Clinical AssignmentTopic: Depressive disorder with recent suicide attempt

**Assignment**: Develop a Case Study similar to those found in your textbook (NOT the same scenario, you will make up your own). *See example Care Plans in your textbook or utilize the Internet to visualize the appearance of a care plan. Put your case study on the page following the instructions.

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**Part I: Develop the Case**

**Scenario**: A detailed patient description. Tell a thorough, descriptive story about the patient and the problem(s) they are having. Include descriptions of the environment, patient actions, family involvement, communication, and nurse actions. Include assessment data from below. This should be a minimum of 2 paragraphs and will likely be longer depending on your attention to detail. *You will find the more detailed your scenario the easier it will be to complete the remainder of the assignment.

**Assessment data**: Next clearly list (A) Objective data and (B) Subjective data based upon your scenario. Identify associated pathophysiology related to the topic. Include at least two ways that the patient is using defense mechanisms in their disease process. Include ABCT assessment guidelines when describing your patient: Appearance (age, posture, body movements, dress, grooming), Behavior (LOC, speech, mood, affect), Cognition (orientation, concentration, recent and remote memory, judgment, insight), and Thought Processes (content, process, perception). *Be sure to use mental health based describing words for patient behaviors/assessment and quote what the patient with that disease might say.

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**Part II: Develop the Plan of Care**

**Nursing diagnosis:** Provide two priority nursing diagnosis including supporting data from your assessment.

**Goals:** Develop two goals for each nursing diagnosis above.

**Interventions:** Next develop three interventions you will implement to meet each goal (*in your overall plan of care for this patient, your interventions must include each of the following: medications most commonly utilized for the disorder, communication techniques, teaching point(s), major safety issue(s), and continuing assessment).

**Rationale:** You need to have a rationale (including source) for each intervention you develop.

***Sources:** You must use a different source for each intervention rationale per goal. For example, for one goal with three interventions you can use (1) your textbook, (2) evidence-based article, and (3) the Internet. You can use the same three sources for your other goal interventions, but there is a minimum total

number of three sources for this assignment. *At least 2 sources on your reference list must be EBP articles.

**Reference page:** Include your references in APA format.

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**Part III:**

Last, you will develop **three** exam questions based upon your scenario. DO NOT copy an exam question from a NCLEX book or your textbook (I can tell, trust me). Your questions should be specific to your scenario (the answer should be discernible from your assessment data, nursing diagnosis, goals, interventions, or rationale). *Include the correct answer **and** the rationale for the correct answer (including a source) after each question you develop.

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**PART I**

**Scenario:** Depressive disorder with recent suicide attempt

The patient is a 40- year- old Hispanic male brought to the ER from suicide attempt and diagnosed with depression. He is elevated at the head about 40 degrees and sitting comfortably with a tired gaze. He seemed in need of grooming and proper hygiene r/t overgrown beard and dry/dirty skin. He is fluent in English and speaks well. His BP is 90/60, T 100C, RR11, O2Sat 90%, and HR 70.

The client attempted suicide because of overwhelming feeling of just not being able to keep going after his wife divorced him about a year ago and losing his job because of his mental state after the divorce; he was a police officer. He tried to commit suicide by using his service pistol in the driveway of his home. A neighbor saw him and immediately called for help. He had been married for 25 years and his wife was, “What kept me going.” As stated by the patient.

He is on Lexapro 20 mg PO every day ; and clonazepam 4mg PO every day, but he stopped taking them about 2 months ago because as stated by the patient, “I did not see the point in taking the anymore.” He lives alone and does not have family in the US except a brother that lives near but have not spoken in a very long time. Patient has a recent (past 6 months) history of excessive drinking and smoking marijuana.

Assessment data:

Patient is a 40- year-old Hispanic male with depression and suicide attempt. His V.S. are BP(RA) is 90/60, T(T) 100C, RR11, O2Sat 90%, and HR 70. Patient is prescribed Lexapro 20

mg PO every day and clonazepam 4mg PO every day for depression. Patient lives alone and his depression has escalated since his divorce and the loss of his job. He was on medication to treat his depression but then he stopped taking them because he did not see the reason to keep taking them. He has not had proper grooming or hygiene adequately for several months AEB skin and hair condition. Patient is tolerating sitting elevated in his bed and his movements are minimal. He is A&Ox4 and his recent and remote memory are intact. Patient drinks everyday up to 12 hard alcohol drinks per day along with smoking marijuana. He was taking his medications, but he stopped taking them.

**PART II**

**Plan of Care:**

1. Nursing Diagnosis: Potential for hopelessness due to losses, stressors, and the burdensome symptoms of depression.

| | Interventions | Rationale | Source |
|---|---|---|---|
| Goal 1.1:<br>By d/c or the end of the 4 weeks, the patient verbalizes feelings and acceptance of the situation over which they have no control. | 1 Assess individual signs of hopelessness. | This helps focus attention on area of individual need. Signs may include decreased physical activity, social withdrawal, comments that indicate hopelessness and despair. | Swearingen and Wright, (2019) |
| | 2 Conduct a suicide assessment to determine the level of suicide risk. | High risk will need to be hospitalized. | Brådvik, L. 2018 |
| | 3 Help the patient identify areas of life that are under their control. | A patient's emotional state may interfere with problem solving. Assistance may be required to identify areas that are under their control and to have clarity about options for taking control. | UC Santa Cruz. 2019 |
| Goal 1.2:<br>Demonstrate independent problem-solving techniques to | 1 Encourage the patient to identify and verbalize feelings and perception, | The process of identifying feelings that underline and drive behaviors | UC Santa Cruz. 2019 |

