N431 Care Plan # 1

Lakeview College of Nursing

Shawn Weber

Demographics (3 points)

Date of Admission 06/21/2021	**Patient Initials** P.F.	**Age** 66 (04/10/55)	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Divorced	**Allergies** Penicillin (urticaria) Norfloxacin (urticaria) Cephalexin (urticaria)
Code Status Full Code	**Height** 165cm	**Weight** 84 kg	

Medical History (5 Points)

Past Medical History: Alcohol abuse, Alcohol dependence, anxiety, depression, colon polyps, hypertension, chronic back pain, hyperlipidemia, gastroesophageal reflux disease (GERD), peptic ulcer disease (PUD).

Past Surgical History: Right knee arthroplasty (02/23/2021), Lumbar vertebral augmentation kyphoplasty with fluoroscopy (01/14/2020)

Family History: Paternal: Alcohol abuse, hypertension **Maternal:** Arthritis, breast cancer, hypertension

Social History (tobacco/alcohol/drugs): Patient drinks 1-2 pints of vodka daily. Client has suffered alcohol dependence since the age of 40. She acknowledges that her alcohol dependance has negatively impacted her life in a negative way. Client denies ever smoking or using illicit drugs.

Assistive Devices: Client wears spectacles. She has a walker from her knee surgery from February which she “gave to her friend.”

Living Situation: Client lives alone in her home in Charleston, IL. Her next-door neighbor visits her daily.

Education Level: Client graduated high school.

Admission Assessment

Chief Complaint (2 points): Chest pain.

History of present Illness (10 points):

66-year-old Caucasian female with a history of significant alcohol abuse presents to SBL ED on 06/21/2021 with complaints of chest pain for the last 2 to 3 days. She says the pain starts in the middle of her chest below the sternum and radiates upward. She describes the pain as a "vague and dull pressure." The client rates the pain as a 7/10. The chest pain is constant, and it is not worsened or lessened with sitting down or walking. Client was given nitroglycerin in the emergency department, but the medication did not stop the chest pain. The client also experiences some mild dyspnea with exertion. The client has tried treating the pain by drinking extra fluids and ibuprofen unsuccessfully. CIWA protocols were put in place due to the client's alcohol abuse. The client started on a banana bag.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Angina Pectoris

Secondary Diagnosis (if applicable): GERD

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

Angina pectoris is the clinical phrase used to refer to anterior chest pain. Angina pectoris is the result of coronary atherosclerotic disease (Hinkle & Cheever, 2017). During physical exertion, not enough blood flow gets to the coronary arteries of the heart. This insufficient perfusion causes ischemia of the cardiac muscle resulting in chest pain. Angina pectoris is typically relieved with rest and nitroglycerin. Other common signs and symptoms clients may experience are feelings of weakness, dizziness, dyspnea, pallor, and diaphoresis. If angina begins to happen more frequently and is unresolved with rest or nitroglycerin, it is unstable angina (Hinkle & Cheever, 2017). Typical vital signs for angina pectoris would be elevated blood pressure, tachycardic, and tachypneic.

Clients experiencing chest pains will typically get a cardiac workup to rule out dysrhythmias or myocardial infarction. A 12 lead-EKG was performed to diagnose any dysrhythmias or ST-elevation. This client's EKG showed an inverted T-wave, familiar in clients with unstable angina (Hinkle & Cheever, 2017). Cardiac labs were drawn periodically, looking for biomarkers that would imply acute coronary syndrome (ACS), which all came back negative. This client received an echocardiogram which did not show any signs of cardiomegaly. However, it does appear that her heart's ejection fraction is low at 40%, which implies she is on the verge of heart failure. The client was sent down for a stress test today to rule out other signs of ACS. Other abnormal lab values were most likely the result of malnutrition because of her chronic alcoholism. Acute angina pectoris is treated with the use of nitrates. The client may also be placed on hypertension medications such as Beta-Blockers which this client is already taking. The clients will be recommended lifestyle changes such as daily exercise and a low-fat diet (Capriotti, 2020).

