

N321 Care Plan # 1
Lakeview College of Nursing
Bao Cuong Tran

Demographics (3 points)

Date of Admission 9/8/2021	Patient Initials M.S	Age 48 (11/1/1972)	Gender Female
Race/Ethnicity African American	Occupation Carle Foundation Hospital	Marital Status Single	Allergies None
Code Status Full Code	Height 170.2 cm	Weight 190 lbs	

Medical History (5 Points)

Past Medical History: Alcohol abuse, anxiety, back pain, diabetes mellitus, hypertension.

Past Surgical History: None

Family History: Mother - hypertension

Social History (tobacco/alcohol/drugs): former smoker; 3 glasses of wine per week; no drug

Assistive Devices: None

Living Situation: Living alone

Education Level: Associate degree

Admission Assessment

Chief Complaint (2 points): Patient fell and hit her head. Patient complains of head, neck, and abdominal pain.

History of present Illness (10 points): A 48-year-old female with history of hypertension presents to the ER after falling and hitting her head. The patient had drunk 3 bottles of wine prior to her fall. The CT scan done by the ER showed no hemorrhage. Patient vomited upon arrival, and complained of head, neck, and abdominal pain that worsen with movement. The patient had a hypoglycemic episode. There was no one-side weakness.

Primary Diagnosis

Primary Diagnosis on Admission (2 points):Alcohol withdrawal

Secondary Diagnosis (if applicable):

Pathophysiology of the Disease, APA format (20 points): When patients stop or drastically reduce their alcohol consumption after weeks, months, or years of heavy drinking, they may have both mental and physical problems. This is what is known as alcohol withdrawal. The signs and symptoms might range from minor to severe. However, if they've experienced alcohol withdrawal before, they're more likely to experience it again the next time they quit (Pamela, 2019). My patient has history of consuming large amount of alcohol in the past. She had been trying to stop on and off and had been to hospital several times due to withdrawal.

Alcohol has a depressing effect on the body, according to physicians. It slows down brain function and alters the way nerves send and receive data. The central nervous system adapts to having alcohol around all the time over time. The body works hard to keep the brain alert and nerves communicating with one another. When the alcohol level suddenly drops, the brain stays in this keyed-up state. That's what causes withdrawal.

The symptoms of alcohol withdrawal can range from mild to serious. Mild symptoms can appear as soon as six hours after you put your glass down. They may include the following: anxiety, hands trembling, headache, nausea, vomiting, insomnia, sweating. The patient experienced anxiety and dizziness after drinking 3 bottles of wine. She then fell and hit her head. She experienced headache constantly, and sometimes nausea. More serious problems, such as hallucinations, can emerge, including hallucinations (around 12-24 hours after stopping drinking) and seizures (during the first two days after stopping drinking). Things that aren't there can be seen, felt, or heard (Capriotti,2018).

Delirium tremens, or DTs as they're commonly referred to, usually begins around this time. Vivid hallucinations and delusions are among the severe symptoms. Only around 5% of persons suffering from alcohol withdrawal have them. Those who do may also suffer from: heart pounding with confusion, fever and high blood pressure, sweating profusely. My patient has a history of hypertension, and the withdrawal symptoms worsen her situation.

After asking questions about my patient's drinking habit, her care provider was able to determent her withdrawal, and making plan for treatment. A supportive environment should be enough to help her through. That includes: a quiet place, soft lighting, limited contact with people, a positive, supportive atmosphere, healthy food and lots of fluids. She is living alone and feeling lonely. Therefore; she is using alcohol to cope which decrease the effectiveness of her rehab.

Pathophysiology References (2) (APA):

Capriotti, Theresa M. and Frizzell, Joan Parker, "Pathophysiology: Introductory Concepts and Clinical Perspectives" (2018). *Faculty Bookshelf* 75.

Pamela, Swearingen L. and Jacqueline, Wright D, "All-in-One Nursing Care Planning Resource" (2019). *Faculty Bookshelf* 75.

