

N311 Care Plan #1

Lakeview College of Nursing

Kathleen Serrano

Demographics (5 points)

Date of Admission 10/14/2020	Patient Initials D.B.	Age 08/01/1964 (56 y/o)	Gender Female
Race/Ethnicity White/Caucasian	Occupation Papa John's Employee	Marital Status Single	Allergies Codeine
Code Status Full Code	Height 5'4"	Weight 158 lb	

Medical History (5 Points)

Past Medical History: Asthma, bronchitis, Bipolar 1 Disorder, COPD, BPD

Past Surgical History: Left foot surgery, partial left thumb amputation, two left knee arthroscopies

Family History: Mother: open heart surgery and lung cancer, father: no known problems

Social History (tobacco/alcohol/drugs): Pt smokes one pack of cigarettes per day, but unknown amount of years as the pt was unconscious. Yes, the patient does consume alcohol, but length of time and what the pt consumes is unknown due to her unconsciousness and unresponsiveness. Upon admittance the pt was screened for alcohol, and the pt's blood alcohol level was 0.290, which is extremely high compared to the reference range which is less than 0.003. Recreational use is unknown, but in the drug monitoring urinalysis a non-negative screening for marijuana cannabinoids was found.

Admission Assessment

Chief Complaint (2 points): Altered mental state

History of present Illness (10 points): Onset: On October 14, a 56 y/o white, single, female was admitted to St. Anthony's hospital for altered mental state via EMS. Police found her unconscious lying in the backyard of the pt's home. The pt neighbors reported to EMS and the Police that the pt "has a history of alcoholism and passes out frequently". Location: the brain.

Duration: approximately late in the evening on October 14, 2020 when the pt was admitted to St. Anthony's. Pt was unconscious and unresponsive when admitted to the ED on October 14, 2020, but more responsive and cognizant on October 15, 2020. Characteristics: the pt is experiencing a state of unconsciousness and unresponsiveness with little reaction to painful and vocal stimuli especially when first admitted to St. Anthony's hospital on the evening of October 14, 2020.

Aggravating: on the pt's night of admittance, October 14, 2020, the pt had a blood alcohol level of 0.290 G/DL and tested non-negative for the cannabinoids screening. Relieving: the pt was not able to relieve her altered mental state as the pt was unconscious. Treatment: Pt was unable to treat her altered mental state as the pt was unconscious.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Altered mental state

Secondary Diagnosis (if applicable): n/a

Pathophysiology of the Disease, APA format (20 points): Altered mental state refers to an instance in which there is a literal alteration in the function of the brain (Stöppler, 2020). In other words, the brain loses the function of judgment, thought, cognizance, control of emotions and motor skills, perception, consciousness, and overall normal behavior (Stöppler, 2020).

Individuals experiencing a change in their mental state may also experience confusion, memory loss which is known as amnesia, delirium, and even dementia in some cases (Stöppler, 2020). An altered mental state is usually caused by various emotional and/or psychiatric issues, other medical diagnoses that can damage the brain such as an ischemic stroke, and alcohol or drug abuse (Stöppler, 2020). In regard to the pt, it is most likely that the reason there was a loss of consciousness is due to her consumption of alcohol and use of cannabinoids. In the pt's drug monitoring screens, her blood alcohol level was 0.290, and there was a non-negative result for

marijuana cannabinoids in her urine. Given that alcohol and marijuana are both depressants, and that the pt's blood alcohol level was so high, that may have been the trigger to her altered mental state (Capriotti, 2016). In the pt's past medical history asthma, bronchitis, Bipolar 1 Disorder, COPD, and BPD are all listed as current illnesses of the pt. All of these medical diagnoses can also affect the pt's mental state, and in combination with two depressants: alcohol and marijuana, it may have caused the loss of consciousness (Capriotti, 2016). Due to the pt being unconscious and not breathing well enough the pt was intubated with an in-line suction and a ventilator in the ED of St. Anthony's hospital on the date of admittance: October 14, 2020. In addition, the few moments in which the pt had moments of consciousness attempted to pull out the tube and had to have non-violent restraints with a quick release knot to prevent the pt from hurting themselves.