Another possible diagnosis for the client's chest pains could be a severe GERD exacerbation brought on by poor nutrition. The client's signs and symptoms do not line up perfectly with typical angina pectoris. The client was relieved of her pain after being admitted, when she was unable to drink alcohol and on constant fluid and electrolyte replacement.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Hinkle, J. L., & Cheever, K. H. (2017). *Clinical handbook for Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Lippincott Williams & Wilkins.

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	3.80-5.41	4.49	4.13	Normal range.
Hgb	11.3-15.2	14.3	12.8	Normal range.
Hct	33.2-45.3	42.8	39.1	Normal range.
Platelets	149-393	218	179	Normal range.
WBC	4.0-11.7	10.4	8.6	Normal range.
Neutrophils	45.3-79.0	80.8	75.9	Neutrophilia is most likely the cause of some form of infection. It may also be influenced by other factors such as the client's stress (Capriotti, 2020).
Lymphocytes	11.8-45.9	10.5	14.0	Lymphocytopenia is often the result of bone marrow suppression (Capriotti, 2020). This client's lymphocytes are trending upwards since she has been admitted so malnutrition may have been the cause of this deficiency.
Monocytes	4.4-12.0	7.4	8.1	Normal range.
Eosinophils	0-6.3	0.8	1.7	Normal range.

Bands	0-5.1	N/A	N/A	N/A

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-	136-145	137	138	Normal range, borderline low.
K+	3.5-5.1	3.5	3.6	Normal range, borderline low.
Cl-	98-107	97	101	Client's electrolytes were trending low when she came in. Client likely suffers constant dehydration and malnutrition due to her high alcohol consumption. This is a likely explanation for her electrolyte imbalance (Capriotti, 2020).
CO2	21-31	28	31	Normal range.
Glucose	74-109	114	103	Hyperglycemia high upon admit most likely due to stress of chest pains, or the client may have just eaten prior to coming to the emergency department (Capriotti, 2020).
BUN	7-25	9	9	Normal range.
Creatinine	0.70-1.20	1.21	1.10	This lab is used to assess for kidney damage. High levels in this client are most likely cause by dehydration (Capriotti, 2020).
Albumin	3.5-5.3	3.8	N/A	Normal range.
Calcium	8.6-10.3	89	8.5	Hypocalcemia is most caused by lack of calcium or Vitamin D in their diet (Capriotti, 2020).
Mag	1.6-2.5	N/A	N/A	N/A
Phosphate	2.5-4.5	N/A	N/A	N/A
Bilirubin	0.3-1.0	0.7	N/A	Normal range.

Alk Phos	34-104	103	N/A	Normal range.
AST	10-30	41	N/A	An elevated AST implies liver damage most likely due to chronic alcohol abuse. Client's AST is only modestly elevated, some clients with alcoholic liver disease may have ASTs twofold-sevenfold the normal value (Capriotti, 2020).
ALT	10-40	29	N/A	Normal range.
Amylase	30-110	N/A	N/A	N/A
Lipase	0-160	N/A	N/A	N/A
Lactic Acid	0.5-2.2	N/A	N/A	N/A
Troponin	0.000-0.030	<0.010	N/A	Normal range.
CK-MB	0.60-6.3	1.37	N/A	Normal range.
Total CK	30-223	66	N/A	Normal range.

