N441 Care Plan

Lakeview College of Nursing

Lindsey Ball

Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Gender**
3/23/2021	EH	61	female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	unemployed	single	aspirin
Code Status	**Height**	**Weight**	
Full code	158.75 cm	70 kg	

Medical History (5 Points)

Past Medical History: alcohol abuse, benign hypertension, depression, GERD, hip pain bilaterally, migraines

Past Surgical History: EGD biopsy, colonoscopy with biopsy

Family History: She stated her mother is deceased and had hepatitis; she had a stroke waiting on a transplant. Her father and her brother both have a history of alcohol abuse.

Social History (tobacco/alcohol/drugs): has 1-2 drinks a day, denies smoking or any drug use

Assistive Devices: none

Living Situation: Education Level: high school

Admission Assessment

Chief Complaint (2 points): SOB, abdominal pain with nausea and vomiting

History of present Illness (10 points):. The patient presented to the ED with abdominal pain with nausea and vomiting for the past 3 days. She states the pain is sharp and constant in the middle of her abdomen. She rated it a 4 on the numeric scale. She tried to drink more alcohol to relieve the pain but nothing helped. The patient states she has not had a meal in over a week. She states she drinks a pint of whiskey daily including a pint before admission. She was brought in by her significant other who also had been drinking. The patient was treated with IV thiamine and sodium bicarbonate in the ED.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): alcoholic ketoacidosis

Secondary Diagnosis (if applicable): AKI

Pathophysiology of the Disease, APA format (20 points):.

The pancreas produces insulin that turns into glucose that cells need to function properly. With alcoholism, the pancreas may stop producing insulin which means the cells do not receive the glucose it needs and the body will start to burn fat for that energy. As the body burns fat, ketones are produced. The buildup of ketones creates the condition of ketoacidosis. Alcoholic ketoacidosis can occur with long term excessive alcohol use. This is because of reduced nutrient intake, ethanol, and dehydration levels.

Signs and symptoms include abdominal pain, nausea, agitation and confusion, decreased in level of consciousness, fatigue, slow movement, Kussmaul's respirations, loss of appetite, nausea and vomiting, and dehydration. To diagnose ketoacidosis, the patient may have a raised anion gap, an increased lactic acid, and ketones are typically found in the urine. They also run a blood glucose test, BUN and creatinine tests, ABGs, and amylase and lipase levels to assess the functioning of the pancreas (Burke, 2018). Treatment includes IV fluids, thiamine, and electrolyte replacement with potassium, phosphorus, and magnesium. These patients are typically admitted to the ICU and the length of stay depends on the severity of the alcoholic ketoacidosis.

The patient presented to the ED with classic signs of diabetic ketoacidosis with abdominal pain and vomiting and nausea. The patient was already malnourished due to her alcohol addiction, but she developed alcoholic ketoacidosis after binge drinking the pint of

whiskey. She also had not eaten in at least a week, so her body was burning fat for energy. She appeared dehydrated and anxious. Her anion gap was 37.7 on admission and 26.4 today. Her ethanol toxicity was 61.9. Her urinalysis showed positive for ketones in her urine. Also, her lactic acid was 1.2. She also had Kussmaul's respirations. These labs are all consistent with her diagnosis of diabetic ketoacidosis. The patient was treated with IV fluids and thiamine in the ED.

Pathophysiology References (2) (APA):

Burke, D. (2018, September 17). Alcoholic Ketoacidosis. Retrieved March 25, 2021, from https://www.healthline.com/health/alcoholism/ketoacidosis#treatment

Swearingen, P. L. (2018). *All-in-one nursing care planning resource: Medical-surgical, pediatric, maternity, and psychiatric-mental health*. Place of publication not identified: MOSBY.

Laboratory Data (15 points)

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	**4.0-5.2**	4.73	4.05	
Hgb	**F:12-15 M: 14-16**	15.4	13.4	
Hct	**F:42-52 M:35-47**	46.3	38.9	This patient is dehydrated (Hinkle, 2018).
Platelets	**140-440**	218	136	
WBC	**4.0-11.0**	14.8	5.1	This patient has an infection or inflammation (Hinkle, 2018).
Neutrophils	**45-75%**	88.5	80.1	This patient has an infection or inflammation (Hinkle, 2018).
Lymphocytes	**20-40%**	7.0	9.2	This patient has an infection or inflammation (Hinkle, 2018).
Monocytes	**4-6%**	4.1	10.5	This patient has an infection or

				inflammation (Hinkle, 2018).
Eosinophils	**<7%**	Labs not drawn	Labs not drawn	
Bands	**<3%**	Labs not drawn	Labs not drawn	

