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SKINNY Reasoning

Part I: Recognizing RELEVANT Clinical Data

History of Present Problem:

Jeremy Brown is a 30-year-old Caucasian male who was brought to the emergency department (ED) by the police after being involved in an altercation at work. Jeremy was at work today, and he threw a large piece of metal at a coworker and began yelling, "Stop following me, I know what you have been up to!" Because Jeremy was very agitated and upset, and the police were called.

Since arriving in the ED, he has been agitated, displaying rapid pressured speech and repeating the phrases he hears the police and others in the ED said. Jeremy reported that he recently stopped taking his risperidone and citalopram because he believed his coworkers have been breaking into his house and poisoning his medications. Jeremy's manager reports that he was diagnosed with schizophrenia five years ago.

Personal/Social History:

Jeremy graduated from college with a 4.0 GPA and was in his first year at law school when he experienced the first episode of acute mental illness and was diagnosed with schizophrenia. He had to drop out of law school at age 24 and never finished. Jeremy lives at home with his mother and father and recently broke up with his girlfriend.

Jeremy likes his job at the foundry but feels he is a disappointment because both of his sisters are lawyers, as is his father. Jeremy has no close friends and only a few acquaintances. Jeremy's mental health had been stable up until the last three months. He has been feeling more paranoid the past three months and experienced a dramatic increase in symptoms when he stopped taking all of his medications one month ago.

What data from the histories are RELEVANT and have clinical significance to the nurse?

RELEVANT Data from Present Problem:	**Clinical Significance:**
-Threw large piece of metal at a coworker •Yelled "stop following me, I know what you've been up to" • Signs of rapid speech & repetition of words •Stopped taking meds because he thinks coworkers are trying to poison him	• Pt should be monitored to make sure of escalation w/ coworkers. Paranoia is Sx of Schizophrenia echolia + pressured speech Sxs of mental illness + Schizophrenia •Pt experiencing paranoia + persecutory delusions which exacerbate Schizophrenia.
RELEVANT Data from Social History:	**Clinical Significance:**
•Recently broke up w/ girlfriend. •Dx Schizophrenia 5yrs. ago. •Feels like a failure because he dropped out of law school due to dx. •~~0~~ Friends. • Feels more paranoid recently since stopping meds.	• Relationship changes can trigger relapse of psych issues. • Pt experiencing acute phase of schizophrena + dx of schizophrena - which explains Sxs. • Feelings of disappointment lead to depression, anxiety etc. • Needs some type of socialization - ie. therapy group • Needs to be placed back on meds. • Family needs education on psych issues • med Reconciliation.

Patient Care Begins:

Current VS:	**P-Q-R-S-T Pain Assessment:**	
T: 97.8 F/36.6 C (oral)	**P**rovoking/Palliative:	Denies pain
P: 100 **(**regular)	**Q**uality:	
R: 22 (regular)	**R**egion/Radiation:	
BP: 130/84	**S**everity:	
O2 sat: 98% room air	**T**iming:	

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

RELEVANT VS Data:	Clinical Significance:
Pulse 100 RR 22 BP 130/86	• Pulse + respirations are elevated BP elevated. Prob caused by exacerbation of Sys.

Current Assessment:	
GENERAL APPEARANCE:	Calm, body relaxed, no grimacing, appears to be resting comfortably
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 to 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, skin turgor elastic, no tenting present

