Group III Shawn Weber, Kristy Geier, Aleisa Gutierrez, Claire Guyon
Jordan Helton, Mallorie Mason

Dementia/Physical Aggression

Ron Jackson, 87 years old

Primary Concept		
COGNITION		
Interrelated Concepts (In order of emphasis) • Psychosis • Mood and Affect • Coping • Clinical Judgment		
NCLEX Client Need Categories	**Percentage of Items from Each Category/Subcategory**	**Covered in Case Study**
Safe and Effective Care Environment		
• Management of Care	17-23%	✓
• Safety and Infection Control	9-15%	
Health Promotion and Maintenance	6-12%	✓
Psychosocial Integrity	6-12%	✓
Physiological Integrity		
• Basic Care and Comfort	6-12%	✓
• Pharmacological and Parenteral Therapies	12-18%	✓
• Reduction of Risk Potential	9-15%	✓
• Physiological Adaptation	11-17%	✓

Part I: Recognizing RELEVANT Clinical Data

History of Present Problem:

Ron Jackson is an 87-year-old Caucasian male with a medical history of hypertension and Alzheimer's disease who was brought to the emergency department (ED) by paramedics for evaluation of hallucinations, increased agitation, and aggressive behavior toward Shirley, his elderly wife. His daughter was visiting and witnessed Ron becoming angry for no apparent reason, telling Shirley she had to leave the house. He then pushed her, causing her to fall to the ground.

Ron has become progressively more agitated the past year and was started on quetiapine. Shirley confirms that Ron has been more verbally abusive the past week, believing that she divorced him and that she needs to get out of the house, but no physical aggression took place until today. Ron currently complains of a headache and insists that he got this because "the Koreans beat me up real good in the ambulance!"

Personal/Social History:

Ron lives at home with Shirley, his wife of 62 years and has three children. Ron is a Korean War veteran who saw active duty and is a retired salesman. Because his wife has been struggling to care for him, his family is in the process of making arrangements for him to reside at a local memory care unit.

What data from the histories are RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential)

RELEVANT Data from Present Problem:	**Clinical Significance:**
Client is aggressive toward wife. Med Hx Alzheimers	Danger to others around him. Safety! Delusions / Hallucinations / Aggressive Behavior
RELEVANT Data from Social History:	**Clinical Significance:**
War Veteran	Mental status puts him in fight or flight mode. Aggressive.

1. ***Identify the relationship between the PMH and home medications. Which medication treats which condition? Draw a line to connect the PMH to the correct medication.***

Past Medical History (PMH):	**Home Meds:**
Hyperlipidemia	Donepezil 10 mg PO at HS
Hypertension	Aspirin 325 mg PO daily
Alzheimer's disease	Memantine 10 mg PO BID
Agitation/Delusions	Simvastatin 20 mg PO HS
	Triamterene-HCTZ 75-50 mg PO daily
	Quetiapine 50 mg PO BID

2. ***Is there a relationship between any problem in his past medical history and the present problem? If so, describe.***

Agitation/Delusions + Alzeimers disease.

Patient Care Begins:

Current VS:	**P-Q-R-S-T Pain Assessment:**	
T: 98.0 F/36.7 C (oral)	**P**rovoking/Palliative:	"Those Koreans banged my head in the ambulance."
P: 78 **(**regular)	**Q**uality:	"That's a stupid question!"
R: 18 (regular)	**R**egion/Radiation:	"My head hurts all over!"
BP: 148/90	**S**everity:	"It just hurts!"
O2 sat: 98% room air	**T**iming:	"All the time."

What VS data are RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential/Health Promotion and Maintenance)

RELEVANT VS Data:	**Clinical Significance:**
BP 148/90 Pain	↑ Delusional, talking about Koreans

Current Assessment:	
GENERAL APPEARANCE:	Thin elderly male, appears stated age, sitting upright on stretcher, appears tense
RESP:	Breath sounds clear with equal aeration bilaterally ant/post, non-labored respiratory effort
CARDIAC:	Pink, warm & dry, no edema, heart sounds regular with no abnormal beats, pulses strong, equal to palpation at radial/pedal/post-tibial landmarks, brisk capillary refill
NEURO:	Oriented to person only, denies hallucinations
GI:	Abdomen flat, soft/non-tender, bowel sounds audible per auscultation in all four quadrants
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact, skin turgor elastic, no tenting present

Mental Status Examination (MSE):	
APPEARANCE:	Disheveled appearance; cooperative at times, other times irritable
MOTOR BEHAVIOR:	Variable; at times pacing and agitated; at other times sits quietly
SPEECH:	Able to understand what the patient is saying
MOOD:	Variable; quiet and calm with sudden episodes of anger, anxiety, and irritability
AFFECT:	Variable: looks calm, then may suddenly appear angry
THOUGHT PROCESS:	Able to understand what the patient is saying
THOUGHT CONTENT:	Paranoid and persecutory delusions/ideation; "Koreans" are harming him; delusions "believes wife divorced him"
PERCEPTION:	Denies hallucinations
INSIGHT:	Grossly impaired; attributes H/A to an attack by "Koreans"; not aware of illness or reason for ER visit
JUDGMENT:	Grossly impaired
COGNITION:	Oriented to person only. Significant short- and long-term memory deficits
SUICIDAL/HOMICIDAL:	High risk for physical aggression toward others; recently assaultive toward wife; unable to assess suicide ideation at this time