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**	**134**	**131**	This patient is dehydrated (Hinkle, 2018).
K+	**3.5-5.0**	**3.7**	**3.9**	
Cl-	**98-107**	**91**	**97**	This value is low because of ketoacidosis (Hinkle, 2018).
CO2	**35-45**	**<7**	**8**	This value is low because of ketoacidosis (Hinkle, 2018).
Glucose	**70-100**	**174**	**225**	This value is high because of stress, fat breakdown, and alcohol use (Hinkle, 2018).
BUN	**6-20**	**16**	**15**	
Creatinine	**0.6-1.3**	**1.47**	**1.16**	This value is high because of AKI (Hinkle, 2018).
Albumin	**3.4-5.4**	**5.3**	Labs not drawn	
Calcium	**8.5-10.5**	**9.1**	**8.3**	
Mag	**1.7-3.4**	**2.4**	**2.0**	
Phosphate	**2.5-4.5**	**5.7**	**1.7**	
Bilirubin	**<1.5**	**0.7**	Labs not drawn	
Alk Phos	**20-140**	**115**	Labs not drawn	
AST	**10-30**	**41**	Labs not drawn	

ALT	**10-40**	**32**	Labs not drawn	
Amylase	**23-85**	Labs not drawn	Labs not drawn	
Lipase	**60-160**	**108**	Labs not drawn	
Lactic Acid	**0.5-1.0**	Labs not drawn	**1.2**	This value is low because of ketoacidosis (Hinkle, 2018).
Troponin	**<0.3**	**0.010**	Labs not drawn	
CK-MB	**5-25**	**6.53**	Labs not drawn	
Total CK	**22-198**	**178**	Labs not drawn	
Anion gap	**8-16**	**37.3**	26.4	This value is low because of ketoacidosis (Hinkle, 2018).

Other Tests 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
INR	**0.86-1.16**	Labs not drawn	Labs not drawn	
PT	**11.9-14.9**	Labs not drawn	Labs not drawn	
PTT	**60-70**	Labs not drawn	Labs not drawn	
D-Dimer	**<250**	Labs not drawn	Labs not drawn	
BNP	**<450**	Labs not drawn	Labs not drawn	
HDL	**>60**	Labs not drawn	Labs not drawn	
LDL	**<130**	Labs not drawn	Labs not drawn	
Cholesterol	**<200**	Labs not drawn	Labs not drawn	
Triglycerides	**<150**	Labs not drawn	Labs not drawn	
Hgb A1c	**<7-8%**	Labs not drawn	Labs not drawn	
TSH	**0.4-4.0**	Labs not	Labs not	

		drawn	drawn	

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 (Hinkle, 2018).
Color & Clarity	**Yellow and clear**	Labs not drawn	**Yellow and clear**	
pH	**6.0**	Labs not drawn	**5.5**	
Specific Gravity	**1.010-1.025**	Labs not drawn	**1.035**	The patient is dehydrated (Hinkle, 2018).
Glucose	**0-0.8**	Labs not drawn	**normal**	
Protein	**Negative**	Labs not drawn	**2+**	The body is breaking down fat related to anorexia (Hinkle, 2018).
Ketones	**Negative**	Labs not drawn	**4+**	The body is breaking down fat related to anorexia (Hinkle, 2018).
WBC	**4.5-11**	Labs not drawn	**2**	
RBC	**4**	Labs not drawn	**10**	The patient is in AKI (Hinkle, 2018).
Leukoesterase	**2-5**	Labs not drawn	**negative**	

Arterial Blood Gas 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
pH	**7.35-7.45**	**6.99**	**7.28**	The body is in acidosis (Hinkle, 2018.)
PaO2	**80-100**	**83**	**122**	The body is in acidosis (Hinkle, 2018.)
PaCO2	**33-45**	**26.8**	**9.9**	The body is in acidosis (Hinkle, 2018.)
HCO3	**22-26**	**7.2**	**9.4**	The body is in acidosis (Hinkle,

				2018.)
SaO2	**90-100**	**50.2**	**98.5**	The body is in acidosis (Hinkle, 2018.)

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**	Labs not drawn	Labs not drawn	
Blood Culture	**Negative**	Labs not drawn	**Results pending**	
Sputum Culture	**Negative**	Labs not drawn	Labs not drawn	
Stool Culture	**negative**	Labs not drawn	Labs not drawn	

Lab Correlations Reference (APA):

Hinkle, J. L., Cheever, K. H., & Hinkle, J. L. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): CT of the abdomen and pelvis with contrast; Chest XR

Diagnostic Test Correlation (5 points): She got the CT because of her complaints of abdominal pain and to rule out pancreatitis. The results showed colonic diverticulosis, no acute findings in the abdomen or pelvis, fatty liver change and mild hepatic enlargement, and a previous cholecystectomy and hysterectomy. The chest x-ray was ordered due to her shortness of breath at admission. It showed a normal heart size, clear lungs, and no visualization of pneumothorax or pleural effusion.