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	1(2-3x for therapeutic range)	N/A	N/A	N/A
PT	9.5-11.8 (1.5-2.5x therapeutic range)	N/A	N/A	N/A
PTT	30-40(1.5-2.5x therapeutic range)	N/A	N/A	N/A
D-Dimer	<=250	N/A	N/A	N/A
BNP	<100	N/A	N/A	N/A

HDL	>60	N/A	66	Normal range.
LDL	<130	N/A	23	Normal range.
Cholesterol	<200	N/A	107	Normal range.
Triglycerides	<150	N/A	87	Normal range.
Hgb A1c	4-5.6 <=6.4?	N/A	5.8	Normal range.
TSH	0.4-4	N/A	N/A	N/A

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	Yellow, amber, clear	N/A	N/A	No urinalysis collected.
pH	5-8	N/A	N/A	N/A
Specific Gravity	1.005-1.035	N/A	N/A	N/A
Glucose	0-14.41	N/A	N/A	N/A
Protein	Negative	N/A	N/A	N/A
Ketones	Negative	N/A	N/A	N/A
WBC	Negative	N/A	N/A	N/A
RBC	0-5	N/A	N/A	N/A
Leukoesterase	0-5	N/A	N/A	N/A

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	7.31-7.41	N/A	N/A	No ABG collected
PaO2	40-50	N/A	N/A	N/A
PaCO2	10-50	N/A	N/A	N/A
HCO3	22-26	N/A	N/A	N/A
SaO2	60-75	N/A	N/A	N/A

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	N/A	N/A	No cultures collected
Blood Culture	Negative	N/A	N/A	N/A
Sputum Culture	Negative	N/A	N/A	N/A
Stool Culture	Negative	N/A	N/A	N/A

Lab Correlations Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

Diagnostic Imaging

All Other Diagnostic Tests (5 points):

Electrocardiogram (EKG)- An EKG was performed on this client to rule out possible dysrhythmias or myocardial infarction. An EKG gives us a "snapshot" of the electrical activity in the heart (Capriotti, 2020).

Echocardiogram- This ultrasound of the heart gives visual of the structures of the heart. It is utilized in diagnosing cardiomegaly as well as determining the client's ejection fraction (Capriotti, 2020).

Chest X-ray (CXR)- This test is preformed to give a noninvasive visualization of the client's lung and heart (Capriotti, 2020).

Chest Computerized Tomography (CT) with Contrast- This test gives a more detailed visualization of the client's lung and heart. The contrast is to allow for a better visualization of the blood vessels (Capriotti, 2020).

Nuclear stress test- This test measures the electrical activity of the heart while the heart is put under stress. This test is utilized to further explore the causes of this client's angina. This test may be used to diagnose dysrhythmias or coronary heart disease (Capriotti, 2020).

Diagnostic Test Correlation (5 points):

EKG- Inverted T-waves is a common diagnostic finding for client's experiencing unstable angina which is consistent with this client's chest pain (Capriotti, 2020).

Echocardiogram- Normal size and structure of the heart with an ejection fraction of 45%. Normal range for an ejection fraction is 50%-70% (Capriotti, 2020).

CXR- No pneumothorax, pleural effusion, or abnormal cardiac findings.

Chest CT- Client has some fatty liver infiltration of the liver. Client likely has some alcoholic related liver disease (Capriotti, 2020).

Nuclear stress test- Due to the client's tremors she is unable to perform a normal stress test. Awaiting results from her stress test, assuming they are normal client is to be discharged shortly after.

Diagnostic Test Reference (1) (APA):

Capriotti, T. (2020). *Davis advantage for pathophysiology: Introductory concepts and clinical perspectives* (2nd ed.). F.A. Davis Company.

