Student Name: Bethany Ivins Date: August 18.2020

IM6 (Acute Psychiatric) Critical Thinking Worksheet

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<tr>
<td>1. DSM-5 Diagnosis and Brief Pathophysiology (include reference):
Major Depressive Disorder: a complex interaction between the availability of neurotransmitters norepinephrine, dopamine, and glutamate, and the regulation and sensitivity of their receptors.

4. Medical Diagnoses: N/A</td>
<td>2. Psychosocial Stressors (i.e. Legal, Environmental, Relational, Developmental, Educational, Substance Use, etc.);
- dad has new wife and baby
- Boyfriend broke up with her
- studying problems
- Friendship problems
- Financial Strain
- Strained relationship with sister r/t recent behavior</td>
<td>3. DSM-5 Criteria for Diagnosis (Asterisk or Highlight Symptoms Your Patient Exhibits and Include References)
Depressed mood most of the day on most days*
Significant weight loss*
Insomnia*
Fatigue*
Feelings of worthlessness*
Decreased concentration
Recurring thoughts of death*
Decreased pleasure in previously enjoyed activities*
Psychomotor agitation</td>
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<td>5. Diagnostic Tests Pertinent or Confirming of Diagnosis
MSE
PHQ-4 Scale (Anxiety/ depression scale)
Hamilton Rating Scale for Depression
Columbia-Suicide Severity Rating Scale (C-SSRS)</td>
<td>6. Lab Values That May Be Affected:
- Thyroid Panel- hypothyroid symptoms can mimic depression
- Nutritional labs due to weight loss (CBC/CMP)
- Drug and Alcohol Screen- drug and alcohol use can increase depression
- Pregnancy Test- Many antidepressants are contraindicated in pregnancy</td>
<td>7. Current Treatment:
Safety plan
Non-suicide contract
Antidepressants
Cognitive Behavioral Therapy
Group therapies
Milieu therapy

Sources:
- Nursing Diagnosis Handbook
- DSM-5
- Varcolis Textbook
- NIMH Suicide Prevention Website</td>
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8. Focused Nursing Diagnosis: Risk for suicide	**12. Nursing Interventions related to the Nursing Diagnosis in #7:** 1. Stay with the patient when possible. **Evidenced Based Practice:** Staying with the patient provides them with a sense of security and trust with the nurse, also strengthens self-worth. 2. Provide a safe environment for the patient by removing any items that they could potentially use for suicide (sharp object, pills, etc.) **Evidenced Based Practice:** Removing potentially harmful objects from the environment will prevent the patient from acting on possible suicidal impulses. 3. Give opportunities for the patient to express emotions and thoughts without fear of judgement. **Evidenced Based Practice:** This helps the patient see that nurses and staff are available for discussing thoughts and feelings and can decrease intensity of some negative emotions.	**13. Patient Teaching:** 1. Teach patient and family symptoms that signal the need for immediate medical attention. 2. Teach patient symptoms of serotonin syndrome and important medication information (see Consent for Psychoactive Medication Sheet) 3. Teach patient appropriate coping strategies to employ when they are overwhelmed such as continuing walks and music therapy.
9. Related to (r/t): Suicide ideation and hopelessness		
10. As evidenced by (aeb): patient stating that she has a plan to kill herself, social isolation, and poor support system.		**14. Discharge Planning/Community Resources:** 1. Find a local support group for young adults with depression for patient to attend. 2. Set up appointment with counseling services at the university for the patient to continue therapy. 3. Show patient how to set medication reminders in smart phone to ensure medication adherence since she is a busy college student and athlete.
11. Desired patient outcome: Patient will state decreased suicidal ideation and have improved assessment scores (MSE) by 1700 on 8/20/2020.		