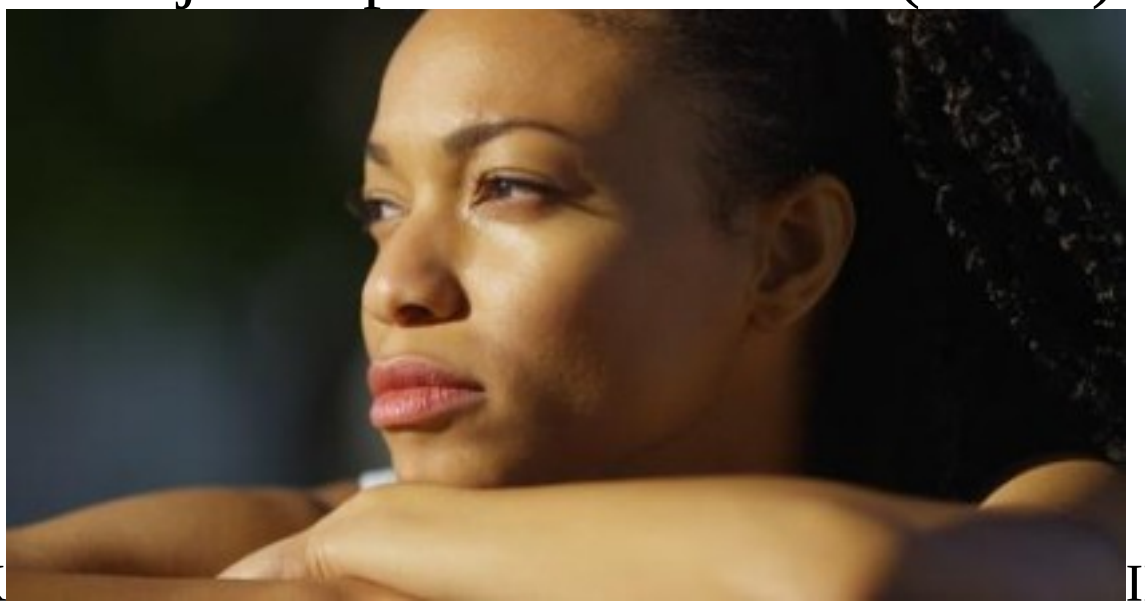
Major Depressive Disorder (MDD)



SK INNY

Reasoning

Marilyn Smith, 28 years old

Primary Concept
Mood and Affect
Interrelated Concepts (In order of emphasis)
• Stress • Coping • Clinical Judgment • Patient Education

NCLEX Client Need Categories	**Percentage of Items from Each Category/Subcategory**	**Covered in Case Study**
Safe and Effective Care Environment		
✓ Management of Care	17-23%	✓
✓ Safety and Infection Control	9-15%	✓
Health Promotion and Maintenance	6-12%	✓
Psychosocial Integrity	6-12%	✓
Physiological Integrity		

✓ Basic Care and Comfort	6-12%	✓
✓ Pharmacological and Parenteral Therapies	12-18%	✓
✓ Reduction of Risk Potential	9-15%	✓
✓ Physiological Adaptation	11-17%	✓

SKINNY Reasoning

Part I: Recognizing RELEVANT Clinical Data

History of Present Problem:

Marilyn Smith is a single, African American 28-year-old female who presents to the emergency department with complaints of "feeling crummy" for the past six months. She reports that she no longer feels like doing any of the things she used to enjoy. "It all seems so pointless." She can't even bother to eat most days and has lost weight recently.

Although she has no energy, she finds it difficult to both fall sleep and stay asleep. Even when she does manage to fall asleep, she never feels rested when she awakes. She reports having difficulty at work as a computer support person because it is so hard for her to concentrate. Last week she called in sick and spent the day in bed crying off and on all day. Last night she found herself crying again and this time she also thought about suicide, which scared her and prompted a visit to the ED. "I don't want to live like this anymore. I feel like I will never be happy again."

