NURSING PROCESS FOCUS Clients Receiving Antidepressant Therapy

Assessment

Prior to administration:

- Obtain a complete health history including allergies, family history of mood disorders, and possible drug interactions.
- Establish baseline assessment of mood disorder. If possible, use a brief objective tool.
- Frequency of assessment will relate to the severity of the mood disorder.
- Obtain history of cardiac (including recent MI), renal, biliary, liver, and mental disorders including ECG and blood studies: CBC, platelets, glucose, blood urea nitrogen (BUN), creatinine, electrolytes, liver function tests and enzymes, and urinalysis.
- Assess neurologic statusal, including seizure activity and identification of recent mood and behavior patterns.

Potential Nursing Diagnoses

- Coping, Ineffective
- Powerlessness
- Thought Processes, Disturbed, related to side effects of drug, lack of positive coping skills
- Knowledge, Deficient, related to drug therapy
- Violence: Self-directed, Risk for
- Urinary Retention, related to anticholinergic side effects of drug
- Noncompliance, related to decreased sexual libido and/or weight gain
- Risk for Injury, related to adverse side effects
- Self-Care, Deficient, related to fatigue
- Nutrition, Imbalanced, Less than body requirements, related to anorexia
- Nutrition, Imbalanced, More than body requirements, related to side effects of medication or eating for comfort
- Grieving, Dysfunctional, related to loss (such as loss of health, job, significant other, etc.)

Planning: Client Goals and Expected Outcomes

The client will:

- Report mood elevation (may use short objective tool, such as the Beck Depression Tool).
- Remain safe from self-harm or harm directed toward others.
- Actively engage in self-care activities.
- Report abilty to fall asleep and stay asleep as was able to do before depression.
- Demonstrate an understanding of the drug's action by accurately describing drug side effects and precautions.

Implementation

Interventions and (Rationales)	Client Teaching/Discharge Planning
▪ Monitor vital signs, especially pulse and blood pressure, especially when initiating treatment. (Imipramine may cause orthostatic hypotension.)	Instruct client to: ▪ Report any change in sensorium, particularly impending syncope. ▪ Avoid abrupt changes in position. ▪ Monitor vital signs (especially blood pressure) properly using home equipment ▪ Consult the nurse regarding "reportable" blood pressure readings (e.g., lower than 80/50 mm Hg).
▪ Administer accurately. Give TCAs at bedtime to aid in sleep and minimize daytime drowsiness. (Always practice safe techniques of medication administration. Giving medication at bedtime will minimize the side effect of drowsiness.)	▪ Instruct client to take medication at bedtime to decrease daytime drowsines.
▪ Observe for signs and symptoms of improved mood, keeping in mind that it may take 2 to 4 weeks to achieve therapeutic effectiveness. (The risk of suicide may increase as energy levels rise.)	Instruct client: ▪ That it may take 2 to 4 weeks for mood to improve. ▪ To report any feelings of suicide.
▪ Observe for serotonin syndrome in SSRI use. (If suspected, discontinue drug and initiate supportive care. Respond according to ICU/emergency department protocols.)	▪ Inform client that overdosage may result in serotonin syndrome, which can be life threatening.
▪ Monitor for paradoxical diaphoresis. (This must be considered a significant sign, especially serious when coupled with nausea or vomiting or chest pain.)	▪ Instruct client to seek immediate medical attention for dizziness, headache, tremor, nausea/vomiting, anxiety, disorientation, hyperreflexia, diaphoresis, and fever.
▪ Monitor cardiovascular status. (Hypertension and stroke or MI and heart failure may be observed.)	▪ Instruct client to immediately report severe headache, dizziness, paresthesias, bradycardia, chest pain, tachycardia, nausea or vomiting, or diaphoresis.
▪ Monitor neurological status. Observe for somnolence and seizures. (TCAs may cause somnolence related to CNS depression. May reduce the seizure threshold.)	Instruct client to: ▪ Report significant changes in neurological status, such as seizures, extreme lethargy, slurred speech, disorientation, or ataxia, and discontinue the drug. ▪ Take dose at bedtime to avoid daytime sedation.

(Continued)

