

Depression/Overdose with Psychosis

RAPID Reasoning



Jenna Taylor, 18 years old

Primary Concept
Mood and Affect
Interrelated Concepts (In order of emphasis)
1. Safety
2. Psychosis
3. Clinical Judgment

Depression/Overdose with Psychosis

History of Present Problem:

Jenna Taylor is an 18-year-old woman who is brought to the emergency department by ambulance after she admitted to her mother that she had taken a “handful” of dextroamphetamine/amphetamine (Adderall) this morning. Mom noted that there are 20 tablets missing. Jenna admits that she has been hearing voices telling her that she is worthless and would be better off dead. She denies visual hallucinations.

As the primary nurse explores these comments further, Jenna states, “The devil is in the place! I can feel it! The voices are telling me that I am going to hell forever.” Jenna appears fearful, anxious and does not maintain eye contact. When she briefly glances and looks your way, she appears to be looking through you.

Personal/Social History:

She was hospitalized three weeks ago for depression and suicidal ideation and was discharged ten days ago. Jenna lives with her mother. Her parents were divorced 12 years ago. She graduated from high school, has few close friends, and has no current plans for her future.

*What data from the histories is **RELEVANT** and has clinical significance to the nurse?*

RELEVANT Data from Present Problem:	Clinical Significance:
RELEVANT Data from Social History:	Clinical Significance:

Patient Care Begins:

Current VS:	WILDA Pain Assessment (5 th VS):	
T: 99.2 F (37.3 C) oral	Words:	Denies
P: 92 (regular)	Intensity:	
R: 20 (regular)	Location:	
BP: 118/70	Duration:	
O2 sat: 98% RA	Aggravate:	
	Alleviate:	

*What VS data is **RELEVANT** and must be recognized as clinically significant by the nurse?*

RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE:	Appears comfortable, no acute distress
RESP:	Breath sounds clear with equal aeration bilaterally, nonlabored respiratory effort
CARDIAC:	Pink, warm and dry, no edema, heart sounds regular with no abnormal beats, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
NEURO:	Alert and oriented to person, place, time, and situation (x4), flat affect
GI:	Abdomen soft/nontender, bowel sounds audible per auscultation in all four quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact

*What assessment data is **RELEVANT** and must be recognized as clinically significant by the nurse?*

RELEVANT Assessment Data:	Clinical Significance:

Mental Status Examination (MSE):	
APPEARANCE:	Dressed in casual clothes, no make-up; no body odor; appears tired and appears stated age; cooperative during interview
MOTOR BEHAVIOR:	Psychomotor agitation, restless
SPEECH:	Speech is rapid, pressured
MOOD/AFFECT:	Appears anxious/fearful
THOUGHT PROCESS:	Illogical and not linear (thoughts do NOT make sense and are disorganized)
THOUGHT CONTENT:	Evidence of psychotic thinking and loss of contact with reality. States, "The devil is in the place! I can feel it! The voices are telling me that I am going to hell forever." Hearing voices telling her that she is worthless and would be better off dead.
PERCEPTION:	Auditory hallucinations present
INSIGHT/JUDGMENT:	Does not have insight, judgment is impaired
COGNITION:	Alert and Oriented x3, has difficulty concentrating
INTERACTIONS:	Has been isolating from friends and family over the last two days
SUICIDAL/HOMICIDAL:	Denies homicidal thoughts, is currently suicidal, and acted on this ideation by taking overdose of medication.

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

RELEVANT Assessment Data:	Clinical Significance:

Lab Results:

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

Complete Blood Count (CBC:)	Current:	High/Low/WNL?
WBC (4.5–11.0 mm ³)	5.2	
Hgb (12–16 g/dL)	14.2	
Platelets (150–450 x10 ³ /μl)	229	
Neutrophil % (42–72)	58	

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

RELEVANT Lab(s):	Clinical Significance:

Basic Metabolic Panel (BMP:)	Current:	High/Low/WNL?
Sodium (135–145 mEq/L)	140	
Potassium (3.5–5.0 mEq/L)	3.6	
Glucose (70–110 mg/dL)	125	
Creatinine (0.6–1.2 mg/dL)	0.5	

RELEVANT Lab(s):	Clinical Significance:

Misc. Labs:	Current:	High/Low/WNL?
Acetaminophen	0.00	
Salicylate	0.00	
Urine pregnancy	Neg	

RELEVANT Lab(s):	Clinical Significance:

Urine Drug Screen:	Current:
Opiates	
Benzodiazepines	
THC	
Amphetamines	
Cocaine	

RELEVANT Lab(s):	Clinical Significance:

Clinical Reasoning Begins...

1. *What is the primary problem that your patient is most likely presenting with?*
2. *What is the underlying cause/pathophysiology of this concern?*

Collaborative Care: Medical Management

Care Provider Orders:	Rationale:	Expected Outcome:
Acetaminophen level Salicylate level Complete blood count (CBC) Basic metabolic panel (BMP) Urine drug screen Urine pregnancy Establish peripheral IV Diazepam 5 mg IV PRN for seizure activity 1:1 watch Check for items of harm Cardiac monitor		

PRIORITY Setting: Which Orders Do You Implement First and Why?

Care Provider Orders:	Order of Priority:	Rationale:
Establish peripheral IV 1:1 watch Check for items of harm Cardiac monitor		

Collaborative Care: Nursing

3. *What nursing priority(s) 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 most thoroughly assess 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 with this patient’s experience, and show that 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 are unfolding 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?