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

Home Medications (5 required)

Brand/Generic	Norvasc/ amlodipine	Catapres/ clonidine	Flexeril/ cyclobenzaprine	Cymbalta/ duloxetine	Prilosec/ omeprazole
Dose	2.5 mg	0.1 mg	10 mg	60 mg	20 mg
Frequency	Twice daily	Twice daily	At bedtime	Daily	Daily
Route	By mouth	By mouth	By mouth	By mouth	By mouth
Classification	Calcium channel blocker	Centrally acting alpha agonist	Skeletal muscle relaxant	Selective serotonin and norepinephrine reuptake inhibitor	Proton pump inhibitor
Mechanism of Action	This medication binds to dihydropyridine and non-dihydropyridine receptor sites in myocardial cells, inhibiting extracellular calcium. This decrease in calcium inhibits the contractility of myocardial tissues.	This medication stimulates alpha-adrenergic receptors in the CNS to produce vasoconstrictive and then stimulates central alpha-adrenergic receptors in the brain stem to lower heart rate and blood pressure.	This drug acts in the brain stem to inhibit tonic muscle hyperactivity. This medication relieves muscle spasms without disrupting muscle function.	Inhibits reuptake of dopamine, neural serotonin, and norepinephrine which potentiates noradrenergic and serotonergic activity in the CNS.	Inhibits gastric secretions by inhibiting proton pump in gastric parietal cells.
Reason Client Taking	To control hypertension.	To manage hypertension.	To treat chronic back	To treat depression.	To treat GERD

			pain.		
Contraindications (2)	Hypersensitivity to amlodipine and its components, hypotension.	Hypersensitivity to clonidine or its components. Hypertension or bradycardia.	Dysrhythmias including a heart block, heart failure.	Chronic liver diseases including cirrhosis. Sever renal impairment.	Concurrent usage of rilprivirine therapy and hypersensitivity.
Side Effects/Adverse Reactions (2)	Dysrhythmias, hypotension.	Dysrhythmia, severe bradycardia, and hepatitis.	Seizures, tremors, and arrhythmias.	Hypertensive crisis, serotonin syndrome.	Hypoglycemia, hepatic dysfunction.
Nursing Considerations (2)	Use cautiously in clients that may have hepatic impairment. Assess for hypotension before administering medication.	Assess the client for a heart block before beginning clonidine therapy, as this drug can worsen an AV block and cause worse dysrhythmias. Elderly clients may be more susceptible to this drug's hypotensive effects.	Use caution in elderly clients due to its anticholinergic effects. Initiate safety precautions to prevent falls in clients using this medication.	Monitor blood pressure before beginning therapy and periodically throughout therapy. Monitor electrolytes in clients taking this medication as it may cause hyponatremia.	Give before meals, preferably in the morning. It may be sprinkled and taken with nonessential foods if the client has difficulty with swallowing.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain baseline liver enzymes. Monitor blood pressure before and after administering.	Obtain baseline liver function tests to assess for hepatic damage. Blood pressure and heart rate before and after administration.	Assess client's level of consciousness before administering as this medication may worsen CNS depression.	Monitor client's liver enzymes, and GFR.	Assess baseline liver function tests prior to beginning therapy.

Client Teaching needs (2)	Notify provider if immediately if there is any dizziness or swelling of the extremities. Take with food to reduce GI upset.	Take this medication exactly as directed and do not stop abruptly as that may cause severe hypertension. Avoid operating vehicles after taking this medication until CNS effects are known.	Avoid drinking alcohol and any other CNS depressants while using this medication. Avoid walking, driving, or any other potentially hazardous activities after taking this medication.	Enteric coating medications must be taken whole and not crushed, chewed, or sprinkled into another substance. Do not stop taking medication abruptly if adverse reaction occurs. This medication must be tapered off slowly.	Avoid alcohol, NSAIDs, and foods that increase gastric irritation as it lessens the effects of the medication. Discontinue immediately if rash or joint pain develops while taking this medication.