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	4.10 – 5.7	3.24	2.97	Excessive alcohol consumption can cause premature RBC destruction

Hgb	12.0 – 20.0	9.4	8.6	Due to decrease RBC from alcohol consumption
Hct	37% - 51%	28.5%	25.8%	Due to decrease RBC from alcohol consumption
Platelets	140 – 400	296	246	
WBC	4.0 – 11.0	4.6	4.4	
Neutrophils				
Lymphocytes				
Monocytes				
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-	136 – 145	144	140	
K+	3.5 – 5.1	4.3	4.0	
Cl-	98 – 107	111	160	Alcohol can cause electrolytes imbalances through increase fluid loss
CO2	21 – 32	18	24	Alcohol lead to metabolic acidosis which cause decrease carbon dioxide and bicarbonate in the blood
Glucose	60 – 99	47	88	The patient had hypoglycemic episode
BUN	7 – 18	6	5	Excessive urination lead to BUN lower
Creatinine	0.70 – 1.3	0.77	0.72	
Albumin	3.4 – 8.0	3.8	3.4	
Calcium	8.5 – 10.1	8.1	7.7	Alcohol disrupts vitamin D production
Mag	1.6 – 2.6	1.1	1.4	Alcohol cause increase magnesium

				excretion
Phosphate				
Bilirubin				
Alk Phos				
AST				
ALT				
Amylase				
Lipase				
Lactic Acid				

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	0.8 – 1.1	1.1		
PT	11 – 13.5	13.4		
PTT	25 - 35	26.6		
D-Dimer				
BNP				
HDL				
LDL				
Cholesterol				
Triglycerides				
Hgb A1c				

TSH				
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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; clear	Yellow; clear		
pH	7.35-7.45	5.0		
Specific Gravity	1.005 – 1.030	1.005		
Glucose		Negative		
Protein	150	500+		Kidney damage leads to excessive protein elimination
Ketones		Trace		
WBC	0 – 5	4		
RBC	0 – 4	3		
Leukoesterase		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				
Blood Culture				
Sputum Culture				
Stool Culture				

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2019). *Mosby's diagnostic and laboratory test reference*. St. Louis, MO: Elsevier.

Diagnostic Imaging**All Other Diagnostic Tests (5 points):**

CT brain w/o contrast: no evidence of an acute intracranial process.

CT cervical spine w/o contrast: no acute fracture.

CT abdomen pelvis w contrast: no acute abnormality.

Diagnostic Test Correlation (5 points):

CT brain w/o contrast: the test is ordered to check for head trauma after fall.

CT cervical spine w/o contrast: the test is ordered to check for neck trauma after fall.

CT abdomen pelvis w contrast: the test is ordered to check for abdomen trauma after fall and consuming 3 bottles of wine.

Diagnostic Test Reference (1) (APA):

Mayo Clinic. (2018). *CT scan*. Mayoclinic.org. <https://www.mayoclinic.org/tests-procedures/ct-scan/about/pac-20393675>

**Current Medications (10 points, 1 point per completed med)
*10 different medications must be completed***

Hospital Medications (5 required)

Brand/Generic	Citalopram/ celaxa	Folic acid/FA -8	Magnesium sulfate	Multivitam in with folic acid	Thiamine/ vitamin B1
Dose	40mg	1mg	4g	400mcg	100mg
Frequency	Daily	Daily	Once	Daily	Daily
Route	Oral	Oral	IV	Oral	Oral
Classification	antidepressa nt	vitamin	Electrolyte replacement	vitamin	vitamin
Mechanism of Action	Block serotonin	produce and maintai n new cells	Assist in phosphate transfer	produce and maintain new cells	prevent vitamin B1 deficiency
Reason Client Taking	anxiety	Methan ol poisonin g	Low magnesium	Methanol poisoning	Alcohol withdrawal syndrome
Contraindicatio ns (2)	Pimozide therapy	Liver disease, epilepsy	MI	Liver disease, epilepsy	Hypersensiti ve to thiamine
Side Effects/Adverse Reactions (2)	Agitation, GI bleeding	nausea	Confusion, dizziness	nausea	Chest pain, nausea
Nursing Considerations (2)	Monitor serotonin syndrome	Monitor allergic reaction	Observe for sign of hypermagnese mia	Monitor allergic reaction	Pregnant, breast feed

