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| **Maryland Next Gen NCLEX Test Bank Project****September 1, 2022** |
| **Case Study Topic**: (& standalone trend) | Suicide Prevention & involuntary admission | **Author:**  |  Lauren Guy MSN, RN-BC, CNEAssistant ProfessorCollege of Southern Maryland  |

**Case Summary**

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| A 19-year-old client is treated in the ED for an overdose. This is the client’s second suicide attempt in the last 6 months, and it is determined that she is at high enough risk of self- harm to warrant an involuntary admission to the behavioral health unit.  |

**Objectives**

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| 1. Recognize the risk for self-harm 2. Anticipate the need for involuntary admission 3. Educate the client about rights when they have been involuntary admitted. |

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| **Case Study Link** | **Case Study QR Code** |
| <https://umaryland.az1.qualtrics.com/jfe/form/SV_3eKszlC4xNo4CJE> |  |
| **Trend QR Code** | **Trend Link** |
|  | <https://umaryland.az1.qualtrics.com/jfe/form/SV_0UGpN9QhEPXfRoG> |

**Case References**

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| 1. Lippincott Advisor. (October 1, 2021). Suicide. Lippincott Advisor for Education - View Document (lww.com)
2. Hogan, L., Mitchell, V., Rutherford, B. (2007). *Rights of Persons in Maryland’s Psychiatric Facilities.* Maryland Department of Health and Mental Hygiene. Rights of Persons in Maryland's Psychiatric Facilities Handbook rotate.pdf
3. CDC. (2021). *Suicide Prevention*. CDC. Risk and Protective Factors (cdc.gov)
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**Case Study Question 1 of 6**

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

* Click to highlight the 3 findings that are **most** urgent.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. Second dose of naloxone given for respiratory rate < 12. 1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is looking at the sharp’s container on the wall. States she has no insurance and “won’t talk to those people again.” |
| **Vital Signs**  |
| Time | 1700 | 1800 |
| Temp | 98.6F/37C | 98.0/36/7C |
| P or HR | 50 | 65 |
| RR | 9 | 12 |
| B/P | 100/65 | 111/75 |
| Pulse oximeter | 92% | 95% |
| Pain | 0 | 0 |

Key

1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional\* and stated, “I just want it to be over.\*” Client is voicing concerns about being in the ED and is looking at the sharp’s container on the wall.\* States she has no insurance and “won’t talk to those people again.”

**Scoring Rule: +/-**

Rationale: The priority concern for this client is safety. The RN should immediately follow up with the brother’s statement about guns being in the house and the client having an active plan to use them to cause harm. The RN should also be concerned about access to the sharps box with her recent suicide attempt and the client’s statement of wanting to end her life.

**Case Study Question 2 of 6**

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. Second dose of naloxone given for respiratory rate < 12. 1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is looking at the sharp’s container on the wall. States she has no insurance and “won’t talk to those people again.” |
| **Vital Signs**  |
| Time | 1700 | 1800 |
| Temp | 98.6F/ 37C | 98.0/36.7C |
| P  | 50 | 65 |
| RR | 9 | 12 |
| B/P | 100/65 | 111/75 |
| Pulse oximeter | 92% | 95% |
| Pain | 0 | 0 |

The toxicology report returns and is positive for oxycodone.

* For each finding, click to specify what risk factor’s the client has for suicide.

|  |  |  |
| --- | --- | --- |
| Assessment/Finding | Risk factor | Not risk factor |
| Previous suicide attempt  | * \*
 |  |
| Recent loss | * \*
 |  |
| 19 years-old |  | * \*
 |
| Weapons in home | * \*
 |  |
| No health insurance |  | \* |

**Scoring Rule: 0/1**

Rationale: Per the CDC, risk factors for suicide include previous suicide attempts, mental illness such as depression, substance use disorder, relationship problems such as a loss, etc.

**Case Study Question 3 of 6**

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. Second dose of naloxone given for respiratory rate < 12. 1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is looking at the sharp’s container on the wall. States she has no insurance and “won’t talk to those people again.”  |
| **Vital Signs**  |
| Time | 1700 | 1800 | 1830 |
| Temp | 98.6F/37C | 98.0/36.7C | 98.2F/37.8C |
| P or HR | 50 | 65 | 80 |
| RR | 9 | 12 | 14 |
| B/P | 100/65 | 111/75 | 120/86 |
| Pulse oximeter | 92% | 95% | 98% |
| Pain | 0 | 0 | 0 |
| **Laboratory Report** |
| Lab | Results | Reference range  |
| Urine tox | Positive for Oxycodone  | Negative  |

The nurse reviews the client assessment data and risk factors.