Hospital Medications (5 required)

Brand/Generic	Tylenol/ acetaminophen	Ativan/ lorazepam	Toprol XL/ metoprolol succinate	Kadian/ morphine	Crestor/ rosuvastatin
Dose	1,000 mg	Dosed based off CIWA score: 9-14= 1 mg >=15=2 mg 2 consecutive scores >=9 = 3 mg.	25 mg	2 mg	20 mg
Frequency	Every 6 hours as needed for	With CIWA score Q4H and 1H after	Twice daily	Every 2 hours as needed for	At bedtime

	pain.	giving lorazepam.		severe pain.	
Route	By mouth	By mouth	By mouth	Intravenous push	By mouth
Classification	Antipyretic, non-opioid analgesic	Benzodiazepine	Beta-adrenergic blocker	Opioid analgesic	HMG-CoA reductase inhibitor
Mechanism of Action	Inhibits enzyme cyclooxygenase, blocking prostaglandin production and interfering with pai impulse generation in the PNS.	This medication potentiates the effects of GABA and other inhibitory neurotransmitters by binding with receptors in the cortical and limbic areas of the CNS,	Inhibits the beta receptor sites located in the heart resulting in decreased cardiac excitability, cardiac output, and cardiac oxygen demand.	Binds with opioid receptors in the brain and spinal cord to produce analgesia and euphoria.	Inhibits HMG-CoA reductase which reduces the amount of LDL synthesized in the body.
Reason Client Taking	To relive mild pain.	To reduce tremors caused by alcohol withdrawal.	To treat hypertension	To manage moderate to severe pain.	To treat hyperlipidemia
Contraindications (2)	Severe hepatic impairment. Severe active liver disease.	Acute angle-closure glaucoma. Hypersensitivity to benzodiazepines.	Acute heart failure, pulse less than 45 beats per minute.	Acute bronchospasm, paralytic ileus, and respiratory depression.	Active liver disease, hypersensitivity to rosuvastatin or its components.
Side Effects/Adverse Reactions (2)	Hepatotoxicity, hypokalemia	Respiratory depression, thrombocytopenia	Bronchospasm, hepatitis.	Increased intracranial pressure, bradycardia, and hypotension.	Hepatitis, pancreatitis.
Nursing Considerations (2)	Use cautiously in clients with hepatic impairments or clients with	Caution clients with depression may have an increased risk in suicidal ideation when	Monitor clients EKG as there is a possibility of a heart block forming in	Use caution in clients with history of alcohol dependance as opioid s may lead to	Use caution in clients who abuse alcohol, as this medication can caused

	alcoholism. Do not exceed a maximum daily dose of 4,000 mg.	beginning this medication. Use caution in clients with past medical history of alcohol abuse as they are at an increased risk for dependance.	clients taking this medication. Monitor for signs of heart failure forming in clients taking this medication.	addiction or misuse. Expect limited dosing in clients with concurrent benzodiazepine therapy, due to increased risk of severe CNS depression.	increased hepatic damage. Expect medication to be discontinued or reduced if liver enzymes are triple their expected range.
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Liver function tests.	Assess client's respiratory status.	Assess clients blood pressure and heart rate. Liver function tests.	Assess for bradycardia. Ensure client is still passing gas or having bowel movements.	Baseline liver function tests and lipid levels.
Client Teaching needs (2)	This medication can be crushed or taken whole. Teach client the signs and symptoms of hepatic toxicity such as easy bruising, or jaundice.	Caution client while ambulating that this medication may cause CNS depression and lead to falls. Avoid alcohol while using this medication as it may cause severe CNS depression.	Do not abruptly discontinue this medication as it may cause rebound hypertension. Check heart rate and blood pressure daily. Hold dose if heart rate is below 60 or systolic blood pressure is below 100.	Avoid alcohol and other CNS depressants while using this medication therapy. Teach client to change positions slowly to reduce the risk of orthostatic hypotension.	Encourage client to follow a low-fat low-cholesterol diet. Notify provider immediately if muscle pain or weakness develops while taking this medication.

