

N323 Care Plan  
Lakeview College of Nursing  
Sarah Evans

## N323 CARE PLAN

**Demographics (3 points)**

<b>Date of Admission</b> 06/24/2021	<b>Patient Initials</b> SW	<b>Age</b> 31	<b>Gender</b> Female
<b>Race/Ethnicity</b> Caucasian	<b>Occupation</b> Direct Support Professional at a group home for developmentally disabled adults	<b>Marital Status</b> “Single” but dating her boyfriend of 7 years who she lives with and has a child with.	<b>Allergies</b> No known allergies
<b>Code Status</b> Full	<b>Observation Status</b> Suicidal Ideation Self Harm	<b>Height</b> 5’1”	<b>Weight</b> 240 lb

**Medical History (5 Points)**

**Past Medical History:** Patient stated she does not have any significant medical history or any surgeries.

**Significant Psychiatric History:** Depression, alcoholism, one suicide attempt, history of self harm.

**Family History:**

Mother (living)-HTN

Father (living)- HTN, former alcoholic.

Sister (living)- thyroid cancer, HTN.

Sister (living)- HTN.

**Social History (tobacco/alcohol/drugs):** Patient has significant history of alcoholism since age 22. Began drinking socially at age 18. She started to drink more at age 22 and would consider herself an alcoholic for about 9 years. Her alcoholism has impacted her life very negatively for about the last three years. Patient stated that she used to drink beer, but now she drinks “cheap vodka”. Most recently she has been drinking about 2 pints per day. Patient smokes about 1/2 a

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pack of cigarettes per week for the last for 12 years. Patient stated she uses marijuana about twice a month and she uses cocaine roughly once a year.

**Living Situation:** Patient has a boyfriend (Ryan) who she has dated for 7 years. She rents a home with him in Rankin, IL. The couple has one 4 year old daughter (Cora) together.

**Strengths:** Patient states her strength is the support of her family.

**Support System:** Patient's support system is her family and significant other.

### **Admission Assessment**

**Chief Complaint (2 points):** "My life was out of control. I was drinking somewhere between 2-4 pints per day. I have bruises all over me from falling down. I missed work twice this week because I just wanted to stay in bed and drink. I knew I needed to get help before I killed myself. I promised myself I'd never be like this and I don't want to be like this anymore."

### **Contributing Factors (10 points):**

**Factors that lead to admission:** Patient has taken perception medication for depression and anxiety in the past (started in 2018 after detoxing at The Pavilion and attending New Choice) but stated she no longer takes her medications because she is not able to get refills of her prescriptions. She said the reason she isn't able to get refills is because she hasn't made it to the appointments to get refills. She is afraid the doctor is going to drop her as a patient for missing appointments. Recently the patient's depression has gotten worse. This week she missed work two days in a row before coming to the Pavilion because she was too drunk and too depressed to get out of the house. When the patient missed work she became suicidal because she started to worry about the financial ramifications of missing work. She gets very anxious about finances.

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**History of suicide attempts:** Patient stated she had one suicide attempt in her teens by cutting her wrists. Patient has visible scars on her wrists from previous suicide attempt and self harm.

**Primary Diagnosis on Admission (2 points):** Alcohol Detox, Secondary Diagnosis is Major Depressive Disorder

**Psychosocial Assessment (30 points)**

History of Trauma				
No lifetime experience: n/a				
Witness of trauma/abuse: n/a				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	NO	YES, patient was 23 years old when she was physically abused by her boyfriend	N/A	Pt described her boyfriend abusing her by hitting her about once a month for most of their relationship. They dated for 2 years.