Pathophysiology References (2) (APA):

Capriotti, Theresa M. and Frizzell, Joan Parker. (2016). *Pathophysiology: Introductory Concepts and Clinical Perspectives* (2nd ed.). F.A. Davis Company.

Stöppler, Melissa Conrad. (2020). *Altered Mental Status: Symptoms & Signs*. MedicineNet, Inc.
https://www.medicinenet.com/altered_mental_status/symptoms.htm

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.90-4.98	3.95	3.48	Pt has a long abrasion on the anterior of right leg, was intubated, and had lots of blood tests run for the CBC, which would explain why

				the RBC count is abnormally low.
Hgb	12.0-15.5	10.9	9.8	Hgb is abnormally low due to a deficient and low RBC count.
Hct	35-45%	34.4%	30.8%	Hct is low because of the low number of RBC's
Platelets	140-400	378	355	
WBC	4.0-9.0	4.0	7.3	
Neutrophils	40-70	44.7	71.8	Neutrophil count is high because of the tube and ventilator as it is a foreign object, and the abrasion on the pt's right leg could have triggered the immune response and therefore the neutrophils as first responders. Pt also had a catheter and could possibly be contracting a UTI.
Lymphocytes	10-20%	42.6%	19.8%	Lymphocytes may be high because of a potential infection in the abrasion on the right leg, or because the ventilator tube is foreign, and the immune system is working to get it out. Pt also had a catheter and could possibly be contracting a UTI.
Monocytes	5%	7.5%	5.9%	Monocytes may be higher due to the ventilator tube, the abrasion on the right leg, and/or a potential infection. Pt also had a catheter and could possibly be contracting a UTI.
Eosinophils				
Bands				

Chemistry **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	135-145	132	141	
K+	3.5-5.1	3.4	3.3	K+ may be lower due to the trauma of unconsciousness. Pt may have deficient potassium

				due to being NPO.
Cl-	98-107	98	107	
CO2	22-29	26.0	24.0	
Glucose	70-99	92	71	
BUN	6-20	8	8	
Creatinine	0.50-1.00	0.89	0.81	
Albumin	3.5-5.2	4.0	4.0	
Calcium	8.4-10.5	7.9	7.5	Pt may have deficient calcium due to being NPO.
Mag				
Phosphate				
Bilirubin	0.0-1.2	0.3	* Unable to obtain	
Alk Phos	35-105	88	*	

Urinalysis **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	Straw and clear transparency	Colorless and clear transparency	* Unable to obtain	IV fluid may have caused the urine to be so clear
pH	5-9	5.0	*	
Specific Gravity	1.003-1.030	1.003	*	
Glucose	Negative	Negative	*	
Protein	Negative	Negative	*	
Ketones	Negative	Negative	*	

WBC	Negative	Negative	*	
RBC	Negative	Negative	*	
Leukoesterase	Negative	Negative	*	

Cultures **Highlight All Abnormal Labs**—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	Negative	Negative	* Unable to obtain	
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (APA):

Lakeview College of Nursing. *Tab: Diagnostics: Lab*. Paper.

(2019, December 16). *Urinalysis (General & Microscopic)*. UNC Medical Center.

<https://www.unccmedicalcenter.org/mclendon-clinical-laboratories/available-tests/urinalysis-general-microscopic/>

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

CT Scan Head: no remarkable findings; everything is normal and without issue.

CXR (chest x-ray): no abnormalities or remarkable findings.

Staph screening: negative result; test was performed due to a catheter being inserted.