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 nurse's drug handbook* (19th ed.). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point):	**Alertness:**	This client is alert.
	Orientation:	She is oriented to person, place, time, and situation.
	Distress:	No distress but she is tremoring in her arms and legs. She is unable to stand on her own due to the tremors.
	Overall appearance:	Client appears to be exhausted.
INTEGUMENTARY (2 points):		
	Skin color:	Skin color is pale, and appropriate for race.
	Character:	Skin is a little moist/clammy at times possibly due to withdrawal but overall dry and intact.
	Temperature:	Warm.
	Turgor:	Skin is loose, < 3 seconds
	Rashes:	No rashes.
	Bruises:	No bruises.
	Wounds:	No wounds.
	Braden Score:	21
	Drains present: Y☐ N ☒	
	Type:	N/A
HEENT (1 point):	**Head:**	Normocephalic with symmetrical facial features.
	Neck:	Trachea centered, thyroid rises/falls with swallowing, 3 + carotid pulse bilaterally.
	Ears:	Tympanic membrane gray bilaterally.
	Eyes:	Pupils equal round reactive to light and accommodation. Sclera white. Client is wearing spectacles.
	Nose:	Nares patent bilaterally. Absent of any discharge or drainage.
	Teeth:	Teeth intact and off-white/yellow. Pink and moist oral mucosa.

CARDIOVASCULAR (2 points):	
Heart sounds:	Heart sounds audible. No murmur or gallop.
S1, S2, S3, S4, murmur etc.	S1, S2
Cardiac rhythm (if applicable):	Normal Sinus Rhythm with inverted T-wave.
Peripheral Pulses:	3+ radial, pedal, and carotid pulses bilaterally.
Capillary refill:	<3seconds.
Neck Vein Distention: Y ☐ N ☒	
Edema Y ☐ N ☒	
Location of Edema:	N/A
RESPIRATORY (2 points):	Auscultated clear lung sounds anteriorly and posteriorly in all 5 lobes of the lungs. Respirations are regular rate and unlabored. Client states she is having no shortness of breath currently.
Accessory muscle use: Y☐ N ☒	
Breath Sounds: Location, character	
GASTROINTESTINAL (2 points):	
Diet at home:	Eats small meals. Skips dinner and sometimes lunch due to her alcohol consumption.
Current Diet	Heart healthy low sodium diet.
Height:	165 cm
Weight:	84 kg
Auscultation Bowel sounds:	Hypoactive bowel sounds in all four quadrants. Client states she is passing gas.
Last BM:	06/20/2021
Palpation: Pain, Mass etc.:	Soft, round, and no pains or masses upon palpation. No hepatomegaly.
Inspection:	
Distention:	No signs of distension or bruising to abdomen.
Incisions:	None
Scars:	None
Drains:	None
Wounds:	None
Ostomy: Y ☐ N ☒	None
Nasogastric: Y ☐ N ☒	
Size: N/A	
Feeding tubes/PEG tube Y ☐ N ☒	
Type: N/A	
GENITOURINARY (2 Points): Color:	Yellow/Amber
Character:	Clear, non-cloudy
Quantity of urine:	180 mL
Pain with urination: Y ☐ N ☒	
Dialysis: Y ☐ N ☒	
Inspection of genitals:	
Catheter: Y ☐ N ☒	N/A
Type: N/A	

Size: N/A	
MUSCULOSKELETAL (2 points):	
Neurovascular status:	Nail beds pink with cap refill < 3 seconds.
ROM:	Poor motor control in all four extremities due to tremors.
Supportive devices:	Client requested a new walker, as she "gave hers away" that she received after her knee surgery this year.
Strength:	4 strength in all four extremities.
ADL Assistance:	Yes
Fall Risk:	Yes
Fall Score:	55
Activity/Mobility Status:	Up with one.
Independent (up ad lib):	No
Needs assistance with equipment:	Yes
Needs support to stand and walk:	Yes
NEUROLOGICAL (2 points): MAEW:	No, client is experiencing tremors making muscle control in all four extremities very poor.
PERLA:	Yes
Strength Equal:	Yes
Orientation:	Person, place, time, and situation.
Mental Status:	Client is cognitive and alert.
Speech:	Speech is clear and sensible.
Sensory:	Sensation intact in all extremities. Can differentiate dull and sharp stimuli.
LOC:	Client is alert and awake.
PSYCHOSOCIAL/CULTURAL (2 pts):	Client has poor coping methods. Client is
Coping method(s):	dependent on alcohol. She acknowledges it is a problem in her life but has no intentions of stopping. Her only support person is her neighbor who visits her daily.
Developmental level:	High school graduate. She can read, write, and make informed decisions.
Religion & what it means to pt.:	Client has considered herself nonreligious since a young age.
Personal/Family Data (Think about home environment, family structure, and available family support):	Client divorced 5 years ago and has lived alone ever since. She does not see or talk to her three children on a regular basis.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	96	110/83	20	37.0	96 (room air)