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<b>Sexual Abuse</b>	<b>NO</b>	<b>No</b>	<b>N/A</b>	<b>N/A</b>
<b>Emotional Abuse</b>	<b>NO</b>	<b>YES, patient was 23 years old when she was emotionally abused by her boyfriend</b>	<b>N/A</b>	<b>Pt stated her boyfriend was extremely emotionally abusive. She said he was emotionally abusive towards her every day for 2 years.</b>
<b>Neglect</b>	<b>NO</b>	<b>NO</b>	<b>N/A</b>	<b>N/A</b>
<b>Exploitation</b>	<b>NO</b>	<b>NO</b>	<b>N/A</b>	<b>N/A</b>
<b>Crime</b>	<b>NO</b>	<b>NO</b>	<b>N/A</b>	<b>N/A</b>
<b>Military</b>	<b>NO</b>	<b>NO</b>	<b>N/A</b>	<b>N/A</b>
<b>Natural Disaster</b>	<b>NO</b>	<b>NO</b>	<b>N/A</b>	<b>N/A</b>
<b>Loss</b>	<b>NO</b>	<b>NO</b>	<b>N/A</b>	<b>N/A</b>
<b>Other</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>
<b>Presenting Problems</b>				
<b>Problematic Areas</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>	
<b>Depressed or sad mood</b>	<b>Yes</b>		<b>Pt described frequency being 5 days a week and lasting all of her waking hours. Patient said she is beginning to feel better because she is not drunk now.</b>	
<b>Loss of energy or interest in activities/school</b>	<b>Yes</b>		<b>Pt stated she always feels tired and has no energy. She wants to stay in bed all day. This occurs daily with an intensity of</b>	

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			<b>5 on a numeric scale of 0-10</b>
<b>Deterioration in hygiene and/or grooming</b>	<b>Yes</b>		<b>Pt stated she feels insecure and disgusting because she does not have any energy to shower or even brush her hair most of the time. Pt stated she feels this way every day.</b>
<b>Social withdrawal or isolation</b>	<b>Yes</b>		<b>Pt stated she never wants to see her friends or do anything social. She feels this way every day.</b>
<b>Difficulties with home, school, work, relationships, or responsibilities</b>	<b>Yes</b>		<b>Pt stated she is having difficulty going to work because of her alcoholism and depression. She feels sick because she is hung over. She missed work twice before being admitted. She also is having relationship problems with her boyfriend. She stated when she is drunk they fight a lot. She also stated her alcoholism and depression hinder her ability to care for her daughter and her home.</b>
<b>Sleeping Patterns</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Change in numbers of hours/night</b>	<b>Yes</b>		<b>Pt stated she has been sleeping 12 hours lately because she feels tired, sick, and depressed. She does this 3-5 nights per week. The other days of the week she barely is able to sleep because of anxiety.</b>
<b>Difficulty falling asleep</b>	<b>Yes</b>		<b>Pt states she has a hard time falling asleep 4 nights per week.</b>
<b>Frequently awakening during night</b>	<b>No</b>		<b>Pt denies awakening during the night.</b>
<b>Early morning awakenings</b>	<b>No</b>		<b>Pt denies waking up early.</b>

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<b>Nightmares/dreams</b>	<b>No</b>		<b>Pt denies night mares.</b>
<b>Other</b>	<b>No</b>		<b>N/A</b>
<b>Eating Habits</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Changes in eating habits: overeating/loss of appetite</b>	<b>Yes</b>		<b>Pt stated she has experienced a loss in appetite. She is not able to finish her meals currently because her stomach is upset and nauseous if she eats too much. This is occurring every day.</b>
<b>Binge eating and/or purging</b>	<b>Yes</b>		<b>Pt stated she binges sometimes because she hasn't eaten and feels very hungry. Then she gets nauseous. She rarely throws up, but it happens occasionally (about once per month). She stated she does not throw up intentionally.</b>
<b>Unexplained weight loss?</b>	<b>No</b>		<b>Pt denies unexplained wight loss.</b>
<b>Amount of weight change:</b>			
<b>Use of laxatives or excessive exercise</b>	<b>No</b>		<b>Pt denies use of laxatives and excessive exercise.</b>
<b>Anxiety Symptoms</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Anxiety behaviors (pacing, tremors, etc.)</b>	<b>Yes</b>		<b>Pt stated she gets chest pain when she feels anxious. She described the pain as sharp and in her lungs, not her heart. She denies any tremors. She stated she gets agitated and scared when she is anxious. On a numeric scale of 0-10 she rated the intensity as a 7 every day.</b>