Personal/Social History:

Marilyn graduated from high school and obtained an associate degree in computer science. She enlisted in the Army to have an adventure and hoped the GI bill would pay for further education once she completed her service. She reports she still feels guilty about making the decision to enlist instead of marrying her high school sweetheart. She was deployed to Iraq and returned home a year ago. She enjoyed her time in the service because she felt she was doing something useful for her country. She did not see combat and did not experience any significant problems while in Iraq. When she returned home, she found out her old boyfriend had married. She recently attempted to contact local universities to explore completing her baccalaureate degree but found the process too overwhelming and just gave up.

When questioned about use of alcohol or drugs, Marilyn reported that she is an occasional drinker, but recently has been drinking more in an attempt to sleep. Denies other drug use. Marilyn has no history of clinical depression. Her grandmother had periods of becoming withdrawn and not leaving the house for days.

What data from the histories are RELEVANT and have clinical significance for the nurse?

RELEVANT Data from Present Problem:	**Clinical Significance:**
1. **Symptoms present for the last 6 months.** 2. **Weight loss and difficulty sleeping** 3. **Decreased work performance** 4. **Thoughts of suicide** 5. **Easily overwhelmed** 6. **Increased use in alcohol** 7. **CLient regrets leaving for military and should have just stayed home to marry highschool sweetheart**	1. **History of onset** 2. **Physical symptoms of depression** 3. **Inability to perform as needed** 4. **Safety risk to self** 5. **Mental presentations of depression** 6. **Substance use as an attempt to cope with depression.** 7. **Client feels guilt and regret**
RELEVANT Data from Social History:	**Clinical Significance:**
Client feels guilty.	**Client may have some genes influence.**

Drinks more to sleep. **Her grandmother had a period of withdrawing and no leaving house for days.**	**The disorder may be caused by lack of sleep and depression.** **Client shows signs of MDD.**

Patient Care Begins:

Current VS:	**P-Q-R-S-T Pain Assessment (5th VS):**	
T: 98.8° F/37.1 (oral)	**P**rovoking/Palliative:	Denies current pain
P: 72 (regular)	**Q**uality:	
R: 12 (regular)	**R**egion/Radiation:	
BP: 112/66	**S**everity:	
O2 sat: 99% room air	**T**iming:	

What VS data are RELEVANT and must be interpreted as clinically significant by the nurse?

RELEVANT VS Data:	**Clinical Significance:**
Vital signs are within normal limits.	**Patients' vital signs create a baseline for assessments.**

Mental Status Examination:	
APPEARANCE:	*Dressed in casual clothes, somewhat disheveled, no make-up; no body odor; appears tired and appears stated age; cooperative during interview.*
MOTOR BEHAVIOR:	*Wringing hands during interview*
SPEECH:	*Speech is a little slowed; slow to respond to questions; does not elaborate unless asked*
MOOD/AFFECT:	*Appears sad; reports feeling anxious and sad all the time. Feels like she will never be able to feel better (hopelessness).*
THOUGHT PROCESS:	*Logical and linear (thoughts make sense and are connected)*
THOUGHT CONTENT:	*Reports feelings of guilt for feeling so bad for "no reason" and for leaving her boyfriend all those years ago.* *Reports having ruminative thoughts that she is of no use to anyone (worthlessness). Denies delusions or paranoid thoughts when assessed* *No evidence of psychotic thinking or loss of contact with reality*

