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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:**
Altercation at work **Threw metal at coworker** **"Stop following me I know what you've been up to."** **Agitated and upset** **Rapid speech and repeating phrases** **Noncompliant with medication** **Dx with schizophrenia 5 years ago** **Believes coworkers broke into his house and poisoned his medication**	**Schizophrenia causes impaired relationships and paranoia, changes thoughts, behavior, emotions and speech patterns.** **Inability to perceive reality.** **Due to him stopping medications abruptly his symptoms are worse**
RELEVANT Data from Social History:	**Clinical Significance:**
No close friends only few acquaintances	**Feelings of loneliness and inadequacy, increased levels of stress**

Dropped out of law school at 24 yrs **Recently broke up with girlfriend** **Feeling paranoid for past 3 months** **Experienced dramatic increase in symptoms when he stopped taking medications** **Feels disappointment and inadequacy since his sisters are lawyers**	**which are worsening schizophrenia, break up relates to poor relationship with people and contributes to stress and worsening schizophrenia**

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:**
Respirations and bp are elevated	**Stress and agitation will cause increased respirations and the increased release of cortisol contributes to elevated glucose**

Current Assessment:	
GENERAL APPEARANCE:	Calm, body relaxed, no grimacing, appears to be resting comfortably
RESP:	Breath sounds clear with equal aeration bilaterally ant/post, unlabored 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; clothes 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:**
All within normal range	**No abnormal findings**
RELEVANT Mental Status Exam Data:	**Clinical Significance:**
Diaphoretic **Uncombed, greasy hair** **Clothes stained and torn** **Speech rapid and pressured** **Repeating words and phrases** **Mood- upset** **Becomes agitated and anxious when**	**Classic signs of schizophrenia include difficulty with adl's, and paranoia and rapid speech** **Speech is positive and mood is negative signs of schizophrenia** **Altered thought process and judgement are changes that occur with schizophrenia (negative signs/symptoms).** **Risk for harming others**

talking about coworkers and medication **Irrational thought process** **Paranoid delusions** **Poor insight and judgment** **Easily distracted** **States he wants to punish coworkers**	

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 low **Glucose high**	**Due to diaphoresis/ poor fluid intake** **Glucose high due to release of excess cortisol due to stress**	**Worsening** **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:**

Schizophrenia non compliance, relapse, psychosis, harm to self and others	**Elevated serotonin and dopamine (Neurotransmitter imbalance)** **Can also be from genetics, less brain tissue and too much CSF**

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	So he can get back on medications and be monitored for aggression and injury to others	Patient and others will remain free from injury
Risperidone 2mg PO	Treats positive and negative symptoms (helps agitation, speech, social withdrawal, and mood)	Improved mood and affect
BID Citalopram 20mg PO at HS	Antidepressant (he is depressed with his life)	Improves mood
Lorazepam 1mg PO every 6 hours PRN for anxiety or agitation	To calm him down	Relaxed
Haloperidol 5mg IM every 4 hours PRN for severe agitation	Agitation	Relaxed

Collaborative Care: Nursing

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

Nursing PRIORITY:	**Safety of the patient and the staff, establishing a trusting relationship and labs, patient and family education**

PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
Reduce stimuli/ provide calm environment **Remove harmful objects** **One-to-one observation** **15 min checks** **Stand off to the side (do not have patient blocking the door)** **Administer medications as ordered** **Individual/group therapy** **ADL's, nutrition and rest**	**Prevent agitation** **Prevents injury to self and others** **Keep client and others safe** **Decrease symptoms** **To develop coping skills and relationship skills** **Meet physiological needs and decrease symptoms**	**Patient remains calm and free from outbursts** **Absence of injury to self and others** **Clear thinking, normal speech** **Managing illness, stress, build support system, positive relationships** **Improved hygiene, balanced nutrition, better sleep, reduces stress**

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

Psychosocial Priorities:	**Coping skills, improved social skills, develop a support system, community resources**

Nursing Interventions:	**Rationale:**	
Assist with ADL's, provide adequate nutrition, provide environment ideal for rest **Involve family in care** **Provide community resources (Individual/group therapy)**	**Meet physiological needs and decrease symptoms** **Recognition of signs of relapse and help to manage illness, and develop a support system** **To help him relate with others who also have schizophrenia, meeting others who can related to him, and helps with social skills**	**Improved hygiene, balanced nutrition, better sleep, reduces stress** **Improved stress management, prevent relapse, medication compliance** **Stronger support system, maintain compliance with treatment**

5. What can you do to engage yourself with this patient's experience, and show that he matters to you as a person? Use of therapeutic communication, (touch, offering of self, active listening). Remaining non-judgemental, establishing a trusting relationship with the patient (let patient know he is safe here), provide education to the patient and his family in regards to relapse prevention