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<b>Panic attacks</b>	<b>Yes</b>		<b>Pt stated she has panic attacks about twice per year. She claimed to have a panic attack “a few weeks ago”. Her panic attacks usually happen because she is worried about her family. On a numeric scale of 0-10 she rated the intensity as a 7.</b>
<b>Obsessive/compulsive thoughts</b>	<b>Yes</b>		<b>Pt stated she often thinks obsessively about bad things happening to her family. She gets very anxious while doing this. It happens 3 times per week.</b>
<b>Obsessive/compulsive behaviors</b>	<b>No</b>		<b>Pt denies obsessive and compulsive behaviors.</b>
<b>Impact on daily living or avoidance of situations/objects due to levels of anxiety</b>	<b>Yes</b>		<b>Pt is currently very worried about paying the bills because she will not be working for at least another month because she is hoping to go to New Choice after detox. She also avoids her parents right now because her dad always knows if she has been drinking because he is a former alcoholic and he gets very upset about her drinking. Pt feels judged by her parents. She feels this way every day.</b>
<b>Rating Scale</b>			
<b>How would you rate your depression on a scale of 1-10?</b>		<b>6/10</b>	
<b>How would you rate your anxiety on a scale of 1-10?</b>		<b>7/10</b>	
<b>Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)</b>			
<b>Problematic Area</b>	<b>Presenting?</b>		<b>Describe (frequency, intensity, duration, occurrence)</b>
<b>Work</b>	<b>Yes</b>		<b>Pt claims she is hung over at</b>

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			<b>work 5 days a week. It negatively impacts her ability to do her job well.</b>	
<b>School</b>	<b>No</b>		N/A	
<b>Family</b>	<b>Yes</b>		<b>Pt stated she fights with her boyfriend a lot when she is drunk. Her daughter is scared when this happens. This occurs 5 days a week.</b>	
<b>Legal</b>	<b>No</b>		N/A	
<b>Social</b>	<b>Yes</b>		<b>Pt stated she feels isolated because of her alcoholism and depression. She feels this way every day. During the shift I observed Sarah I saw her enjoying talking and socializing with her room mate.</b>	
<b>Financial</b>	<b>Yes</b>		<b>Pt stated she is very stressed about not working currently. She is afraid of being fired because she didn't go to work for two days before she was admitted. She is stressed about this every day.</b>	
<b>Other</b>	<b>No</b>		N/A	
<b>Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient</b>				
<b>Dates</b>	<b>Facility/MD/Therapist</b>	<b>Inpatient/Outpatient</b>	<b>Reason for Treatment</b>	<b>Response/Outcome</b>

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01/01/2018	<p><b>Inpatient</b>  <b>Outpatient</b>  <b>Other:</b></p> <p><b>At The Pavilion</b></p>	Inpatient	Alcohol Detox and Rehab at New Choice	<p><b>Some improvement</b>          Pt stated she felt very happy while she was at New Choice. She was taking her medication at that point and feeling very good. She was sober for about 5 months. Then she did not get her prescriptions refilled so she ran out of them. Then she visited a friend who had beer available at his house and she felt overcome by the impulse to drink. She has been drinking again ever since about 06/01/2018.</p>
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**Personal/Family History**

Who lives with you?	Age	Relationship	Do they use substances?	
Ryan	25	Boyfriend	Yes	Marijuana every day for pain and depression.
Cora	4	Daughter	No	

**If yes to any substance use, explain: Ryan uses marijuana daily. Pt stated he does this because of back pain and because it helps with his depression.**

**Children (age and gender): Cora (age 4, female)  
 Who are children with now? Cora is currently being cared for by Ryan as well as Sarah's parents.**