Diagnostic Test Reference (APA):

Hinkle, J. L., Cheever, K. H., & Hinkle, J. L. (2018). *Brunner & Suddarths textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/Generic	Famotidine (Pepsid)	Sucralfate (Carafate)	melatonin	Atorvastatin (Lipitor)	Omeprazole (Prilosec)
Dose	40 mg	1 g	3 mg	10 mg	40 mg
Frequency	daily	QID	PRN	daily	BID
Route	PO	PO	PO	PO	PO
Classification	H2-receptor antagonist	Antiulcer	Herbal	Antihyperlipidemic	Antiulcer
Mechanism of Action	Inhibits gastric acid secretion	Buffers stomach acid	Promotes sleep	Enhances LDL receptors on liver cells	Suppresses basal and stimulated acid secretion
Reason Client Taking	GERD	Prevent ulcers	insomnia	HTN, Prevent MI or stroke	GERD
Contraindications (2)	Severe renal dysfunction, anuria	Aspirin, renal failure	Caffeine, nicotine	Hepatic disease, hypersensitivity	Other PPIs, benzimidazoles
Side Effects/Adverse Reactions (2)	Constipation/diarrhea, dizziness	Dry mouth, hyperglycemia	Abdominal cramps, decreased alertness	Hyperglycemia, abdominal pain	Headache, abdominal pain
Nursing Considerations (2)	Use caution in older adults. Use caution with impaired renal or hepatic function	Use cautiously in renal failure patients, give on an empty stomach	Give at bedtime, use caution with other CNS depressants	Report any acute cardiac condition, report hypotension	Give before meals in the morning, monitor stools
Key Nursing Assessment(s) Prior to Administration	I+O, VS	Glucose level	VS	Liver function tests	I+O, VS
Client Teaching needs (2)	Dissolve in water. Avoid NSAIDS	Take at least one hour before meals, do not take with any other	Do not drive after taking, take at bedtime	Take as prescribed, monitor glucose closely	Can mix with yogurt or applesauce, report black tarry stool

		medications			

Hospital Medications (5 required)

Brand/Generic	Pantoprazole (Protonix)	Acetaminophen (Ofirmev)	Lactobacillus rhamnosus	Calcium carbonate (Tums)	Ondansetron (Zofran)
Dose	40 mg	1,000 mg	1 tab	500 mg	4 mg
Frequency	Daily	Q6H PRN	daily	Q6H PRN	Q6H PRN
Route	IV push	IV piggyback	PO	PO	IV push
Classification	Antiulcer, PPI	Analgesic	Dietary supplement	Antacid	Antiemetic
Mechanism of Action	Inhibits proton pump in gastric cells	Pain reliever	Keeps “good” bacteria in and “bad” bacteria out	Neutralizes gastric acid	Blocks serotonin receptors
Reason Client Taking	GERD	Pain	c.diff prophylaxis	Heartburn	Nausea
Contraindications (2)	Hypersensitivity, c.diff	Alcohol, oral contraceptives	Short bowel syndrome, weak immune system	Hypercalcemia, severe renal dysfunction	Long QT syndrome, hypersensitivity
Side Effects/Adverse Reactions (2)	Headache, diarrhea	Dizziness, nausea	Nausea, stomach bloating	Constipation, bone and muscle pain	Headache, diarrhea
Nursing Considerations (2)	Dilute with 10 ml of NS, give over 2 minutes	Long term use can lead to liver disease	monitor for 4abdominal distension, monitor color and consistency of stool	Ensure adequate nutrition, monitor bowels	Monitor for serotonin syndrome, maintain adequate fluid intake
Key Nursing Assessment(s) Prior to Administration	Assess occult blood, liver enzymes, symptoms of heart burn	Assess pain level and VS	I+O, VS	Creatinine and renal function tests	Lung sounds
Client Teaching needs (2)	Should be taken 30 minutes before a meal, used as short term treatment	Can cause nausea, report a change in pain level	Can be taken with or without food, can mix with applesauce if cannot swallow the pill whole	Thoroughly chew before swallowing, take only as needed	Avoid OTC cold medications, take as prescribed

Medications Reference (APA):