* Drag the most appropriate word from the choices to fill in the blank of the following sentence.

The top care priority for the client is to

|  |
| --- |
| Word Choices |
| Implement suicide precautions \* |
| Perform hourly suicide risk assessments |
| Monitor respiratory status  |
| Admit to behavioral health |

**Scoring Rule: 0/1**

**Rationale:** The client is presenting with several safety concerns, and it is crucial to keep them safe. While it is important to continue suicide risk assessments, it is clear the client is presenting with immediate safety needs related to suicidal comments and behaviors and suicide precautions must be implemented. Hourly suicided assessments are not sufficient.

**Case Study Question 4 of 6**

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. Second dose of naloxone given for respiratory rate < 12. 1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is adamant she will not stay. States she has no insurance and “won’t talk to those people again.”  |
| **Vital Signs**  |
| Time | 1700 | 1800 | 1830 |
| Temp | 98.6F/37C | 98.0/36.7C | 98.2F/37.8C |
| P  | 50 | 65 | 80 |
| RR | 9 | 12 | 14 |
| B/P | 100/65 | 111/75 | 120/86 |
| Pulse oximeter | 92% | 95% | 98% |
| Pain | 0 | 0 | 0 |
| **Laboratory report** |  |  |  |
| Lab | Results | Reference range  |
| Urine tox | Positive for Oxycodone  | Negative  |
| **Orders** |
| 1. Implement Suicide Precautions 2. Suicide Risk Assessment Q1H 3. Implement 1:1 Observer 4. Transfer to behavioral health  |

The nurse receives orders to admit the client to the behavior health unit for suicide risk.

* For each potential intervention, click to specify whether the intervention is indicated or not indicated for suicide precautions.

|  |  |  |
| --- | --- | --- |
| Potential Intervention | Indicated  | Not Indicated  |
| Remove all sharp objects from the room  | * \*
 |  |
| Consult the Chaplin  |  | * \*
 |
| Remove unnecessary cables, cords, and equipment  | * \*
 |  |
| Conduct frequent safety assessments  | * \*
 |  |
| Take vital signs every 5 minutes  |  | * \*
 |
| Screen visitors  | * \*
 |  |
| Apply restraints  |  | * \*
 |

**Scoring Rule: 0/1**

**Rationale:** The room should be prepared with limited linen, removal of all sharp objects, and removal of unnecessary cables, cords, and equipment when a client is on suicide precautions. There is not necessarily a restriction on staff or visitors. Visitors should be screened, and a Chaplin can be consulted per the client request. It is important to conduct frequent safety assessments, but vital signs every 5 minutes and restraints are not necessary currently.

**Case Study Question 5 of 6**

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. Second dose of naloxone given for respiratory rate < 12. 1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is adamant she will not stay. States she has no insurance and “won’t talk to those people again.”1900. Client refuses to be admitted to the behavioral health unit. Provider notified.1930. Emergency detention order obtained. |
| **Vital Signs**  |
| Time | 1700 | 1800 | 1830 |
| Temp | 98.6F/37C | 98.0/36.7C | 98.2F/36.7C |
| P or HR | 50 | 65 | 80 |
| RR | 9 | 12 | 14 |
| B/P | 100/65 | 111/75 | 120/86 |
| Pulse oximeter | 92% | 95% | 98% |
| Pain | 0 | 0 | 0 |
| **Laboratory report** |  |  |  |
| Lab | Results | Reference range  |
| Urine tox | Positive for Oxycodone  | Negative  |
| **Orders** |
| 1. Implement Suicide Precautions 2. Suicide Risk Assessment Q1H 3. Implement 1:1 Observer 4. Transfer to behavioral health  |

The client refuses to be admitted to the behavioral health unit and an emergency detention order for involuntary admission to the behavioral health unit is obtained.

