Mental Health Case: Li Na Chen, Part 1

Documentation Assignments

1. **Document the search of Mrs. Chen and her belongings on admission.**

Mrs. Chen was explained the reason for the search of her belongings in order to maintain safety for her due to her suicide risk as well as for others. The items removed were a nail file, unwrapped tweezers, a travel sewing kit, a decorative pill box, a personal cell phone, a belt, shoelaces, and a string from her hoodie.

2. **Document the safety checks for Day 1.**

The scene was checked for safety and deemed appropriate because the nurse could get out of the room if needed.

3. **Document the findings of the mental status examination of Mrs. Chen on admission.**

Mrs. Chen is appropriately dressed for age and weather. She is clean and well-kept other than her hair, which is slightly disheveled. She has a slumped posture with no automatisms, such as tics, tremos, akathisia, or restlessness. Her mood is sad and depressed and her affect is congruent with her thought content. She does not have any indications of speech variations, like neologisms, aphasia, or pressured speech. Her thought content involved worries, frustrations, hopelessness/helplessness. She denies hallucinations. Thought process is goal-directed. She acknowledges self-harm or suicide urges as well as acknowledging death wish without suicidal intent. She denies homicidal ideation. She is positive for anhedonia. Mrs. Chen is orientated X3 with long-term memory deficits but a focused attention span. Her insight is good.

4. **Document the findings of the suicide assessment of Mrs. Chen.**

Mrs. Chen stated, " I cannot even do one thing right," "I don't want help; I just want to get away from this pain," "I don't think I can go on," when asked if Mrs. Chen has any thoughts or wishes to harm or kill herself.

5. **Identify and document key nursing diagnoses for Mrs. Chen.**

Risk for Suicide, Ineffective Coping, Helplessness

6. **Referring to your feedback log, document all nursing care provided and Mrs. Chen's response to this care.**

Feedback Log

0:00	You checked scene safety. It was correct to check scene safety in order to maintain your own safety.

0:06	You introduced yourself.
0:37	You washed your hands.
1:20	You asked the patient: Is it OK for your husband to be here, while we talk? It was correct to let the patient give her consent for letting her husband be a part of the interview.
1:38	The patient said: Jack has always been there for me, and I have let him down.\nYou answered: You have let him down? \nYou used the therapeutic technique of restating.
2:12	You identified the patient.
2:28	You asked if the patient had any known allergies.
2:34	You made a safety check of the surroundings and the patient's belongings.
3:37	You measured the blood pressure.
3:53	You checked the pulse oximetry.
4:11	You assessed the respiration.
4:22	You measured the temperature.
4:37	You checked the radial pulse.
6:13	You asked the patient: Have you had any changes in your appetite over the past month? The patient said: I am not hungry.
6:36	You asked the patient: Tell me about any changes you have had in your sleep over the past few weeks? The patient said: I sleep all the time but never feel rested.

6:55	You asked the patient: Do you have energy to do the normal activities necessary to get through the day?
7:09	The patient said: I can't do this anymore.\nYou answered: You can't do this anymore? \nYou used the therapeutic technique of restating.
7:37	You educated about the psychiatric diagnosis.
8:21	You asked the patient: I would like to ask you a series of questions about how you are feeling to help me better understand how together we can start to plan your care. These are questions I ask all of the patients I see. May I ask you these questions?
8:47	The patient said: Can you finish these questions later?\nYou answered: I realize this must be tiring for you; however, I need to finish your assessment now. \nYou used the therapeutic technique of giving information.
11:07	You asked the patient: Do you have any thoughts or wishes to harm or kill yourself?
11:22	The patient said: I cannot even do one thing right.\nYou answered: One thing right? \nYou used the therapeutic technique of restating.
11:31	You supported the patient about keeping safe.
11:40	You asked the patient: Do you think it would be better if you were not alive?
11:51	The patient said: I don't want help; I just want to get away from this pain.\nYou answered: Tell me more about your pain. \nYou used the nontherapeutic technique of probing.
11:5	You asked the patient: Do you have any thoughts or wishes to

7	harm anybody else? The patient said: No.
12:03	You asked the patient: Have you ever tried to harm or kill somebody else?
12:20	The patient said: I don't think I can go on.\nYou answered: Are you thinking about hurting yourself? \nYou used the therapeutic technique of restating.
12:25	You asked the patient: Can you tell me what a desired outcome of treatment would be for you? The patient said: I don't know. I can't do anything right.
12:38	You supported the patient's husband.
12:54	You asked the patient: How do you understand your problems?
13:07	The patient said: I'm nothing.\nYou answered: Do you feel that you have no self-worth? \nYou used the therapeutic technique of translating into feelings.
13:11	You asked the patient: Do you ever see or hear things that other people do not? The patient said: No, I do not.
13:18	You asked the patient: Do you find that you worry more than others? The patient said: I worry about many things.
13:26	You asked the patient: Are you frightened of anything?
13:36	The patient said: No one will care about me anymore.\nYou answered: Who do you care about? \nYou used the therapeutic technique of exploring.
14:3	You removed potentially dangerous objects.

