonstrate effective therapeutic communication strategies to facilitate the nurse-client relationship with clients suffering from clinical depression and substance abuse.
2. Demonstrate effective suicidal ideation assessment.
3. Demonstrate effective assessment of physical parameters associated with alcohol withdrawal and use of CIWA tool for appropriate treatment, client education, and initiation of substitution therapy
4. Demonstrate ability to understand and administer both ordered and PRN medications presented on a MAR.
5. Demonstrate effective client education pertaining to SSRI antidepressant medication use.

6. Demonstrate effective client education regarding antipsychotic medication use.

#### V. Background for Scenario:

- Patient Description:

49 Y O single Caucasian male with multiple past PMH hospitalizations, admitted through ED, secondary to increasing depression with suicidal ideation (SI), and alcohol abuse. Patient lives alone, has no daytime structure. Highest level of education is high school. Past social history indicates possible sexual abuse. Patient currently denies SI but has had past attempts using knives; details regarding these attempts are unclear. Patient denies any legal history of violent/criminal behaviors.

- Admitting Assessment Data & Mental Status Examination (MSE):

Patient appears older than stated age of 49. He is heavy set with fair grooming. Mild psychomotor retardation noted. Maintains eye contact, though at times is staring intently and seems preoccupied. Concentration is poor. Mood is reported as depressed and anxious. Affect is odd, anxious and constricted in range. Speech halting at times. Thought process significant for thought blocking. Denies any visual or auditory hallucinations. No delusions elicited. He currently denies suicidal ideation or homicidal ideation. Judgment and insight are fair.

- History of Present Illness (HPI):

This is one of multiple hospitalizations for this man who has a diagnosis of schizoaffective disorder. The patient has a history of alcohol dependence and this intensified after his friend recently died. Also, the patient's father died last year on the patient's birthday, of prostate cancer. The patient himself was diagnosed with lymphoma in 2010, and underwent biopsy of axillary lymph nodes in 2010; resolved but he states this is contributory to his increasing depression and SI. He admits to increased drinking of "about 6 beers a day and some vodka". He reports having blackouts. He denies any change in weight or appetite. He reports his concentration is poor, sleep is decreased. He reports his mood as depressed and he says he feels overwhelmed. The client self-admitted to the ED because of feeling unsafe, but upon admission to the unit he denies SI. He also denies symptoms of psychosis, although he appears preoccupied and guarded during the interview. He appears to have some thought blocking, but when questioned, reports he is "trying to concentrate". No history of withdrawal seizures or DTs. Patient has been admitted for substance abuse numerous times, at several locations.

#### VI. Scenario Description:

- Room set-up: Traditional PMH interview room, with vital sign assessment tools, and some sort of sharp object within client's reach.
- Student instructions: Considering the client's intake information, your nursing assessment, and the client's MAR, perform the client's evening medication pass. You will be observed for your therapeutic communication competency, your physical and mental health assessment skills, and your medication administration competency.

The student will simulate an evening medication pass with the patient using the client presenting information and attached MAR, physically assessing the client, interview the client using therapeutic communication skills, and then medicate the client based on physical &

mental assessment of the client. Students may have access to Drug Reference textbooks or PDAs for drug information.

- Actor instructions: The actor (Fred, the client) should appear very depressed, with minimal eye contact, and behave as specified in the client description and admission MSE. At a point when the student uses poor therapeutic communication skills (or during SI assessment), the actor should express frustration and threaten to harm self, by grabbing the sharp object in the room. The student should use therapeutic communication skills to de-escalate the patient, and then suggest appropriate PRN medication along with scheduled medication administration, according to MAR (Appendix B).

#### VII. Student Objectives:

Students must perform the following during the scenario:

1. Introduce self, verify client identity, explain procedure of medication administration and physical assessment process to client (purpose of visit)
2. Perform hand-hygiene
3. Perform brief mental status assessment for client orientation
4. Assess potential for withdrawal using CIWA tool
5. Confirm intake information, asking client additional open-ended questions pertaining to his HPI and past presentations
6. Assess for SI in patient using therapeutic communication skills:
  - Assess ideation
  - Assess plan
  - Assess means to carry out plan
7. Educate client:
  - Alcohol use & abuse: signs and symptoms of alcohol withdrawal (elevated VS, tremors, nausea/vomiting, DTs, diaphoresis, seizures)
  - substitution therapy using benzodiazepines (side effects, physical assessment indicators of withdrawal)
  - supportive medications given for alcohol withdrawal and reasons for administration (thiamine, folic acid, magnesium oxide, Wernicke Korsakoff's encephalitis)
  - All other inpatient medication orders on MAR
8. Demonstrate safety practices associated with medication administration (5 rights, patient identification, hand hygiene, VS assessment)

#### VIII. Scenario Evaluation:

Evaluation of the student's performance on the simulation should include the following criteria:

ACTION:	OBSERVED:
Appropriate introduction & client identification, including explanation of client assessment & medication administration process	

Hand hygiene performed	
Brief mental status assessment for client reality assessment & orientation	
Assess potential for acute withdrawal using CIWA tool: assesses VS and other parameters on CIWA tool	
Educates client about risks associated with acute withdrawal	
Medicates client using substitution therapy PRN protocol	
Use therapeutic communication to assess client's mood, affect, thought processes, communication patterns	
Use therapeutic communication to assess SI in client: intent, plan, and ability to carry out plan	
Ensures client safety by using therapeutic communication skills to de-escalate patient when patient becomes agitated	
Administers ordered and PRN medications as needed according to MAR using five rights	
Assesses client for pain	
Re-assesses client following medication administration for VS reduction and CNS stabilization	

#### IX. Scenario Debriefing:

Topics to cover during debriefing:

- Student & Instructor:
  1. How would you evaluate your nursing skills and competency in this scenario?
  2. What would you have done differently?
  3. What was your biggest challenge/obstacle?
- Student Group & Instructor:
  1. How was the SI assessment handled? What would you change?
  2. Was missing from the client education? If so, what?
  3. What nursing interventions would need to occur as follow-up care for this client?
  4. What on-going assessments would be appropriate for this client following this interview & medication administration?