				(temporal)	
1211	110	136/96	20	37.0	96 (room air)

Vital Sign Trends:

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0745	Numeric	N/A	0/10	N/A	N/A
1211	Numeric	N/A	0/10	N/A	N/A

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV:	20 Gauge
Location of IV:	Left antecubital
Date on IV:	06/21/2021
Patency of IV:	IV is patent. Client is receiving continuous infusion of a banana bag.
Signs of erythema, drainage, etc.:	No signs of erythema, infiltration, or drainage.
IV dressing assessment:	Transparent dressing.

Intake and Output (2 points)

Intake (in mL)		Output (in mL)	
Caffeine free diet coke	225 mL	Void	200 mL
OJ	120mL	Void	180 mL
IV fluids 41ml/hr.*7hr=	287 mL		
Ate 100% of breakfast following her stress			

test.	

Nursing Care

Summary of Care (2 points)

Overview of care: Client was stressed the importance of alcohol cessation upon admission and placed on CIWA protocol. Client last had alcohol on 06/20/21 and had suffered tremors since admission. After the completion of her stress test client requested to be taken off CIWA and given a dose of alcohol for therapeutic use for her alcohol withdrawal symptoms.

Procedures/testing done: Client had just gone down for a nuclear stress test.

Complaints/Issues: No chest pains felt on 06/22/21. Client is suffering tremors which have been helped with lorazepam given as per CIWA protocol. Tremors subsided after she received her one-time dose 60 mL of vodka.

Vital signs (stable/unstable): Client is experiencing some tachycardia and diastolic hypertension. Otherwise, vital signs are stable.

Tolerating diet, activity, etc.: No complaints of heart healthy diet. Client is up with one.

Physician notifications: Provider okayed the use of one-time therapeutic vodka since the client has no intentions of continuing alcohol cessation upon discharge from the hospital. Provider states client is okay for discharge pending normal results for her stress test.

Future plans for patient: Client is okay for discharge as soon as stress test results are read. No further testing is indicated.

Discharge Planning (2 points)

Discharge location: Client is to be discharged to home. Client may be required to get a ride or take a taxi home due to the administration of alcohol.

Home health needs (if applicable): N/A

Equipment needs (if applicable): Client states she would like a new walker upon discharge for her tremors. She had a walker from her right knee arthroplasty that she had given away. Upon learning that insurance would be unlikely to pay for another walker she stated she does not need it.

Follow up plan: Client will follow up with her regular provider 2-3 days after discharge.

Education needs: Heart healthy diet information. Client is not interested in pursuing alcohol cessation.