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17:49 You submitted the Mental Status Examination form. Some of your assessment answers were incorrect.Regarding the indicator "1. Appearance. Grooming": You should not have checked any indications.

You should have asked the patient what was going on with her.

You should have asked the patient about when she felt her best.

18:29 You called the charge nurse. This is reasonable at this point.

The focus of this scenario is on patient safety following a suicide attempt and the necessary therapeutic communication skills required for ongoing assessment and support. Although it is important to acknowledge the potential physiologic complications that can arise with overdosing of acetaminophen and ibuprofen, this scenario addresses the mental health issues. Atypical antidepressants may be prescribed for patients who have an inadequate response to selective serotonin reuptake inhibitors or experience side effects. In this case, the patient's medications have recently been adjusted to include a serotonin norepinephrine reuptake inhibitor antidepressant, venlafaxine. This drug blocks the reuptake of serotonin, norepinephrine, and dopamine (weakly). Side effects of venlafaxine include an increase in blood pressure and pulse, nausea and vomiting, headache, dizziness, drowsiness, dry mouth, and sweating. This drug also can impact liver function tests (specifically AST and ALT) as well as kidney tests (specifically creatinine). Because this patient also has taken an overdose of acetaminophen and ibuprofen, these tests will be important to monitor.

You got 90%

7. Document patient education regarding medications.

Mrs. Chen was educated that her physician will be adjusting her medications while she is admitted to the hospital. Mrs. Chen was educated that it's important for her to adhere to the treatment plan and

openly communicate with hospital staff. Mrs. Chen was educated on the healthcare team finding the right mix of medications and other treatments to help her through her difficult time.

8. **Document your handoff report in the SBAR format to communicate the care plan for Mrs. Chen to the nurse on the next shift.**

Situation: Li Na Chen is a 40-year-old Chinese female who presented to the emergency room (ER) accompanied by her husband, Mr. Jack Chen. Mr. Chen reported that upon his return home today, he found his wife crying on the bathroom floor surrounded by several empty pill bottles. He reported that his wife told him "she can't live like this" and "she simply cannot function this way anymore." She has been admitted from the ER with major depression and suicide attempt.

Background: Li Na was diagnosed with depression 3 years ago, and she has had two suicide attempts with drug overdose over the past 3 years, requiring hospitalization both times. Her last attempt was 1 year ago. She sees a psychiatric nurse practitioner with prescriptive authority. Her treatment plan includes pharmacologic antidepressant therapy and biweekly counseling sessions. Her usual dose of sertraline was 100 mg, but 2 weeks ago, the nurse practitioner recommended tapering her sertraline and beginning a trial of venlafaxine. Since then, the nurse practitioner has been on vacation, and Li Na is scheduled for a follow-up upon her return from vacation. During the past 2 weeks, Li Na has made three visits to the community clinic with varying complaints of low back pain and headaches with increasing difficulty sleeping through the night. She has been prescribed extra-strength ibuprofen (600 mg) 4 times a day and as-needed extra-strength acetaminophen (500 mg). These are the drugs she overdosed on in her suicide attempt. Her husband also reports that she has lost 10 lb in the past month due to lack of appetite.

Assessment: The pill bottles for her recently prescribed acetaminophen and ibuprofen accompanying her appear empty. Mrs. Chen claims to have been using the medications as prescribed by the community clinic. Her husband reports that she may have taken approximately 6000 mg of acetaminophen and 4800 mg of ibuprofen. Acetylcysteine 7000 mg in 200 mL of 5% dextrose in water was given in the ER, and she underwent a gastric lavage; many recognizable pills were identified in the contents. Her vital signs are being monitored; the last set of vitals done at 1500 are as follows: temperature, 37°C (98.6°F); heart rate, 80 beats/min; respiratory rate, 16 breaths/min; and blood pressure, 112/70 mmHg. Blood for laboratory tests was obtained in the ER. The results are available in the chart. The acetaminophen level was 80 mcg/mL, and the ibuprofen level was 150 mcg/mL. They also assessed her depression in the ER using the Hamilton Depression Scale. The result is in her chart. I performed a Mental Health Status Examination. The result is in her chart. Any potentially dangerous objects were removed from Mrs. Chen belongings.

Recommendation: Maintain safety precautions and safety checks. Continue monitoring vital signs. Perform Mental Health Status Examination in five days to compare to baseline.