Jones & Bartlett Learning. (2018). *2018 Nurses drug handbook.*

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	A+Ox4. No signs of distress. Appears moderately anxious. Appears malnourished, lips cracked and dry.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** **Drains present: Y☐ N ☒** **Type:**	Skin appeared pink and warm. Slightly diaphoretic. Temperature was between 36.5-36.8 degrees Celsius within normal limits. No rashes, or wounds. She had a small bruise on her left elbow. Skin turgor was normal, capillary refill less than 3 seconds Braden score of 18 making her a mild skin risk. No drains present Redness, swelling, and warmth to the RLE.
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	Head appeared normocephalic. Patent airway. Her trachea is midline. No ear pain, nasal congestion, or sore throat. Extraocular motions are intact. No recent visual problems. Her temporal membranes are clear bilaterally. Nasal passages are clear and moist. She does not wear dentures or glasses.
CARDIOVASCULAR (2 points): **Heart sounds:**	Heart sounds appeared normal. S1 and S2 sounds were heard without any S3 or S4 sounds.

S1, S2, S3, S4, murmur etc. **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☐ N ☒** **Location of Edema:**	Sinus arrythmia. No murmurs, gallops, or rubs. Peripheral radial pulses were normal 3+ bilaterally. Peripheral dorsalis pedis pulses were normal 2+ bilaterally. Nail bed color is normal for ethnicity. Capillary refill less than 3 seconds. Lower extremities showed no edema bilaterally. No neck vein distention.
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character** **ET Tube:** **Size of tube:** **Placement (cm to lip):** **Respiration rate:** **FiO2:** **Total volume (TV):** **PEEP:** **VAP prevention measures:**	Lungs sounds heard to auscultation bilaterally in all 5 lobe fields. No accessory muscle use needed. Respiratory rate was 37 and 24. No ET tube. VAP prevention measures include elevating the head of bed, hand hygiene, and providing oral care.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ☒** **Nasogastric: Y ☐ N ☒** **Size:** **Feeding tubes/PEG tube Y ☐ N ☒** **Type:**	Regular diet at home and in the hospital. 158.75 cm tall, 70 kg Bowel sounds active in all four quadrants No pain upon palpation No distention, incisions, scars, drains, or wounds Last BM was today, 3/23. She stated she had 3 counts of diarrhea. No ostomy, NG, or feeding tubes Abdomen appeared flat and non-tender.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒**	Voiding without difficulties. Urine is yellow and clear. No odor. Her total output was not recorded. She uses a bed pan since she is oxygen dependent.

Dialysis: Y ☐ N ☒ **Inspection of genitals:** **Catheter: Y ☐ N ☒** **Type:** **Size:** **CAUTI prevention measures:**	No bladder distension or pain with urination. No dialysis No catheter CAUDI prevention measures include appropriate catheter use, hang hygiene, cleaning around the catheter daily, and keeping the drainage bag lower than the bladder.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☒** **Fall Risk: Y ☒ N☐** **Fall Score:** **Activity/Mobility Status:** **Independent (up ad lib)** ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	Active ROM Currently on no supportive devices. She can get up independently. She can turn herself in the bed. Fall risk of 44 making her a moderate fall risk .
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☒** **PERLA: Y ☒ N☐** **Strength Equal: Y ☒ N ☐ if no - Legs ☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	A+Ox4 Moves all extremities Pupils equal, round, and reactive to light. Pupils were 3 cm bilaterally. Strength was equal in all extremities bilaterally. Affect and communication was appropriate for developmental age. Normal cognition. Speech is slightly slurred. No lightheadedness or focal weakness No sensory deficits noted No LOC
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	The patient uses alcohol as a coping method. The highest level of completed education stated was high school. She does not practice religion. She has support from her significant other and her daughter. She currently lives with her significant other who also has a history of alcohol abuse.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	107	96/61	37	37.7	99

1100	88	105/66	24	36.5	99

Vital Sign Trends/Correlation:

She is tachypneic due to anxiety and nausea. She was also tachycardic because of anxiety. She was having Kussmaul's respirations. Her respiratory rate decreased from 37 to 24 because she was laying down and resting.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	numeric	Abdomen right side	4	Sharp	Administered Protonix
1100	numeric	Abdomen right side	4	sharp	Comfort care

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	18G AC inserted on admission (3/23). 18G AC inserted on admission (3/23). No complications, patent, dressing clean/dry/intact.
Other Lines (PICC, Port, central line, etc.)	
Type: **Size:** **Location:** **Date of insertion:** **Patency:** **Signs of erythema, drainage, etc.:** **Dressing assessment:**	There were no other lines inserted. CLABSI prevention measures include hand hygiene, appropriate skin antiseptic, ensure the prep agent has completely dried before inserting a central line, and use proper PPE including sterile gloves, gown, cap, and a mask.