**Household dysfunction, including separation/divorce/death/incarceration:**

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<p>Pt grew up in a home where both of her biological parents were married and lived together for all of her childhood. Pt stated her parents often fought verbally because her father was an alcoholic. He has been sober for 6 years.</p> <p>Pt also stated that she and her boyfriend fight a lot by yelling.</p> <p>Pt denies divorce and incarceration as contributing factors to her household dysfunction.</p>		
<p><b>Current relationship problems: Fighting with her boyfriend by yelling 5 days a week.</b></p> <p><b>Number of marriages: 0</b></p>		
<p><b>Sexual Orientation:</b> Bisexual</p>	<p><b>Is client sexually active?</b> Yes</p>	<p><b>Does client practice safe sex?</b> No</p>
<p><b>Please describe your religious values, beliefs, spirituality and/or preference:</b></p> <p>Pt stated she does not have any religious values, beliefs, or spiritual preferences at this time.</p>		
<p><b>Ethnic/cultural factors/traditions/current activity:</b></p> <p><b>Describe: Pt stated she does not have any ethnic, cultural factors, traditions, or current activities that will impact her care. She stated her culture is “regular American culture”.</b></p>		
<p><b>Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates):</b> Patient stated she was arrested in 2018 for aggravated assault with a deadly weapon. Pt claimed she was framed and didn't do anything but the police believed the person who implicated her. She was able to have the charges lowered to a misdemeanor because she hired a good lawyer. Pt stated she was drunk at the time but didn't actually do anything wrong.</p>		
<p><b>How can your family/support system participate in your treatment and care?</b></p> <p>Pt stated her sisters and parents will be very supportive of her treatment. Her father was an alcoholic and wants nothing more than for his daughter to become sober. Pt stated her boyfriend is an enabler but after she goes through rehab she thinks he will be much better about not enabling her. Pt stated she wants her family to help by not getting alcohol for her and by taking all of the alcohol out of her home. She also stated she wants their help to avoid alcohol at any social gatherings because she has not learned how to control her impulse to drink. She stated if “it is around I will drink it every time”.</p>		
<p><b>Client raised by: Natural Parents</b></p>		
<p><b>Significant childhood issues impacting current illness:</b></p>		

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Pt stated her father's alcoholism impacts her current illness.
<p><b>Atmosphere of childhood home:</b></p> <p>Pt stated her home was comfortable and chaotic while growing up. She was not abused but experience a lot of stress due to her father's alcoholism.</p>
<p><b>Self-Care:</b></p> <p>Pt is able to perform her ADLs independently.</p>
<p><b>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</b></p> <p>Pt stated that both of her sisters and her father are bipolar. They all take medication for bipolar disorder.</p>
<p><b>History of Substance Use:</b></p> <p>Father was an alcoholic through all of pt's childhood until 6 years ago. Pt has used alcohol socially since age 18 and started having a problem with alcohol around age 22. Her drinking has very negatively impacted her life since 2018.</p>
<p><b>Education History:</b></p> <p>Pt graduated high school in 2009 and has taken some college classes to pursue either teaching or nursing. She wants to go back to school, but worries that she can't because of her anxiety.</p>
<p><b>Reading Skills:</b></p> <p>Pt stated her reading skills are good.</p>
<p><b>Primary Language: ENGLISH</b></p>
<p><b>Problems in school: None</b></p>
<b>Discharge</b>
<p><b>Client goals for treatment: Patient wants to learn how to avoid drinking alcohol when it</b></p>

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**is available. She wants to learn to manage cravings by using other coping skills. She knows alcohol will always be available but she has to learn how to abstain.**

**Where will client go when discharged?** Pt will go home upon discharge

### Outpatient Resources (15 points)

Resource	Rationale
<b>Crosspoint Human Services</b> 210 North Hazel St. Danville, IL 61832 (217) 446-1217 <a href="http://www.crosspointhumanservices.org">www.crosspointhumanservices.org</a>	This resource has counselors available for individuals experiencing a mental health crisis. They also offer counseling. They also offer medical appointments to facilitate prescription refills.
<b>Suicide Hotline</b> 1-800-273-8255	This hotline provides trained staff to talk with those who are experiencing suicidal ideations and help them to de-escalate and get the help they need.
<b>LOOSID Sober Social Network App</b>	This app is recommended by The New York Times and Forbes and states it is a community for recovering alcoholics to find support in recovery. It helps track sobriety and encourage addiction recovery through social networking.