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.
1. Risk for decreased cardiac output related to angina pectoris as evidenced by ejection fraction below the expected range.	Client was admitted for evaluation of chest pains and diagnostic tests show high probability of some form of heart disease.	**1.** Keep the head of the bed in the upright position. **2.** Conserve client's energy by ensuring she receives adequate rest periods.	Keeping the head of the bed up decreases oxygen demand, which decreases the workload on the heart. Preserving the client's energy, keeping ambulation to a minimum, reduces her cardiac workload, giving her time to heal.
2. Risk for injury related to unsteady gate, as evidenced by involuntary tremors experienced because of withdrawal.	This client has gone 2 days without alcohol. The client is used to drinking about 1.5 pints of liquor a day and as a result is experiencing	**1.** Place call light within reach of client. Instruct client to utilize the call light if the client requires assistance ambulating to the restroom. This is to ensure client safety	Client is compliant in utilizing the call light each time she requires to ambulate.

	tremors that make her a fall risk.	and no falls. **2.** Place client on seizure precautions. Client's going through alcohol withdrawal may experience seizures, putting them at risk for injury.	Seizure precautions put in place. Padded side rales in place and bed is in the lowest position.
3. Imbalanced nutrition related to alcohol addiction as evidenced by the client skipping meals to drink.	Clients that have an alcohol addiction tend to "drink their meals" which means their bodies do not get adequate nutrition needed.	**1.** Teach client a heart healthy diet that is low in sodium. **2.** Encourage client try to get 30 minutes of moderate exercise a day.	Client acknowledged that her diet was not adequate and pledged to eat more heart healthy foods upon discharge. Client acknowledges importance of activity in keeping a good metabolism and a healthy heart.
4. Risk for electrolyte imbalance related to alcohol addiction as evidenced by low electrolytes upon admission.	Electrolytes are vital for fluid balance, muscle contraction, and nerve function. Severe electrolyte imbalances could put the client at risk for cardiac dysrhythmias.	**1.** Teach client the importance of maintaining fluid electrolyte balance. **2.** Teach client good dietary sources of electrolytes.	Client acknowledges that her alcohol abuse puts her at severe risk of fluid and electrolyte imbalance. Client acknowledges potential dietary sources to replenish electrolytes.

Other References (APA): N/A

Concept Map (20 Points):

Subjective Data

Client experienced a "dull" chest pain which she rated as a 7/10 in the emergency department.
Client experienced some dyspnea with exertion.
Client's pain is currently a 0/10.

Nursing Diagnosis/Outcomes

1.Risk for decreased cardiac output related to angina pectoris as evidenced by ejection fraction below the expected range.
Blood pressure and heart rate return to normal range before discharge.
2.Risk for injury related to unsteady gate, as evidenced by involuntary tremors experienced because of withdrawal.
Client experiences no falls during her hospitalization.
3.Imbalanced nutrition related to alcohol addiction as evidenced by the client skipping meals to drink.
Client eats three full meals per day during her hospitalization.
4.Risk for electrolyte imbalance related to alcohol addiction as evidenced by low electrolytes upon admission.
Client's electrolytes return to a normal range before discharge.

Objective Data

Imaging:
EKG shows NSR with T-wave inversion
Echo shows normal heart structure with an ejection fraction of 41%
Pending results of stress test.
Assessment: Client is experiencing severe tremors because of alcohol withdrawal.
Abnormal labs:
Neutrophils: 80.8
Lymphocytes: 10.5
Cl-: 97
Glucose: 114
Creatinine: 1.21
Calcium: 8.5
AST: 41

Patient Information

66-year-old Caucasian female. History of HTN, alcohol abuse, anxiety, depression, admitted at SBL with chief complaint of chest pains lasting 2 days.

Nursing Interventions

1. Keep the head of the bed in the upright position.
2. Conserve client's energy by ensuring she receives adequate rest periods.
3. Place call light within reach of client. Instruct client to utilize the call light if the client requires assistance ambulating to the restroom. This is to ensure client safety and no falls.
4. Place client on seizure precautions. Client's going through alcohol withdrawal may experience seizures, putting them at risk for injury.
5. Teach client a heart healthy diet that is low in sodium.
6. Encourage client try to get 30 minutes of moderate exercise a day.
7. Teach client the importance of maintaining fluid electrolyte balance.
8. Teach client good dietary sources of electrolytes.