#### X. Suggested Revisions to Scenario:

Options for variations during scenario include:

- MAR alterations:

- Add insulin-dependent DM to Axis III; include need for BS assessment to address CIWA findings of increased BP & decreased LOC.
- Change day on MAR the student is doing the assessment & medication administration from day 1 to day 3.
- Change MAR to have no standardized PRNs available to initiate substitution therapy; SN must call provider & use SBAR to get meds ordered.
- Patient Alterations:
  - Client has a seizure during interview.
  - Client refuses his medications.

#### XI. Associated Tools for the Scenario:

1. Appendix A: CIWA Tool
2. Appendix B: Fred. E Medication Administration Record

#### XII. References:

1. Townsend, M. C. (2012). *Psychiatric mental health nursing: Concepts of care in evidence-based practice (7th Ed.)*. Philadelphia, PA: F. A. Davis Company.
2. Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: The revised Clinical Withdrawal Assessment for Alcohol scale (CIWA-Ar). *British Journal of Addiction*, 84. 1353-1357.

Appendix A:  
The revised Clinical Withdrawal Assessment for Alcohol scale (CIWA-Ar)

<b>Category:</b>					<b>Score (check one):</b>			
<b>Pulse:</b>	<80				0			
	81-100				1			
	101-110				2			
	111-120				3			
	121-130				4			
	131-140				5			
	141-150				6			
	>150				7			
<b>Sweating:</b>	none				0			
	palms moist, barely perceptible				1			
	beads of sweat on forehead				4			
	drenched				7			
<b>Tremor (hand):</b>								
	none				0			
	not visible but can be felt in fingertip				1			
	moderate with patient's arm extended				4			
	severe				7			
<b>Anxiety:</b>	none				0			
	mild				1			
	moderate with patient's arm extended				4			
	sever (panic state)				7			
<b>Tactile, auditory, or visual disturbances:</b>								
	none				0			
	present but minimal				1			
	frequent				4			
	continuous hallucinations				7			
<b>Agitation:</b>	none				0			
	somewhat				1			
	fidgety & restless				4			
	pacing, or constantly thrashing about				7			
<b>Nausea &amp;/or vomiting:</b>								
	none				0			
	mild nausea, no vomiting				1			
	some nausea with vomiting or dry heaves				4			
	constant nausea with vomiting/dry heaves				7			
<b>Headache:</b>								
	none				0			

	mild				1				
	moderate with patient's arm extended				4				
	severe				7				
<b>TOTAL SCORE: Clients scoring less than 10 do not usually require medication for withdrawal.</b>									

Adapted from: Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989).  
 Assessment of alcohol withdrawal: The revised Clinical Withdrawal Assessment for Alcohol scale (CIWA-  
 Ar). *British Journal of Addiction*, 84. 1353-1357

**Appendix B:****Fred E. Medication Administration Record**

<b>Client: Fred E.</b>						
<b>Date of Birth: 03/07/1964</b>						
<b>Admission Date:</b>						
<b>10/09/2013</b>						
<b>Allergies: NKDA</b>						
<b>Ordered Medications:</b>						
	<b>Start:</b>	<b>Stop:</b>	<b>Time:</b>	9/9/13	9/10/13	9/11/13
Risperidone (Risperdal)	9/09/13		900			
3mg PO BID			2100			
Fluoxetine (Prozac)	9/09/13		2100			
60mg PO daily @ HS						
Thiamine (Vitamin B1)	9/09/13		900			
100mg PO BID			2100			
Magnesium oxide	9/09/13		900			
400mg PO BID			2100			
Folic acid (Folvite)	9/09/13		900			
1mg PO daily						
Divalproex sodium (Depakote)	9/09/13		0600			
500mg PO QAM						
Divalproex sodium (Depakote)	9/11/13		2100			
1000mg PO QHS						
<b>PRN medications:</b>						
Chlordiazepoxide (Librium)	9/09/13	9/10/13	0600			
50mg PO TID per taper protocol			1300			
PRN: alcohol withdrawal, day 1			2100			
Chlordiazepoxide (Librium)	9/10/13	9/11/13	0600			
25mg PO TIB per taper protocol			1300			



PRN: alcohol withdrawal, day 2			2100			
Lorazepam (Ativan) PRN	9/09/13	9/14/13				
1mg PO Q 3 hours, for s/s of withdrawal						
Metoclopramide (Reglan) PRN	9/09/13					
10mg PO TID, for nausea/vomiting						
Trimethobenzamide (Tigan) PRN	9/09/13					
200mg IM Q6 hours, for nausea/vomiting						
Trazedone (Desyrel) PRN	9/09/13	9/11/13				
50mg PO QHS for insomnia						