### Current Medications (10 points)

**\*Complete all of your client's psychiatric medications\***

<b>Brand/Generic</b>	<b>thiamine</b>	<b>citalopram</b>	<b>diazepam</b>	<b>diphenhydrami</b>	<b>melatonin</b>
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	<b>vitamin B1</b>	<b>Celexa</b>	<b>Valium</b>	<b>ne Benedryl</b>	
<b>Dose</b>	<b>100 mg</b>	<b>10 mg</b>	<b>5-20g</b>	<b>25 mg</b>	<b>3 mg</b>
<b>Frequency</b>	<b>DAILY</b>	<b>DAILY at 0800</b>	<b>PRN</b>	<b>PRN</b>	<b>PRN</b>
<b>Route</b>	<b>Oral</b>	<b>Oral</b>	<b>Oral</b>	<b>Oral</b>	<b>Oral</b>
<b>Classification</b>	<b>Vitamin</b>	<b>Antidepressant</b>	<b>Anticonvulsant Anxiolytic Controlled substance schedule IV</b>	<b>Antihistamine, sedative- hypnotic</b>	<b>Antipyretic/ opioid analg</b>
<b>Mechanism of Action</b>	Combines with adenosine triphosphate (ATP) in the liver and kidneys to produce thiamine diphosphate.	Inhibits neural re-uptake of serotonin which increases available serotonin levels at nerve synapses which can help with depression.	GABA inhibits excitatory stimulation which can help control emotional behavior	Sedative effects are related to CNS depression.	Binds to receptors of melatonin which induces sleep
<b>Therapeutic Uses</b>	To treat vitamin B1 insufficiency	Used for treatment of depression	Treat signs and symptoms of alcohol detox	Used as a sleep aid and to treat allergic reactions	Used as a sleep aid
<b>Therapeutic Range (if applicable)</b>	n/a	N/A	N/A	N/A	N/A
<b>Reason Client Taking</b>	Vitamin B1 deficiency r/t alcoholism.	Depression	Treatment for alcohol detox	To help the pt sleep at night if melatonin has not worked	To help fall asleep

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<b>Contraindications (2)</b>	Hypersensitivity	Do not use within 14 days of MAO, prior use of methylene blue.	Acute angle closure glaucoma, children under 6 months	breastfeeding, newborn infants, hypersensitivity	current immunosuppressive therapy, pt seizure history
<b>Side Effects/Adverse Reactions (2)</b>	warmth sweating	CVA seizures	ataxia confusion	dizziness drowsiness	abdominal cramps, alertness decrease
<b>Medication/Food Interactions</b>	Can make some antibiotics slightly less effective.	bupirone, fentanyl,	antacids fluoxetine	barbiturates and other CNS depressants, alcohol use	sodium oxybutyrate, acetaminophen
<b>Nursing Considerations (2)</b>	Do not exceed daily recommended dose if pregnant. Do not administer if client is hypersensitive to thiamine.	Monitor client for serotonin syndrome, dosage changes can cause agitation, chills, and fever.	Use with caution for those with substance abuse because it can cause dependence, hepatic and renal impairment.	Take drug with food to minimize GI upset, tell pt to not use alcohol while taking this medication.	Use caution for clients under 20 years of age with impaired liver function

<b>Brand/Generic</b>	<b>ondansetron Zofran</b>	<b>hydroxyzine pamoate Vistaril</b>	<b>loperamide Imodium</b>		
<b>Dose</b>	<b>8 mg</b>	<b>50 mg</b>	<b>2mg</b>		

