

Major Depressive Disorder (MDD)

RAPID Reasoning STUDENT

Marilyn Smith, 28 years old

Primary Concept	
Mood and Affect	
Interrelated Concepts (In order of emphasis)	
1. Stress 2. Coping 3. Clinical Judgment 4. Communication 5. Collaboration 6. Patient Education	

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 Her grandmother had periods of becoming withdrawn and not leaving the house for days.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:
RELEVANT Data from Social History:	Clinical Significance:

Patient Care Begins:

Current VS:	P-Q-R-S-T Pain Assessment (5th VS):	
T: 98.8° F/37.1 (oral)	Provoking/Palliative:	Denies current pain
P: 72 (regular)	Quality:	
R: 12 (regular)	Region/Radiation:	
BP: 112/66	Severity:	
O2 sat: 99% room air	Timing:	

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

RELEVANT VS Data:	Clinical Significance:

Mental Status Examination (MSE):

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:

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:

Lab Results:

Basic Metabolic Panel (BMP:)	Current:	High/Low/WNL?	Previous:
Sodium (135–145 mEq/L)	145		Not available
Potassium (3.5–5.0 mEq/L)	4.0		Not available
Glucose (70–110 mg/dL)	80		Not available
Creatinine (0.6–1.2 mg/dL)	.8		Not available

What lab results are RELEVANT and must be interpreted as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Complete Blood Count (CBC:)	Current:	High/Low/WNL?	Previous:
WBC (4.5–11.0 mm ³)	5.0		Not available
Neutrophil % (42–72)	44		Not available
Hgb (12–16 g/dL)	12.2		Not available
Platelets (150–450 x10 ³ /µl)	150		Not available

What lab results are RELEVANT and must be interpreted as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Misc. Labs:	Current:	High/Low/WNL?	Previous:
T3 (Normal range) 4.6–12 ug/dl	4.6		Not available
T4 (Normal Range) 80–180 ng/dl	82		Not available
TSH (Normal Range) 0.5–6 uU/ml	5		Not available

What lab results are *RELEVANT* and must be recognized as clinically significant by the nurse?

RELEVANT Lab(s):	Clinical Significance:	TREND: Improve/Worsening/Stable:

Clinical Reasoning Begins...

1. *What is the primary problem that your patient is most likely presenting?*

2. *What is the underlying cause/pathophysiology of this primary problem?*

Collaborative Care: Medical Management

Care Provider Orders:	Rationale:	Expected Outcome:
Admit pt. to unit under voluntary admission Initiate milieu therapy Initiate safety measures according to unit protocol VS upon admission then daily Regular diet. Monitor intake. Sertraline 50 mg PO per day Trazodone 50 mg PO PRN for sleep. May repeat x1 Lorazepam .5 mg PO PRN for acute agitation		

Collaborative Care: Nursing

3. *What nursing priority (ies) will guide your plan of care? (if more than one-list in order of PRIORITY)*

4. What interventions will you initiate based on this priority?

Nursing Interventions:	Rationale:	Expected Outcome:

5. What body system(s) will you assess most thoroughly based on the primary/priority concern?

6. What is the worst possible/most likely complication to anticipate?

7. What nursing assessments will identify this complication EARLY if it develops?

8. What nursing interventions will you initiate if this complication develops?

9. What psychosocial needs will this patient and/or family likely have that will need to be addressed?

10. How can the nurse address these psychosocial needs?

Caring and the “Art” of Nursing

1. *What is the patient likely experiencing/feeling right now in this situation?*
2. *What can you do to engage yourself with this patient’s experience, and show that he/she matters to you as a person?*

Use Reflection to THINK Like a Nurse

Reflection-IN-action (Tanner, 2006) is the nurse’s ability to accurately interpret the patient’s response to an intervention in the moment as the events unfold to make a correct clinical judgment.

1. *What did I learn from this scenario?*
2. *How can I use what has been learned from this scenario to improve patient care in the future?*