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:**
Keith has rapid and pressure speech. He was violent at work and is repeating phrases he hears. He was diagnosed with schizophrenia five years ago but stopped taking his medication.	The information is significant because the healthcare team is able to use this information to help diagnose and treat the problem going on.
RELEVANT Data from Social History:	**Clinical Significance:**
When the patient was in school he had to drop out due to schizophrenia. Several factors could be affecting his mental health such as he feels that he is a disappointment and his recent breakup with his girlfriend. He does live with family but doesn't have other support such as friends. He stopped taking his medication one month ago.	The information shows that he is diagnosed with schizophrenia and recently has had many stress triggers.

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:	

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

RELEVANT VS Data:	**Clinical Significance:**
His blood pressure and respirations are elevated.	This information is an important tool in gauging the patient's health and helping to determine if there are any other ailments. We don't have his baseline vitals available but this could indicate that at minimum there is some stressors going on.

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:**
There are no physical ailments noted on the physical assessment.	This is significant because it shows that there isn't an underlying physical ailment causing his behavior.
RELEVANT Mental Status Exam Data:	**Clinical Significance:**
He is diaphoretic, unkempt, paranoid, and is having delusions. He reports feeling very upset, is agitated, and anxious.	These are signs that the patient is there due to schizophrenia. This diagnosis will help to determine a treatment plan.

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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	Na+ is low. Continue to monitor.	Worsening
Glucose	High but could be due to stress. Can double check with an A1C test.	Worsening
WBCs	WNL	Stable
Potassium	WNL	Stable
Neutrophils	WNL	Stable
Hgb	WNL	Stable
Creatinine	WNL	Stable
Platelets	WNL	Stable

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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:**
The patient is having a schizophrenic episode.	Schizophrenia is a mental disorder. There is no cure but symptoms can be managed. It is unknown what exactly causes schizophrenia but it may be due to genetics, brain chemistry, and the environment. Neurotransmitters in the brain don't function properly. This causes a person to interpret reality abnormally. This can result in delusions and hallucinations.

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	The patient needs to be hospitalized and stabilized.	The symptoms will decrease.
Risperidone 2mg PO BID	Anti-psychotic medication.	Treats positive and negative symptoms. Decreased delusions, paranoia.
Citalopram 20mg PO at HS	Antidepressant medication.	Decreases depression.
Lorazepam 1mg PO every 6 hours PRN for anxiety or agitation	Benzodiazepine medication to stabilize mood.	Stabilize mood.
Haloperidol 5mg IM every 4 hours PRN for severe agitation	Anti-psychotic medication, helps decrease agitation.	Treats positive symptoms.

Collaborative Care: Nursing

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

Nursing PRIORITY:	Keep patient safe, assess risk for suicide, manage symptoms, provide ordered medication.

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PRIORITY Nursing Interventions:	Rationale:	Expected Outcome:

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

Psychosocial Priorities:	Provide a calm environment,	
Nursing Interventions:	**Rationale:**	
Provide a calm environment. Educate family. Establish trust between you and the client. Encourage group therapy and medication adherence.	This patient needs a low stimulation environment. Helps the family to become a better support system. Encourages the patient to feel safe and take treatment. Therapy and medication can help improve his symptoms.	

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)*

The nurse should be non-judgmental to encourage trust building with the patient. The nurse should also use active listening and other therapeutic communication techniques.

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