NURSING PROCESS FOCUS Clients Receiving Antidepressant Therapy *(Continued)*

Implementation

Interventions and (Rationales)	Client Teaching/Discharge Planning
▪ Monitor mental and emotional status. Observe for suicidal ideation. (Therapeutic benefits may be delayed. If severely depressed, outclients should have no more than a 7-day medication supply.) Monitor for underlying or concomitant psychoses such as schizophrenia or bipolar disorders. (The drug may trigger manic states.) When used as antianxiety agents, client may need temporary antianxiety agent or sleep aid. (Therapeutic levels are not immediately reached.).	Instruct client: ▪ To immediately report dysphoria or suicidal impulses ▪ To commit to a "no-self-harm" verbal contract ▪ That it may take 10 to 14 days before improvement is noticed, and about 1 month to achieve full therapeutic effect.
▪ Observe for anticholinergic or antiadrenergic adverse effects. (Cardiovascular effects are most serious, but other unwanted effects include CNS symptoms, gastrointenstinal problems, blurred vision, urinary retention, sexual dysfunction, and weight gain).	▪ Instruct client to report any changes bowel or bladder routines, blurred vision, weight gain, or sexual dysfunction.
▪ Monitor sleep–wake cycle. Observe for insomnia and/or daytime somnolence. Establish baseline data on onset and duration of sleep disorder. (Baseline data provide information as to whether symptoms are improving.)	Instruct client to: ▪ Take drug very early in the morning if insomnia occurs, to promote normal timing of sleep onset. ▪ Avoid driving or performing hazardous activities until effects of drug are known. ▪ Take at bedtime if daytime drowsiness persists. ▪ Follow principles of sleep hygiene.
▪ Monitor renal status and urinary output. (This drug may cause urine retention owing to muscle relaxation in urinary tract. Imipramine is excreted through the kidneys. Fluoxetine is slowly metabolized and excreted, increasing the risk of organ damage. Urinary retention may exacerbate existing symptoms of prostatic hypertrophy.)	Instruct client to: ▪ Monitor fluid intake and output. ▪ Notify the healthcare provider of edema, dysuria (hesitancy, pain, diminished stream), changes in urine quantity or quality (e.g., cloudy, with sediment). ▪ Report fever or flank pain that may indicate a urinary tract infection related to urine retention
▪ Use cautiously with elderly or young clients. (Diminished kidney and liver function related to aging can result in higher serum drug levels, and may require lower doses. Children, owing to an immature CNS, respond paradoxically to CNS drugs.)	Instruct client that: ▪ The elderly may be more prone to side effects such as hypertension and dysrhythmias. ▪ Children on imipramine for nocturnal enuresis may experience mood alterations.
▪ Monitor gastrointestinal status. Observe for abdominal distention. (Muscarinic blockade reduces tone and motility of intestinal smooth muscle, and may cause paralytic ileus.)	Instruct client to: ▪ Exercise, drink adequate amounts of fluid, and add dietary fiber to promote stool passage. ▪ Consult the nurse regarding a bulk laxative or stool softener if constipation becomes a problem.
▪ Monitor liver function and blood studies including CBC, differential, platelets, prothrombin time (PT), partial thromboplastin time (PTT), and liver enzymes. (These results determine signs and symptoms of hepatotoxicity.)	Instruct client to: ▪ Report nausea, vomiting, diarrhea, rash, jaundice, epigastric or abdominal pain, tenderness, or change in color of stool. ▪ Adhere to laboratory testing regimen for blood tests and urinalysis as directed.
▪ Monitor hematologic status. Observe for signs of bleeding. (Imipramine may cause blood dyscrasias. Use with warfarin may increase bleeding time.)	Instruct client to: ▪ Report excessive bruising, fatigue, pallor, shortness of breath, frank bleeding, and/or tarry stools. ▪ Demonstrate guaiac testing on stool for occult blood.
▪ Monitor immune/metabolic status. Use with caution in clients with diabetes mellitus or hyperthyroidism. (If given in hyperthyroidism, it can cause agranulocytosis. Imipramine may either increase or decrease serum glucose. Fluoxetine may cause initial anorexia and weight loss, but with prolonged therapy may result in weight gain of up to 20 lb.)	▪ Instruct diabetic clients to monitor glucose level daily and consult nurse regarding reportable serum glucose levels (e.g., less than 70 and more than 140 mmol/L). ▪ Instruct client that anorexia and weight loss will diminish with continued therapy.

NURSING PROCESS FOCUS Clients Receiving Antidepressant Therapy *(Continued)*

Implementation

Interventions and (Rationales)	Client Teaching/Discharge Planning
▪ Observe for extrapyramidal and anticholinergic effects. In overdosage, 12 hours of anticholinergic activity is followed by CNS depression. Do not treat overdosage with quinidine, procainamide, atropine, or barbiturates. (Quinidine and procainamide can increase the possibility of dysrhythmia, atropine can lead to severe anticholinergic effects, and barbiturates can lead to excess sedation.)	Instruct client to: ▪ Immediately report involuntary muscle movement of the face or upper body (e.g., tongue spasms), fever, anuria, lower abdominal pain, anxiety, hallucinations, psychomotor agitation, visual changes, dry mouth, and difficulty swallowing. ▪ Relieve dry mouth with (sugar-free) hard candies or chewing gum, and by drinking fluids. ▪ Avoid alcohol-containing mouthwashes, which can further dry oral mucous membranes.
▪ Monitor visual acuity. Use with caution in narrow-angle glaucoma. (Imipramine may cause an increase in intraocular pressure. Anticholinergic effects may produce blurred vision.)	Instruct client to: ▪ Report visual changes, headache, or eye pain. ▪ Inform eye care professional of imipramine therapy.
▪ Ensure client safety. (Dizziness caused by postural hypotension increases the risk of fall injuries.)	Instruct client to: ▪ Call for assistance before getting out of bed or attempting to ambulate alone. ▪ Avoid driving or performing hazardous activities until blood pressure is stabilized and effects of the drug are known.

Evaluation of Outcome Criteria

Evaluate effectiveness of drug therapy by confirming that client goals and expected outcomes have been met (see "Planning").

- The client reports an elevation of mood.
- The client is free of self-harm and verbalizes no intent to harm others.
- The client initiates self-care activities.
- The client reports ability to fall asleep and stay asleep at night.
- The client demonstrates an understanding of the drug's action by accurately describing drug side effects and precautions.

See Table 16.1 for a list of drugs to which these nursing actions apply.