PERCEPTION:	*States she occasionally hears her name at night when attempting to sleep, but knows it is her imagination. Denies any other hallucinations, illusions, or depersonalization when assessed.*
INSIGHT/JUDGMENT:	*Insight – Knows she doesn't feel "right" but does not recognize symptoms as part of clinical depression; unable to identify any precipitant. Judgement intact as evidenced by seeking help.*
COGNITION:	*Alert and Oriented x3;* *Recent and remote memory intact as evidenced by how she answered interview questions; Demonstrated ability to abstract when tested by asking about proverbs;* *Fund of knowledge and intelligence is at least average based upon vocabulary used by the patient;* *Patient reports difficulty concentrating. When attention span was tested using serial sevens test, patient declined to participate.*
INTERACTIONS:	*Patient reports withdrawing from friends prior to admission. Unable to assess currently.*
SUICIDAL/HOMICIDAL:	*Patient admits she thinks about suicide but would never act on it because she wouldn't want to hurt her parents. She has no plan when she thinks about suicide. States she does have her own gun at home.* *Denies homicide ideation or thoughts of self-harm.*

What MSE assessment data are RELEVANT and must be interpreted as clinically significant by the nurse?

RELEVANT Assessment Data:	**Clinical Significance:**
Patient is somewhat disheveled and appears tired.	**She may be too depressed, lack interest or energy to care how she looks.**
Wringing hands.	**She may be nervous or upset.**
She is slow to respond to questions and only elaborates unless she is asked.	**She is willing to talk but doesn't want to open up. Patients with depression interact minimally with a few words or a gesture.**
She reports feeling anxious and sad all the time and feels as if she will never be able to feel better.	**A sign of MDD (hopelessness).**
She feels guilty for "no reason" and she is of no use to anyone.	**A sign of MDD (helplessness).**
She knows she doesn't feel right but does not recognize symptoms as part of clinical depression.	**Patients with MDD have limited insight and are unaware of their behavior, feelings, or illness.**
Patient reports difficulty concentrating and declined to participate in the serial sevens test.	**Patients have difficulty concentrating or paying attention.**
Patient reports withdrawing from	**Depression causes strain in relationships and they avoid social relationships because they feel overwhelmed.**

friends prior to admission. **She thinks about suicide but doesn't act on it.**	**Patient with depression have thoughts of suicide and its important to assess by asking directly.**

Current Assessment:	
GENERAL APPEARANCE:	Appears somewhat tired and anxious
RESP:	Breath sounds clear with equal aeration bilaterally ant/post, non-labored respiratory effort
CARDIAC:	Pink, warm & dry, no edema, heart sounds regular with no abnormal beats, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks, brisk cap refill
NEURO:	Alert & oriented to person, place, time, and situation (x4)
GI:	Abdomen flat, soft/non-tender, bowel sounds audible per auscultation in all four quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact, skin turgor elastic, no tenting present

What PHYSICAL assessment data are RELEVANT and must be interpreted as clinically significant by the nurse?

RELEVANT Assessment Data:	**Clinical Significance:**
Appears somewhat tired and anxious	**Patient had previously stated that she has not been able to stay asleep although she is always exhausted, lack of sleep can cause anxiety.**

Diagnostic Results:

Basic Metabolic Panel (BMP)					
	Na	K	Gluc.	Creat.	
Current:	145	4.0	80	0.8	
Complete Blood Count (CBC)					
	WBC	% Neuts	HGB	PLTs	Bands
Current:	5.0	44	12.2	150	

Thyroid Panel					
	T3	T4	TSH		
Current:	4.6	82	5		

What data must be interpreted as clinically significant by the nurse? *(Reduction of Risk Potential/Physiologic Adaptation)*

RELEVANT Diagnostic Data:	**Clinical Significance:**
T3 **T4**	**T3 and T4 levels could be high due to anxiety, and feelings of irritation. An overactive thyroid can cause sleep problems by overstimulating the nervous system causing nighttime arousals.**

Part II: Put it All Together to THINK Like a Nurse!