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<b>Frequency</b>	<b>PRN</b>	<b>PRN</b>	<b>PRN</b>		
<b>Route</b>	<b>PO</b>	<b>PO</b>	<b>PO</b>		
<b>Classification</b>	<b>Antiemetic</b>	<b>Anxiolytic</b>	<b>Antidiarrheal</b>		
<b>Mechanism of Action</b>	<b>Blocks serotonin receptors at the vagal nerve terminals in the intestine which reduces nausea and vomiting.</b>	<b>CNS depressant effects are to CNS and are dependent on the dosage.</b>	<b>Acts by slowing intestinal motility by binding to opiate receptors in the wall of the intestine.</b>		
<b>Therapeutic Uses</b>	<b>To treat nausea/vomiting.</b>	<b>To treat anxiety</b>	<b>To treat diarrhea</b>		
<b>Therapeutic Range (if applicable)</b>	<b>N/A</b>	<b>N/A</b>	<b>N/A</b>		
<b>Reason Client Taking</b>	<b>Nausea</b>	<b>Client has overwhelming anxiety</b>	<b>Diarrhea is a common side effect of alcohol withdrawal.</b>		
<b>Contraindications (2)</b>	<b>Use of apomorphine, or hypersensitivity to ondansetron.</b>	<b>Early pregnancy, prolonged QT interval</b>	<b>bloody stool, abnormal EKG</b>		
<b>Side Effects/Adverse Reactions (2)</b>	<b>hypotension, arrhythmias</b>	<b>torsades de pointes, prolonged QT interval</b>	<b>dizziness drowsiness</b>		

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<b>Medication/Food Interactions</b>	<b>SSRIs (increased risk of serotonin syndrome), rifampin.</b>	<b>Reduces effect of some antibiotics like azithromycin, antidysrhythmic medication</b>	<b>anticholinergics, opioids</b>		
<b>Nursing Considerations (2)</b>	<b>This medication may contain aspartame. Avoided giving to patients with phenylketonuria. Correct hypokalemia or hypomagnesemia before administration of ondansetron.</b>	<b>Use cautiously in patients with low heart rate or pre-existing heart disease.</b>	<b>This drug may lead to constipation, assess fluid and electrolyte levels.</b>		

**Medications Reference (1) (APA):**

2020 Nurse's drug handbook (Nineteenth edition. ed.). (2020). Jones & Bartlett Learning.

**Mental Status Exam Findings (20 points)**

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<b>APPEARANCE:</b> <b>Behavior:</b> <b>Build:</b> <b>Attitude:</b> <b>Speech:</b> <b>Interpersonal style:</b> <b>Mood:</b> <b>Affect:</b>	<p>Patient is alert and oriented x4. She appears well groomed. Was a bit anxious during assessment. She stated she had poor hygiene upon admission. Patient was very kind and opened up to student nurse. She was very willing to answer questions. Her affect during the interview was flat.</p>
<b>MAIN THOUGHT CONTENT:</b> <b>Ideations:</b> <b>Delusions:</b> <b>Illusions:</b> <b>Obsessions:</b> <b>Compulsions:</b> <b>Phobias:</b>	<p>Patient's thoughts were very straight forward. She answered questions with short sentences and only expanded upon content when asked to. She was oriented to person, place, and time. Upon admission pt was suicidal but did not have any ideations about suicide or self harm during the day of the interview. Pt denied delusions, illusion, compulsions, and phobias. The only obsessive thought the patient shared was worries about family being in an accident or dying unexpectedly.</p>
<b>ORIENTATION:</b> <b>Sensorium:</b> <b>Thought Content:</b>	<p>Pt was oriented to person, place, and time. Her thoughts were clear and easily communicated to the nursing student.</p>
<b>MEMORY:</b> <b>Remote:</b>	<p>Pt stated her memory has deteriorated in the last three years while her alcoholism has been worse. She was able to tell me about her childhood a bit, but could not remember anything from the time of her admission due to being very intoxicated.</p>
<b>REASONING:</b> <b>Judgment:</b> <b>Calculations:</b> <b>Intelligence:</b> <b>Abstraction:</b> <b>Impulse Control:</b>	<p>The patient stated her judgement in regard to decision making is impulsive. Her intelligence is average. She stated she received Bs and Cs in high school. She stated college was very difficult for her due to anxiety, not content. She was able to converse well and stay on topic during the assessment.</p>
<b>INSIGHT:</b>	<p>Pt seemed very insightful about her alcoholism. She knows what she needs to do to become sober and stay sober, but she has not yet connected the actions that are necessary for her to be able to attain this long</p>