Mental Status Examination:	
APPEARANCE:	Diaphoretic, uncombed shoulder-length, somewhat greasy hair; cloths are stained and torn. Cooperative with the admission process.
MOTOR BEHAVIOR:	No abnormal muscle movements
SPEECH:	Rapid and pressured. Client often repeats words and phrases he hears others in the emergency room say. The client says, "He was brought to the emergency room" over and over again when he is not distracted or engaged in conversation.
MOOD:	Reports feeling very upset
AFFECT:	Becomes agitated/anxious when talking about his co-workers and his meds; guarded and suspicious, mood and affect are congruent.
THOUGHT PROCESS:	Linear but irrational
THOUGHT CONTENT:	Displays paranoid delusions that coworkers are following him to hurt him and are poisoning his medication.
PERCEPTION:	Denies auditory or visual hallucinations, or feelings of depersonalization (feeling detached from self or environment)
INSIGHT:	Poor-believes he was brought in to the emergency room for protection from his coworkers
JUDGMENT:	Poor-stopped meds and is acting aggressively towards co-workers
COGNITION:	Alert and oriented times 4 (person, place, time and purpose), is easily distracted
INTERACTIONS:	Is in good control when talking with nursing staff, his boss, and police.
SUICIDAL/HOMICIDAL:	Denies any suicidal thoughts or thoughts of self-harm. Stated he wants to "punish" his co-workers.

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

RELEVANT Assessment Data:	Clinical Significance:
• Calm + Relaxed	• Affect + effect misaligned.
• mood upset	• Changes in mood + behavior are symptomatic of psychosis.
RELEVANT Mental Status Exam Data:	**Clinical Significance:**
- A/O x 4	- Pt aware to self, place, time + events. RO Secondary issues.
- Poor hygiene/appearance	- Diminished care (self care)
- Pressured Speech	- acute episode of schizophrenia
- Paranoia	- Sx seen during schizophrenic episode.
- Poor insight + judgement	- Pt inappropriate behaviors, monitor closely.
- States he wants to punish coworkers.	• Needs further evaluation using mental health assessment tools (Lethargy assessment tool).

Diagnostic Results:

BMP:	Sodium (135–145)	Potassium (3.5–5)	Glucose (70–110)	Creatinine (0.6–1.2)
Current:	130	3.5	160	1.1
Prior:	135	3.8	128	1.0
CBC:	WBC (4.5-11)	Neutrophil (42-72%)	Hgb (12-16)	Platelets (150-450)
Current:	6.5	60	12.5	250
Prior:	8.2	68	12.8	289

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:**
• Sodium ↓	• Malnourishment • Fluid/electrolyte imbalance	• worsening
• Glucose ↑	Poss. diabetes	Worsening
• Potassium ↓	Heart contracillaty good. Monitor I+O	Worsening
• creatinine	Monitor Kidney Function	Stable
• WBC	• trending down ↓ Nutrition	Worsening
• Neutrophil	- evaluate infection -> side effect of psych meds.	worsening
• Hbg	- evaluate anemia, bleeding - Needs monitored.	worsening
• platlets	- evaluate decreased clotting or increased risk for clotting. Needs monitored.	worsening

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:**
Acute Psycosis related to schizophrenia	Client is noncompliant with his medication. Cause of schizophrenia is not known but is suspected to relate to genetic, brain chemical, and environmental factors. Stressors such as viral infections, malnutrition, and traumatic events are believed to contribute.

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:**
Admit to the inpatient mental health unit on a voluntary status	Pt is experiencing sxs that need to be stabilized.	He will be voluntary & needs to stabilize Schizophrenia
Risperidone 2mg PO BID	Antipsychotic med.	
Citalopram 20mg PO at HS	antidepressant - assoc. psychotic episode	
Lorazepam 1mg PO every 6 hours PRN for anxiety or agitation	Benzo - helps stabilize mood tx anxiety	- decrease depression
Haloperidol 5mg IM every 4 hours PRN for severe agitation	Antipsychotic that tx psychotic sxs	- decrease anxiety - Reduce agitation

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:
1. Provide a safe environment and Milieu Therapy.	This will help the patient feel safe and comfortable.	Making the client feel safe will allow the client to open up.
2. Build trust with the patient and use therapeutic communication	This establishes a good nurse/patient relationship	The client will be able to trust the nurse.
3. Suicide Assessment	Client is in distress.	Client cannot harm himself

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

Psychosocial Priorities:		
Nursing Interventions:	**Rationale:**	
Put client on 1-1 observation	Make it impossible for client to harm self or others.	Safety!
Suicide assessment	Ensure Clients risks	

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

Therapeutic Communication.

Follow through Promises.

Don't be too confrontational.