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:**
A+Ox1 Disheveled look	Oriented to person only, denies hallucinations. Unable to care for self.
RELEVANT Mental Status Exam Data:	**Clinical Significance:**
Variable Mental Status paranoria	Client's mood is very inconsistent Outbursts of aggrecion Judgement & insight grossly impaired percisutory delusions lack of insight

Lab Results:

Complete Blood Count (CBC)					
	WBC	HGB	PLTs	% Neuts	Bands
Current:	5.8	14.5	154	69	0
Last Adm:	6.5	14.2	188	75	0

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?
(Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**
	WNL	

Basic Metabolic Panel (BMP)					
	Na	K	Gluc.	Creat.	
Current:	142	3.3	114	1.3	
Last Adm:	144	3.5	121	1.2	

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?
(Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**
	Glucose a little ↑ may be due to stress. K+ lowish, give electrolytes.	

Urinalysis + UA Micro										
	Color:	Clarity:	Sp. Gr.	Protein	Nitrite	LET	RBCs	WBCs	Bacteria	Epithelial
Current:	Yellow	Clear	1.020	Neg	Neg	Neg	Neg	Neg	Neg	None
Last Adm:	Yellow	Clear	1.020	Neg	Neg	Neg	Neg	Neg	Neg	None

What lab results are RELEVANT and must be recognized as clinically significant by the nurse?
(Reduction of Risk Potential/Physiologic Adaptation)

RELEVANT Lab(s):	**Clinical Significance:**	**TREND: Improve/Worsening/Stable:**
	WNL	

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

1. ***Interpreting relevant clinical data, what is the primary problem? What primary health-related concepts does this primary problem represent?*** *(Management of Care/Physiologic Adaptation)*

Problem:	**Pathophysiology of Problem in OWN Words:**	**Primary Concept:**
Delusion/ violent	Mental Status has deteriorated to the point where he is no longer cognicent of what is going on	Cognition

Collaborative Care: Medical Management

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

Medical Management:	**Rationale:**	**Expected Outcome:**
Violence precautions	Keep everyone safe	Safety
Continue home medications	Control B/P, ↓effects alzheimers.	
Lorazepam 0.5 mg. po PRN every 4 hours x 24 hours	Contrd Anxiety, calm down client. Sedation	
Acetaminophen 2 tabs (325 mg) every 4 hours PRN pain. Not to exceed 4000 mg in 24 hours	Control Pain	
Consult: Mental Health/Behavioral Health professional	Get mental Status Stable	
Referral to social work for help with memory care facility placement after d/c from hospital	Client/wife unable to adress ADLs for client	

Collaborative Care: Nursing

3. What nursing priority (ies) will guide your plan of care? *(Management of Care)*

Nursing PRIORITY:		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
Safety Assist c ADLs	Client unable to help self.	

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

Psychosocial PRIORITIES:		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
CARE/COMFORT: ***Caring/compassion as a nurse*** Therapeutic Communication ***Physical comfort measures***	Gain client trust Offer physical pressence Perform ADLs, keep client clean/dry.	find triggers of aggressive behaviors
EMOTIONAL (How to develop a therapeutic relationship): ***Discuss the following principles needed as conditions essential for a therapeutic relationship:*** • *Rapport* • *Trust* • *Respect* • *Genuineness* • *Empathy*	Engage c pt, show that they are valued/cared for by nurse	Client comfort ↑

Evaluation: Sixty Minutes Later…

You go into the patient's room to re-evaluate his status. He states to you, "There are people who want to get me!" Ron becomes agitated and looks you in the eye and angrily states, "Who the hell are you and what are you doing in my house!" You tell him that he is at the hospital and in a safe place. He replies, "I am at home and what the hell are you doing here!" He suddenly takes his right arm and attempts to punch you and narrowly misses your face…

1. What data is RELEVANT and must be interpreted as clinically significant by the nurse?
(Reduction of Risk Potential)

RELEVANT Data from Present Problem:	**Clinical Significance:**
Client is in distress, attempts to assault nurse	

2. Has the status improved or not as expected to this point? Does your nursing priority or plan of care need to be modified in any way after this evaluation assessment? *(Management of Care, Physiological Adaptation)*

Evaluation of Current Status:	**Modifications to Current Plan of Care:**
Paranoid!	Help client calm down understand current environment.

3. Based on your current evaluation, what are your CURRENT nursing priorities and plan of care?
(Management of Care)

CURRENT Nursing PRIORITY:		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**

Use Reflection to Develop Clinical Judgment

What did you do well in this case study?	**What knowledge deficits did you identify?**
What did you learn?	**How will you apply learning caring for future patients?**