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	<b>term.</b>
<b>GAIT:</b> <b>Assistive Devices:</b> <b>Posture:</b> <b>Muscle Tone:</b> <b>Strength:</b> <b>Motor Movements:</b>	<b>Pt has several bruises on arms bilaterally, left shoulder, and right knee due to falling while intoxicated. She stated that she often falls while intoxicated. During the shift pt's gait was steady and her balance was intact. Pt exhibits average muscle tone and strength. No motor deficits were observed. Pt stated all of these things decline when she is drunk which causes her to fall and injure herself.</b>

## Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1400	98	<b>178/116</b>	16	97.2	99
1700	72	<b>168/96</b>	16	98.0	98

## Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1429	0	N/A	N/A	N/A	N/A
1400	Numeric 2	headache bruises	"not that bad"	achy	N/A
1700	Numeric 2	headache bruises	"not that bad"	achy	N/A

## Dietary Data (2 points)

<b>Dietary Intake</b>
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<b>Percentage of Meal Consumed:</b>	<b>Oral Fluid Intake with Meals (in mL)</b>
<b>Breakfast: 15%</b>	<b>Breakfast: 480 mL (OJ and water)</b>
<b>Lunch: 25%</b>	<b>Lunch: 480 mL (chocolate milk and water)</b>
<b>Dinner: 25%</b>	<b>Dinner: 480 mL (water)</b>

**Discharge Planning (4 points)****Discharge Plans (Yours for the client):**

After successful completion of New Choice Sarah will attempt to live a sober life for the rest of her life. My plans for her are to continue taking her depression and anxiety meds long term. I would like for her to continue seeing a therapist to help her as she learns to deal with the availability of alcohol after discharge. I would also like for her to either join an AA group or use the app (or one like it) to find a support group of other people who have similar issues. If she has support her outcomes will be better. I hope her boyfriend will become very involved in her recovery and no longer enable her alcoholism. I hope Sarah will continue to go to necessary doctor appointments in order to refill her prescriptions. I think engaging in social outings needs to be done carefully as Sarah does not react well when alcohol is present. She needs to avoid situations where there could be alcohol available until she is more confident in her ability to abstain.

**Nursing Diagnosis (15 points)**

**\*Must be NANDA approved nursing diagnosis and listed in order of priority\***

## N323 CARE PLAN

<b>Nursing Diagnosis</b> <ul style="list-style-type: none"><li>• Include full nursing diagnosis with “related to” and “as evidenced by” components</li></ul>	<b>Rational</b> <ul style="list-style-type: none"><li>• Explain why the nursing diagnosis was chosen</li></ul>	<b>Immediate Interventions (At admission)</b>	<b>Intermediate Interventions (During hospitalization)</b>	<b>Community Interventions (At discharge)</b>
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## N323 CARE PLAN

<p>1. Risk for Injury related to acute intoxication as evidenced by client's blood alcohol level upon admission.</p>	<p>The nurses first priority is always client safety starting with ABCs. When this client was admitted she was falling because she was extremely intoxicated. Her safety is the first priority.</p>	<p>1. The patient's fall risk was evaluated and she was rated as a high risk for falls. Fall risk precautions were implemented .</p> <p>2. Pt will be reassessed for her fall risk. Until she is no longer a fall risk she was asked to stay in bed or to walk with a tech.</p> <p>3. Vitals were obtained every 4 hours.</p>	<p>1. The risk for injury due to intoxication subsided quickly as she became less intoxicated.</p> <p>2. Vitals and CIWA protocol checks continue every 4 hours.</p> <p>3. Nurse will administer medications to help with alcohol withdrawal side effects.</p>	<p>1. Patient verbal commitment from alcohol future</p> <p>2. Pt has plan in avoid situation alcohol is a</p> <p>3. Patient will in family in her and allow to continue to</p>
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N323 CARE PLAN