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| take control over their life. | | enable patients to begin taking control of their lives. | |
| | 2 Express hope to the patient with realistic comments about the patient's strengths and resources. | Patients may feel hopeless, but it is helpful to hear positive expression from others. | Swearingen and Wright, (2019) |
| | 3 Teach the patient about crisis intervention services such as suicide hotlines and other resources. | It is vital to provide patients with resource for support and safety when thoughts and feelings about suicide become difficult to manage. | Brådvik, L. 2018 |
| Goal 1.3: Increase self-esteem. | 1. Encourage the patient to engage in self-care grooming activities. | Attending to grooming is often an initial step in feeling better about oneself. | Brådvik, L. 2018 |
| | 2. Explore the patient's personal strength and suggest making a list to use as a reminder when negative thoughts return. | Having a written list to review can help patient during difficult times. | UC Santa Cruz. 2019 |
| | 3. Teach thought-stopping techniques and positive reframing. | Many depressed people engage in self-critical thinking and need to be taught to consciously stop that type of thinking and substitute positive thinking in its place. | Swearingen and Wright, (2019) |

2. Nursing Diagnosis: Knowledge, deficit related to drug therapy.

| | Interventions | Rationale | Source |
|---|---|---|---|
| Goal 2.1: Achieve a therapeutic level of treatment regimen with Lexapro and clonazepam for medication treatment. | 1 Monitor vital signs. Observe respiratory patterns, especially during sleep, for evidence of apnea or shallow breathing. | Benzodiazepines can reduce the respiratory drive in susceptible clients. | Swearingen and Wright, (2019) |
| | 2. Monitor | Confusion or lack of | Brådvik, L. 2018 |

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| | neurological status, especially level of consciousness. | response may indicate overmedication. | |
| | 3 Teach what to avoid eating or drinking such as caffeine and grapefruit juice. | These products can reduce or enhance the drug's effectiveness. | |
| Goal 2.2:<br>By the time of d/c, the patient can verbalize accurate information about the prescribed medications and their potential side effects. | 1 Assess the patients knowledge level regarding the use of medication to improve depressive symptoms. | It is essential to find out what patients know and do not know about the medication prescribed to treat their depression. | UC Santa Cruz. 2019 |
| | 2. Caution about the importance of taking the medication at the prescribed dose and time interval. | Some medications require certain blood levels to be therapeutic therefore patients need to take them at the time and dose prescribed. | Swearingen and Wright, (2019) |
| | 3. Teach the physiologic action of the prescribed antidepressant and how it alleviates symptoms of depression. | Many depressed patients' resist taking their medication because they fear being "addicted", antidepressant are not addictive drugs. | Brådvik, L. 2018 |
| Goal 2.3:<br>Need for health teaching due to unfamiliarity with the causes, signs and symptoms and treatment of depression. | 1. Assess the patient's knowledge about depression and its cause. | Many people believe that depression is caused by character weakness. It is a physiologic response to stress , loss, and imbalance of the brain chemistry. | Brådvik, L. 2018 |
| | 2. Inform the patient about the major symptoms of depression. | Depression is more than just being sad, it involves loss of interest in normal activities, change in sleep, eating habits, weight, feelings of worthlessness and guilt and many other | UC Santa Cruz. 2019 |

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| | | symptoms. | |
| | 3. Explain that depression is treatable. | Medications are usually indicated for treatment. They do not solve the stressor or problem, but they provide the energy to deal with these issues. | Swearingen and Wright, (2019) |

## References

Brådvik, L. 2018 Sep. *Suicide Risk and Mental Disorders*.15(9): 2028.

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Swearingen P.L. Wright J. (2019). *All-in-One nursing planning resource***.** (pp. 746-752).

St.Louis: Elsevier Inc.

UC Santa Cruz. 2019. *Depression and suicide.* Retrieved April 11, 2020 from

https://caps.ucsc.edu/resources/depression.html

**PART III**

**NCLEX Questions with Rationale:**

Question #1: Lexapro should not be given to:

a. <12 years-old
b. DM patient
c. >45 year-old-females
d. Males on heparin

Answer: A. <12 years old. Lexapro has an increased risk for suicide in children under 12 years of age. (FDA.gov)

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Question #2: The patient tells the nurse, “ I am so tired of living my life.” The nurse’s response should be:

a. If you took your medication you would feel a lot better about your life.
b. Take a nap, it will make you feel better.
c. So, you are tired of living your life?
d. Sometimes I take hot showers when I have negative feelings.

Answer: C. The nurse acknowledges the patient’s feelings and gives him a chance to explain and open up. (Mental Health ATI)

Question #3: A patient with depression understands to look for symptoms of depression when:

a. They are not able to stop eating cereal.
b. Start to feel tired and want to sleep for longer than 8 hours.
c. Their blood pressure is 145/76
d. They took their last medication 2 weeks ago.

Answer: B. The earliest signs of depression are wanting to sleep for >8 hours and not feel rested. (Videbeck, 2018).