**Current Medications (10 points, 2 points per completed med)
*5 different medications must be completed***

Medications (5 required)

Brand/Generic	Hydrocodone-acetaminophen	Quetiapine	Prazosin	Mirtazapine	Metoprolol succinate
Dose	325 mg	100 mg	1 mg	7.5 mg	50 mg
Frequency	3x daily	1x daily	1x daily	1x daily	1x daily
Route	PO	PO	PO	PO	PO
Classification	Opioid analgesic	Dibenzothiazine derivative	Alpha blocker	Tetracyclic antidepressant	Beta1-adrenergic blocker
Mechanism of Action	Produces pain relief in the gray matter, medulla, and spinal cord by binding and then activating the opioid receptors in these three areas.	Sometimes produces antipsychotic effects by interfering with dopamine receptor sites, specifically dopamine type 2.	Inhibits alpha1-adrenergic receptors.	Can inhibit neuron reuptake of norepinephrine and serotonin.	Decreases cardiac excitability, output, and oxygen demand, and helps decrease blood pressure.
Reason Client Taking	For pain and anxiety	For BPD and Bipolar 1 Disorder	For hypertension	For BPD and Bipolar 1 Disorder	For hypertension
Contraindications (2)	Acute or severe bronchial	Hypersensitivity to quetiapine,	Hypersensitivity to prazosin,	Hypersensitivity to mirtazapine,	Acute heart failure,

	asthma or significant respiratory depression.	dementia	syncope	mania	cardiogenic shock
Side Effects/Adverse Reactions (2)	Coma, hypotension	Depression, myocarditis	Bradycardia, hypersensitivity reactions	Cerebral ischemia, seizures	CVA, hepatitis

Medications Reference (APA):

Jones & Bartlett Learning, LLC. (2020). *2020 Nurse’s Drug Handbook* (19th ed.).

Assessment

Physical Exam (18 points)

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	<p>Not alert and not oriented to time, place, and person; pt is unconscious Some distress while unconscious; thrashing and combative Grass, leaves, and dirt in hair, body, and bed, greasy hair, and in hospital gown</p>
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Pale Dry/Normal Warm Normal turgor 2+ None None Rt leg abrasion, and amputated left thumb 12 due to non-violent restraints</p>

<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head and neck symmetrical, normal cephalic Patient's ears are normal without discharge Could not open eyes bad EOM, unconscious Symmetrical and no deviation Missing some teeth and a few cavities</p>
<p>CARDIOVASCULAR: Heart sounds: S1, S2, S3, S4, murmur etc. Cardiac rhythm (if applicable): Peripheral Pulses: Capillary refill: Neck Vein Distention: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Edema Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Location of Edema:</p>	<p>S1 and S2 were normal; heard S3 gallop, but no rubs n/a peripheral pulses 2+ symmetric; capillary refill less than two seconds. No neck vein distension. No sign of edema</p>
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Normal respirations with ventilator, but sounds labored, wheezy in the left lung, and coarse snore-like sound in rt lung</p>
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Pt was unconscious unable to obtain information 5'4" 158 lb Bowel sounds are normal in all quadrants Unable to obtain information None No abnormal findings when inspecting distention, incisions, scars, drains, but abrasion on lower rt leg.</p>
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/></p>	<p>Yellow Colorless and clear Voided about 350mL of urine</p>

<p>Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	<p>Slightly pale and dark pubic hair French Foley Bag 16"</p>
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: Activity/Mobility Status: Independent (up ad lib) <input type="checkbox"/> Needs assistance with equipment <input type="checkbox"/> Needs support to stand and walk <input type="checkbox"/></p>	<p>Unable to perform ROM due to pt being intubated and with a ventilator. Pt was also unconscious, restrained, and on bedrest. High; 11 on the Braden scale No d/t being unconscious No d/t being unconscious No d/t being unconscious</p>
<p>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech: Sensory: LOC:</p>	<p>Pt was unconscious for a majority of the time especially while being intubated, and still even after extubating pt. Unable to obtain strength information, but mostly weak d/t being unconscious and sedated. Not cognitive of space, time, or location; could not speak in the few instances pt was awake could barely write on a board with a pen to communicate. Could not speak until tube was taken out and was very quiet and coarse with few words. Not alert.</p>
<p>PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):</p>	<p>Unable to obtain information d/t pt being mostly unconscious or asleep. Father called to check up on pt. Lives with male roommate.</p>