<p>2. Risk for suicide and self directed violence related to depression and anxiety as evidenced by, "I have been feeling worthless and like everything is going wrong. I don't want to live this way anymore, I have thought about killing myself."</p>	<p>The patient has problems with anxiety and depression that severely impact her alcoholism when she is not taking her medication and have caused her to have SI and thoughts of SH.</p>	<ol style="list-style-type: none"> <li>1. Pt was assessed for suicidal ideation and self harm upon admission.</li> <li>2. Nurse administered prescribed medications.</li> <li>3. Nursing staff attempted to decrease stimulation to help with anxiety.</li> </ol>	<ol style="list-style-type: none"> <li>1. Pt will be assessed for SI and SH every day.</li> <li>2. Nurse will administer prescribed medications.</li> <li>3. Pt will attend daily groups and psycho therapy sessions.</li> </ol>	<ol style="list-style-type: none"> <li>1. Patient will therapy with psychothe</li> <li>2. Patient will medicatio</li> <li>3. Patient agree medical care SH retu</li> </ol>
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N323 CARE PLAN

<p>3. Ineffective health maintenance related to inability to complete measures necessary to remain sober as evidenced by, "I couldn't refill my prescriptions because I kept missing my doctor appointments," and "when I saw beer at my friend's house I couldn't help myself so I started drinking again".</p>	<p>The patient was able to articulate what she needs to do to remain sober, but she is extremely concerned about her ability to implement these actions long term.</p>	<ol style="list-style-type: none"> <li>1. Patient was started on CIWA protocol to monitor alcohol withdrawal.</li> <li>2. Patient was provided medication to reduce withdrawal manifestations.</li> <li>3. Patient safety was maintained because she was intoxicated at time of admission.</li> </ol>	<ol style="list-style-type: none"> <li>1. Nurse will continue to assess pt's withdrawal process using CIWA.</li> <li>2. Pt will continue to be given medication to reduce withdrawal symptoms until symptoms alleviate.</li> <li>3. Staff will offer pt many group therapy and individual therapy sessions to help her learn coping strategies to help with impulse control and alcoholism.</li> </ol>	<ol style="list-style-type: none"> <li>1. Patient will commit to AA or use another form of support group upon discharge.</li> <li>2. Pt will commit to appointments and refill necessary prescriptions.</li> <li>3. Pt will avoid situations where alcohol is present until she is stronger and able to control her drinking.</li> </ol>
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**Other References (APA):**

Swearingen, P. L., & Wright, J. D. (2019). All-in-one nursing care planning

**Concept Map (20 Points):**

### Subjective Data

Client stated she has been drinking about 2 pints of vodka every day for several years. Pt claimed to have thoughts of suicide and self harm.

### Nursing Diagnosis/Outcomes

Risk for Injury related to acute intoxication as evidenced by upon admission.

Patient verbalizes commitment to abstain from alcohol.

Pt has plan in place to avoid situations where alcohol is present.

Patient will involve her family in her treatment and allow them to help.

2. Risk for suicide and self directed violence related to depression.

by, "I have been feeling worthless and like everything is going wrong this way anymore, I have thought about killing myself."

### Objective Data

Pt was alert and oriented x 4. Her vitals were all within normal limits except for her blood pressure which was 178/116 at the start of my shift. She had several visible bruises and scars.

### Patient Information

Pt has a history of alcoholism and depression with alcoholism and depression and anxiety. She is will detox and then attend New Choice.

Pt is overwhelmed with stress and anxiety. My medications weren't working.

Social Worker convinced me to seek help."

### Nursing Interventions

Pt will be assessed for risk of injury.

2. Nurse will administer PRN lorazepam as needed.

3. Pt will attend daily groups.

Nurse will monitor for signs of withdrawal.

the risk for injury due to intoxication as she became lethargic.

2. Vitals and CIWA protocol will be monitored hourly.

3. Nurse will administer medication for withdrawal symptoms.

