SKINNY Reasoning

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:**
Found unresponsive c empty pill bottle Irrational response to being told to slow down, denial @ ED Cuts/scars blackouts	Suicide attempt/overdose Possible Mental Illness, personality disorder Risk for Self harm
RELEVANT Data from Social History:	**Clinical Significance:**
Inconsistant/irrational emotions Excess drug/alcohol use + Cutting interpersonal problems	Personality disorder Poorly coping with mental illness Trouble c relationships

Patient Care Begins:

Current VS:	**P-Q-R-S-T Pain Assessment:**	
T: 99.0 F/37.2 C (oral)	**P**rovoking/Palliative:	Provoked by movement of leg
P: 86 **(**regular)	**Q**uality:	Dull
R: 20 (regular)	**R**egion/Radiation:	Left inner thigh
BP: 130/82	**S**everity:	2/10
O2 sat: 98% room air	**T**iming:	Continuous

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

RELEVANT VS Data:	**Clinical Significance:**
BP 130/82	High blood pressure.

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:**
appears uncomfortable. 4cm Cut left thigh. multiple scars	Anxious Long Hx of cutting behavior
RELEVANT Mental Status Exam Data:	**Clinical Significance:**
fidgeting. Anxiety 8/10. feels remorse trust issues Possible Denial	Client is nervous but acknowledges she needs help. Unclear why she thinks everyone "lets her down" Client insists all taking was on accident

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:**
ALT 38 AST 34	Values indicate damage to liver	Worsening
ETOH	Client had very high blood alcohol @ admission	improving/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:
Bipolar Disorder Safety	Client shows mood swings from highs to lows. Poor coping mechanisms in substance abuse & cutting. Risk for self harm, and alcohol withdrawal. Place client in safe environment without ways to self harm and monitor.

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:
Voluntary admission to behavioral health unit	Monitor, get Bipolar disorder under control.	Better Coping Mechanism.
CIWA every shift or as indicated. Treat with Ativan for symptoms of withdrawal - score above 15	Benzos help c alcohol withdrawal symptoms	↓ side effects of withdrawal
Close Observations for positive suicide, self-harm or violence ideation and if patient is unable to contract for safety per unit protocol	Client tried to kill self c pills while alone	↓ likelihood of suicide attempt.
Milieu therapy	Give client sense of community	↑ clients self awareness of her problems
Fluoxetine 20 mg PO in AM	SSRI antidepressant	treat depression
Topiramate 100 mg PO every 12 hours	Can be used to Control BP mood swings	↓ mood swings
Olanzapine 2.5 mg PO every 6 hours PRN acute agitation	Antipsycotic	treat Bipolar Disorder
Lorazepam 1 mg PO every 4 hours PRN for ETOH withdrawal symptoms	Benzo, treat withdrawal symptoms from alcohol	↓ side effects alcohol withdrawal.

Collaborative Care: Nursing

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

Nursing PRIORITY:		
Nursing Interventions:	**Rationale:**	**Expected Outcome:**
Maintain low Stimuli environment Safety CIWA Monitor Client	Keep Client from being overwelmed Remove things that could be used for self harm	Minimize anxiety Client is Safe

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

Psychosocial Priorities:		
Nursing Interventions:	**Rationale:**	**Expected Outcome:**
Moderate Cardio Administer meds CIWA Group therapy	Redirects aggessive behavior Treat clients anxiety, mood therapy	Stress relief Controlled anxiety

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)*

Show client that you are happy they are there for you to help them.

Anticipate needs, offer electrolyte fluids, Competent skills, be on time & assesments.

Preserve dignity- theraputic communication. Pt education, Meds / side effects