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1200	79	97/60	18	97.8	97%

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
*Unable to obtain	*	*	*	*	*

***Unable to obtain due to pt being unconscious and intubated.**

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
<p>Pt is NPO;</p> <p>Only input 190mL</p>	<p>On October 14, 2020 voided 1,075 mL; the output is very high compared to intake because pt consumed so much alcohol a majority of the output is from that consumption. October 15, 2020 pt voided 350 mL into foley bag via catheter</p>

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and “as evidenced by” components 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 		<ul style="list-style-type: none"> How did the patient/family respond to the nurse’s actions? Client response, status of goals and outcomes, modifications to plan.
1. Altered mental	Pt was	1. Attempt to	Goal to wake pt not met

<p>state</p>	<p>unconscious as evidenced by being unconscious with a 0.290 blood alcohol level, and a non-negative test for marijuana cannabinoids via the urine.</p>	<p>wake pt with painful and vocal stimuli. 2. Had to restrain pt with quick release knots due to thrashing and slight combativeness while unconscious.</p>	<p>due to the pt being severely unconscious possibly because of drug and alcohol abuse, and respiratory depression. Goal met as the restraints helped the pt calm down while unconscious and not able to pull out ventilator.</p>
<p>2. Impaired motor functions: respiratory and loss of bodily functions</p>	<p>Pt came in with severe respiratory depression as evidenced by her unconsciousness and her present illness of COPD and asthma; along with that the pt had consumed a high amount of alcohol and also used marijuana cannabinoids, which can potentially cause respiratory depression.</p>	<p>1. Pt had to be ventilated, intubated, and had to have an in-line suction inserted. Pain and sedative administered around the clock. 2. Foley catheter inserted due to pt being unable to output with a lot of fluid in the bladder.</p>	<p>Goal met as nurse helped pt breath at a somewhat normal level and suction all the secretions from blocking the pt's airway. Goal met as medications were administered. Goal met pt was able to void 350 mL into foley bag.</p>

Other References (APA):

Concept Map (20 Points):

Subjective Data

Pt was unable to report any subjective data as the pt was unconscious for a majority of her time at St. Anthony's ICU. In the morning on October 15, 2020 the pt was able to respond to vocal stimuli but could not speak as she had been intubated on October 14, 2020 when she was admitted to the ED at St. Anthony's hospital.

Nursing Diagnosis/Outcomes

Altered mental state related to intoxication as evidenced by being unconscious with a 0.290 blood alcohol level, and a non-negative test for marijuana cannabinoids via the urine.
 Goal to wake pt not met due to the pt being severely unconscious possibly because of drug and alcohol abuse, and respiratory depression.
 Had to restrain pt with quick release knots due to thrashing and slight combativeness while unconscious
 Goal met as the restraints helped the pt calm down while unconscious and not able to pull out ventilator
 Pt had to be ventilated, intubated, and had to have an in-line suction inserted. Pain and sedative administered around the clock.
 Goal met as nurse helped pt breath at a somewhat normal level and suction all the secretions from blocking the pt's airway. Goal met as medications were administered.
 Foley catheter inserted due to pt being unable to output with a lot of fluid in the bladder.
 Goal met pt was able to void 350 mL into foley bag.

Objective Data

Client's chief complaint is altered mental state. She is diagnosed with intoxication and delirium.
 Vitals:
 BP: 97/60
 RR: 18
 Temp: 97.8
 SpO2%: 97%
 Pulse: 79

Patient Information

CT scan did not show anything remarkable or any abnormalities. CXR also did not show any remarkable or any abnormalities. Staph screening test was negative.

Nursing Interventions

Attempt to wake pt with painful and vocal stimuli.
 Had to restrain pt with quick release knots due to thrashing and slight combativeness while unconscious.
 Pt had to be ventilated, intubated, and had to have an in-line suction inserted. Pain and sedative administered around the clock.
 Foley catheter inserted due to pt being unable to output with a lot of fluid in the bladder.
 Suctioning secretions every 15 minutes.