Date on dressing: **CUROS caps in place: Y ☐ N ☒** **CLABSI prevention measures:**	

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
122.00 ml of IV fluid	3 counts of diarrhea

Nursing Care

Summary of Care (2 points)

Overview of care: We will continue to monitor her for seizure activity and withdrawal symptoms.

Procedures/testing done: ABGs

Complaints/Issues: abdominal pain

Vital signs (stable/unstable): unstable

Tolerating diet, activity, etc.: NPO except ice chips

Physician notifications: none today

Future plans for patient: CIWA protocol, order for Ativan

Discharge Planning (2 points)

Discharge location: home with significant other

Home health needs (if applicable): referral to Alcoholic Anonymous

Equipment needs (if applicable): NA

Follow up plan: following up with her PCP after she is discharged as well as checking out a group like Alcoholics Anonymous

Education needs: She needs education of the cessation of alcohol use and complications of health risks if she does not stop drinking.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
Fluid volume deficit related to decreased intake of fluids and excessive vomiting and nausea as evidenced by a high specific gravity.	Her specific gravity was 1.035.	Monitor respirations. Assess neurological status every 2 hours.	She had Kussmaul's respirations and was A+Ox4.
Malnutrition related to ketoacidosis as evidenced by anion gap.	Her anion gap was 37.3 on admission and 26.4 today.	Monitor glucose levels. Monitor electrolyte levels.	The patient is hyperglycemic. Her glucose level was 174 on admission and 225 today. She was

			also hyponatremic with a sodium level of 134 on admission and 131 today.
Anxiety related to cessation of alcohol intake as evidenced by tachycardia, tachypnea, and overall appearance.	Her heart rate and respiratory rate were elevated. She appeared anxious and slightly diaphoretic.	Create a calm environment. Orient the patient to reality.	After creating a calm environment, her respiratory rate went from 37 to 24. She was A+Ox4.
Risk for injury related to seizures as evidenced by alcohol withdrawal.	This patient is a long-term alcoholic. Without alcohol, her body will withdrawal from the substance and could start seizing.	Initiate CIWA protocol including seizure precautions. Thiamine was given in the ED to prevent seizures.	The patient had extreme nausea and vomiting with anxiety. She did not have tremors, headache, agitation, or tactile, auditory, or visual disturbances. The patient remained free of seizures during the shift.
Risk for decreased cardiac output related to direct effect of alcohol on the heart as evidenced by the effect of alcohol on the heart.	Her admission ethanol toxicology level was 61.9 which means without alcohol, she will withdrawal.	Monitor I+O and VS. Monitor cardiac rate and rhythm.	Her VS were tachycardic and tachypneic. She was in sinus arrhythmia.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Abdominal pain
Nausea
Anorexia for a week prior to admission
3 episodes of diarrhea

Nursing Diagnosis/Outcomes

Fluid volume deficit related to decreased intake of fluids and excessive vomiting and nausea as evidenced by a high specific gravity.
Outcome: The patient will be well hydrated by discharge.
Malnutrition related to ketoacidosis as evidenced by anion gap.
Outcome: The patient will be able to eat and keep a meal down before discharge
Anxiety related to cessation of alcohol intake as evidenced by tachycardia, tachypnea, and overall appearance.
Outcome: The patient will keep her anxiety at a tolerable level by discharge
Risk for injury related to seizures as evidenced by alcohol withdrawal.
Outcome: The patient will remain free of seizure activity by discharge.
Risk for decreased cardiac output related to direct effect of alcohol on the heart as evidenced by the effect of alcohol on the heart.
The patient will remain free of cardiac complications by discharge.

Objective Data

Labs are relevant to infection, ketoacidosis, and dehydration
Patient can ambulate independently
Ketonuria
Ethanol toxicology level of 61.9
CT of the abdomen and pelvis showed mild hepatic enlargement

Patient Information

Patient is a 61-year-old female who presented at the emergency department for SOB, abdominal pain and nausea and vomiting for the past 3 days. She was diagnosed with alcoholic ketoacidosis.

Nursing Interventions

Monitor vital signs: Pulse oximetry, blood pressure, heart rate, and respiration rate. Report significant findings
Auscultate breath sounds frequently.
Assess patient's pain.
Administer PRN pain medication, if prescribed.
Administer medications as prescribed.
Provide frequent breaks and rest periods in between activities
Establish honest, therapeutic communication in an empathetic manner
Explain all interventions, diagnostics and medications
Initiate CIWA protocol
Maintain a calm environment