What should the nurse teach the client about the process of an involuntary psychiatric admission? Select all that apply

* The client must be a danger to themselves or others\*
* The client has the right to refuse in physically intrusive research \*
* They can be admitted for up to 5 years in a psychiatric facility
* The client should seek legal counsel to contest this situation
* Friends and family are unable to visit during this admission.
* The client must receive verbal and written notice of their rights \*

**Scoring Rule: +/-**

**Rationale:** An involuntary psychiatric admission is granted when a client is a danger to themselves or others and if a client is unwilling to be admitted. The client must be given verbal and written information within 12 hours stating the reason for the involuntary admission, availability of legal services and their right to talk to a lawyer. Clients retain the right to be cared for in the least restrictive environment and the right to refuse to participate in any form of human subjects research.

**Case Study Question 6 of 6**

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. Second dose of naloxone given for respiratory rate < 12. 1800. Respiratory status has improved. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is adamant she will not stay. States she has no insurance and “won’t talk to those people again.”1900. Client refuses to be admitted to the behavioral health unit. Provider notified.1930. Emergency detention order obtained.  |
| **Vital Signs**  |
| Time | 1700 | 1800 | 1830 |
| Temp | 98.6F/37C | 98.0/36.7C | 98.2F/36.7C |
| P or HR | 50 | 65 | 80 |
| RR | 9 | 12 | 14 |
| B/P | 100/65 | 111/75 | 120/86 |
| Pulse oximeter | 92% | 95% | 98% |
| Pain | 0 | 0 | 0 |
| **Laboratory** **report** |  |  |  |
| Lab | Results | Reference range  |
| Urine tox | Positive for Oxycodone  | Negative  |
| **Orders** |
| 1. Implement Suicide Precautions 2. Suicide Risk Assessment Q1H 3. Implement 1:1Observer4. Consult to behavioral health  |

* For each client statement, click to specify whether the client statement indicates an understanding, or no understanding of teaching provided.

|  |  |  |
| --- | --- | --- |
| Statement | Understanding | No understanding |
| “So, I can go home after I take my medications?” |  | * \*
 |
| “My brother can visit with me.” | * \*
 |  |
| “I will not be able to see my best friend while I am hospitalized.” |  | * \*
 |
| “Even though I want to go home, I must stay.” | * \*
 |  |
| “If I promise not to take any more oxycodone, I can go home.”  |  | * \*
 |
| “Because of my depression and suicide attempts, I must stay and get help.”  | * \*
 |  |

**Scoring Rule: 0/1**

**Rationale:** The client verbalizes understanding when she states her brother can visit with her, friends and family are not limited to visitation. The client verbalizes understanding that even though she wants to be discharged, legally she will be admitted against her wishes due to her history of depression and suicide attempts.

Trend

The 19-year-old- female was treated in the emergency department for an oxycodone overdose.

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| **Nurses’ Notes** |
| 1700. The client was brought to the emergency department by ambulance accompanied by her brother. Client’s brother found the client unconscious on the bathroom floor with an empty oxycodone bottle. The brother reports the client is struggling with moderate depression after the sudden loss of their mother, and this is the client’s second suicide attempt in the last 6 months. Client’s brother reports he is very anxious about the client returning home because there are guns in the house. Yesterday he overheard her say that she had a plan to use the gun to end it all. The client was treated with naloxone in the ambulance. Upon arrival the client is lethargic and confused. T98.6F/37C, P 50, RR9, B/P 100/65 Pulse oximeter 92% on RA. Second dose of naloxone given. 1800. Respiratory status has improved. T98.0F/36.7C, P 65, RR12, B/P 112/75 Pulse oximeter 95% on RA. Client is alert, oriented, but agitated and is pacing in room. Admits the overdose was intentional and stated, “I just want it to be over.” Client is voicing concerns about being in the ED and is adamant she will not stay. States she has no insurance and “won’t talk to those people again.” |

* Complete the sentence from the list of options

|  |  |
| --- | --- |
| The nurse concludes the client | is stable enough for dischargeis at significant risk for self- harm\*should be restrained |
| The nurse’s best action is to | discharge the clientnotify the physician\*proceed with admitting the client |
| and  | schedule a follow-up appointmentobtain an emergency detention order\*request security help restrain the client  |

**Scoring Rule: 0/1**

**Rationale:** The client is now alert and oriented which is an improvement from admission in 1700. Pain is unchanged but the client’s respiratory system has improved. The client appears to be agitated/anxious about the involuntary admission which is a decline in psychological status from admission.