1. After interpreting relevant clinical data, what is the primary problem?
(Management of Care/Physiologic Adaptation)

Problem:	**Pathophysiology in OWN Words:**
Thyroid imbalance	**Patients with thyroid disorders are more likely to experience depressive symptoms. Hyperthyroidism is when the thyroid gland produces too much thyroid hormone. Thyroid regulates metabolism in every organ of the body, including the brain. The thyroid gland can mimic a number of psychiatric disorders ranging from anxiety, depression, and psychosis.**

Collaborative Care: Medical Management

2. State the rationale and expected outcomes for the medical plan of care. *(Pharm. and Parenteral Therapies)*

Medical Management:	**Rationale:**	**Expected Outcome:**

1.Admit pt. to unit under voluntary admission 2. Initiate milieu therapy 3. Initiate safety measures according to unit protocol 4.VS upon admission then daily 5. Regular diet. Monitor intake. 6. Sertraline 50 mg PO per day 7. Trazodone 50 mg PO PRN for sleep. May repeat x1 8. Lorazepam .5 mg PO PRN for acute agitation	1.Pt. with major depression disorder still has the ability to solve problems. Voluntary admission provides autonomy for Pt. 2.The milieu therapy provides safety for the pt. 3. Provide a safe environment. 4. Measures of physical health. 5. Maintain physical health. 6. SSRIs antidepressant, leading treatment for depression 7. Patient has difficulty sleeping. 8. Help pt. Sleep .	Patients would be admitted voluntarily. For 2 & 3, the patient feels safe and comfortable. For 4, and 5. No physical issue present. Maintain health. Reduced depressive mood. For 7 &8: Patient shows no problem sleeping.

Collaborative Care: Nursing

3. What nursing priority (ies) will guide your plan of care? *(Management of Care)*

Nursing PRIORITY:		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
Assess suicidal ideation. **Safety measure by following facility proctorol.** **Assess sleep, eating habits, and neurological patterns.** **Monitor intake** **Determine client's perception of the illness and coping methods.**	**Safety is always the priority for the client and others.** **This helps the client to feel comfortable and allows her to socialize with others.** **Observing client eating habits helps to eat adequate meals and gain weight.** **Inadequate sleep, nutrition, and neurological conditions can be contributing factors.** **Coping and perception help to determine education needs.**	**Assessment will guide nurses to determine the need of the client.** **Therapeutic communication and socializing will occur. Sleep and eating habits will improve. Positive rather than negative.**

4. What psychosocial/holistic care PRIORITIES need to be addressed for this patient?
(Psychosocial Integrity/Basic Care and Comfort)

Psychosocial PRIORITIES: psychosocial restoration		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
CARING/COMFORT: *How can you engage and show that this pt. matters to you?* Assess individual signs of hopelessness. Interact with the client on topics with which she is comfortable. **Physical comfort measures:** Reduced feelings of guilt and anxiety.	It may include social withdrawal, decreased physical activity, and comments made by patients that indicate despair and hopelessness. Comfortable topics would encourage clients to communicate.	Patients will express their feelings and thoughts. Trust can be established between nurse and client. Comfortable environment encourages clients to discuss more difficult topics.
EMOTIONAL SUPPORT: *Principles to develop a therapeutic relationship* Use silence and active listening when interacting with the patient. Encourage the patent to ventilate feelings in whatever way is comfortable, verbal or nonverbal.	Silence will convey expectations that the patient will communicate and acceptance of the patient's difficulty with communication. Expressing feelings may help relieve despair and hopelessness.	Patient will communicate and learn or discover coping strategies. The patient will express feelings directly with congruent verbal and nonverbal messages.
SPIRITUAL CARE/SUPPORT: Encourage the patient to examine spiritual supports that may provide hope.	May be able to find the hope through spiritual practice.	Patients will express the acceptance of life events and find hope.
CULTURAL CARE/SUPPORT: (If Applicable)		

5. What educational/discharge priorities need to be addressed to promote health and wellness for this patient and/or family? *(Health Promotion and Maintenance)*

Educate the patient on the importance of adhering to the medical regimen; advise patients not to stop medicines abruptly. Give patient resources to support groups, and order a referral to a therapist. Prioritize sleep and habits to promote sleep. Prioritize creating a routine to promote healthy habits.