

Part I: Recognizing RELEVANT Clinical Data

History of Present Problem:

Karen West is a 26-year-old single female who was admitted to the mental health unit this morning (0200) for a possible overdose of pills following a fight with Steve, her boyfriend of six months. Steve shared that Karen flew into a rage when he suggested that she “slow down” on her drinking at a party last night. She stormed out after throwing a drink at him. When he arrived home an hour later Karen was breathing, but unresponsive with an open bottle of unknown pills on the floor. Steve called 911, and she brought to the emergency department (ED).

In the ED, Karen began to awaken and stated that she remembers getting angry at her boyfriend at the party and thinks she may have thrown a drink in his face. When she gets that angry, “Everything goes black.” She feels embarrassed at what she did but is more upset that her boyfriend turned out to be “like everybody else. People always let you down. He will probably leave me now, won’t he?” She remembers she couldn’t calm down after she got home and just kept taking more and more pills hoping that would help. She states, “I wasn’t trying to kill myself.” There is a recent superficial cut on her left thigh that is 4 cm in length. She admits that her life is getting out of control again and agreed to admit herself voluntarily to a behavioral health unit, so she doesn’t “do something crazy.”

Personal/Social History:

Karen describes herself as someone who never feels content. She can feel deliriously happy at one point and then sad or angry ten minutes later. She tries to put on a happy face for others, but almost always feels anxious. Even when things are going well, she states that she feels like she is a fraud. She admits that sometimes the only way to feel better is to cut herself. She revealed “old” razor blade cuts (scarring) to her inner thighs. She frequently drinks and uses marijuana to calm down.

She was hospitalized once in her freshman year of college for depression and “cutting.” She saw a therapist for a few weeks and started on an antidepressant, but the therapist was “awful,” and the medication made her gain weight, so she quit both.

What data from the histories are RELEVANT and have clinical significance to 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:	
T: 99.0 F/37.2 C (oral)	Provoking/Palliative:	Provoked by movement of leg
P: 86 (regular)	Quality:	Dull
R: 20 (regular)	Region/Radiation:	Left inner thigh
BP: 130/82	Severity:	2/10
O2 sat: 98% room air	Timing:	Continuous

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

RELEVANT VS Data:	Clinical Significance:

Current Assessment:	
GENERAL APPEARANCE:	Appears to be uncomfortable.
RESP:	Breath sounds clear with equal aeration bilaterally ant/post, nonlabored 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/nontender, bowel sounds audible per auscultation in all four quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact except superficial 4 cm cut to left inner thigh. Multiple scars from previous self-harm cutting

Mental Status Examination:	
APPEARANCE:	Disheveled with no body odor; appears younger than stated age.
MOTOR BEHAVIOR:	Fidgeting in chair; wringing hands
SPEECH:	Clear with normal rate and rhythm
MOOD/AFFECT:	Reports feeling sad and remorseful for her behavior. Flat affect. Reports feeling anxiety level of 8 out of 10.
THOUGHT PROCESS:	Linear, logical
THOUGHT CONTENT:	Currently reality-based thinking. No evidence of delusional thinking when assessed. Some evidence of cognitive distortions
PERCEPTION:	Denies hallucinations
INSIGHT/JUDGMENT:	Insight fair – knows she needs some help now. Judgment: Fair to poor: Tends to think about using maladaptive coping skills
COGNITION:	Alert and orientated x4. Reports some memory issues around the events of previous night Short term memory intact when tested. Long-term memory grossly intact – able to give an accurate history
INTERACTIONS:	Reports “people always let you down” so she doesn’t trust people
SUICIDAL/HOMICIDAL: Self-Harm	Admits she could have died “by accident” from taking so many pills. Reports she thinks about ending it all but denies a suicide plan. Feels so anxious that she thinks about cutting herself while in the hospital to help herself calm down.

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

(Reduction of Risk Potential/Health Promotion & Maintenance)

RELEVANT Assessment Data:	Clinical Significance:
RELEVANT Mental Status Exam Data:	Clinical Significance:

Diagnostic Results:

BMP:	Sodium (135–145)	Potassium (3.5–5)	Glucose (70–110)	Creatinine (0.6–1.2)
Current:	138	4.8	99	1.0
Prior:	140	4.5	88	1.1
CBC:	WBC (4.5-11)	Neutrophil (42-72%)	Hgb (12-16)	Platelets (150-450)
Current:	7.0	44	12.8	229
Prior:	8.9	58	13.2	298
LFT:	Albumin (3.5–5.5 g/dL)	Total Bili (0.1–1.0 mg/dL)	ALT (8–20 U/L)	AST (8–20 U/L)
Current:	3.9	0.8	38	34
Prior:	4.1	0.5	24	22
Misc:	ETOH level	Acetaminophen	Aspirin	
Current:	0.28	0.0	0.0	
Prior:	n/a	n/a	n/a	

What data must be interpreted as clinically significant by the nurse? (Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Diagnostic Data:	Clinical Significance:	TREND: Improve/Worsening/Stable:

Part II: Put it All Together to THINK Like a Nurse!

1. After interpreting relevant clinical data, what is the primary problem?

(Management of Care/Physiologic Adaptation)

Problem:	Pathophysiology in OWN Words:

Collaborative Care: Medical Management

2. State the rationale and expected outcomes for the medical plan of care. (Pharm. and Parenteral Therapies)

Care Provider Orders:	Rationale:	Expected Outcome:
<p>Voluntary admission to behavioral health unit</p> <p>CIWA every shift or as indicated. Treat with Ativan for symptoms of withdrawal - score above 15</p> <p>Close Observations for positive suicide, self-harm or violence ideation and if patient is unable to contract for safety per unit protocol</p> <p>Milieu therapy</p> <p>Fluoxetine 20 mg PO in AM</p> <p>Topiramate 100 mg PO every 12 hours</p> <p>Olanzapine 2.5 mg PO every 6 hours PRN acute agitation</p> <p>Lorazepam 1 mg PO every 4 hours PRN for ETOH withdrawal symptoms</p>		

Collaborative Care: Nursing

3. *What is the nursing PRIORITY and plan of care? (Management of Care)*

Nursing PRIORITY:		
Nursing Interventions:	Rationale:	Expected Outcome:

4. *What psychosocial/holistic care PRIORITIES need to be addressed for this patient? (Psychosocial Integrity)*

Psychosocial Priorities:		
Nursing Interventions:	Rationale:	Expected Outcome:

5. *What can you do to engage yourself with this patient's experience, and show that he/she matters to you as a person? (Psychosocial Integrity/Basic Care and Comfort)*