Home Medications (5 required)

Brand/ Generic	Tylenol/ acetaminop hen	losartan /Cozaar	Metoprolol tartrate/ Lopressor	Fluticasone Propionate/ lescol	rivaroxaba n /Xarelto
Dose	325mg	50mg	50mg	50mcg	20mg
Frequency	PRN	daily	daily	PRN	daily
Route	oral	oral	oral	Nasal spray	oral
Classification	nonopioid	Angiotensi n receptor blockers	antihyperten sive	antilipemic	Factor Xa inhibitors
Mechanism of Action	Inhibit cyclooxygen ase	Block binding of angiotensin	Inhibit stimulation of beta	Interfere with hepatic enzymes	Block active site
Reason Client Taking	pain	hypertensio n	hypertension	Manage cholesterol level	Reduce risk of stroke
Contraindicati ons (2)	Hepatic impairment ; liver disease	Renal impairmen t; hypersensit ive	Acute heart failure; cardiogenic shock	Breast feeding; acute hepatic disease	Active bleeding; hypersensit ive
Side Effects/Advers e Reactions (2)	Fever; headache	Dizziness; nausea	Depression; confusion	Dizziness; fatigue	Dizziness; GI bleeding
Nursing Consideration s (2)	Hepatic impairment : dose based on patient weight	Monitor blood pressure; monitor renal function	Access ECG	Increase risk of liver dysfunction in alcoholics	Monitor for signs of hypersensit ive

Medications Reference (1) (APA):

Institute for Safe Medication Practice: ISMP Medication Safety Alert. <http://www.ismp.org/>.

Jones & Barlett Learning. (2020). 2020 Nurse's Drug Handbook. Burlington, MA

Assessment

Physical Exam (18 points)

<p>GENERAL (1 point): Alertness: Orientation: Distress: Overall appearance:</p>	<p>Alerted and oriented to person, place, time when awake No acute physical distress</p>
<p>INTEGUMENTARY (2 points): Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: Braden Score: 19 Drains present: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type:</p>	<p>Skin is warm, no rashes, or lesions on exposed skin, or bruise. Wound on right knee due to the fall No palpable cervical or supraclavicular adenopathy bilaterally Normal turgor</p>
<p>HEENT (1 point): Head/Neck: Ears: Eyes: Nose: Teeth:</p>	<p>Head atraumatic and normocephalic Neck supple Pupils equal bilaterally, no icterus, conjunctival exudate bilaterally No ear discharge, no facial swelling, no external otitis/rhinitis/pharyngitis/oral thrush Complain of headache</p>
<p>CARDIOVASCULAR (2 points): 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>Clear S1&S2 sound, no murmurs, gallops, or rubs No chest pain Peripheral pulses are palpable Cap refill is less than 3 second No edema No cyanosis</p>
<p>RESPIRATORY (2 points): Accessory muscle use: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Breath Sounds: Location, character</p>	<p>Distant lungs sound No cough, choking</p>
<p>GASTROINTESTINAL (2 points): Diet at home: Current Diet Height: Weight: Auscultation Bowel sounds:</p>	<p>Abdomen is soft, nontender, normal bowel sounds, no hepatosplenomegaly No nausea, diarrhea</p>

<p>Last BM: 9/9/2021 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>GENITOURINARY (2 Points): Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Type: Size:</p>	<p>Normal amount of urine Urine is yellow, clear, no bad odor</p>
<p>MUSCULOSKELETAL (2 points): Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Fall Risk: Y <input checked="" type="checkbox"/> N <input type="checkbox"/> Fall Score: 13 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>Negative for myalgias, joint swelling, and arthralgias Limited assistance – one person assist no cyanosis Unsteady gait, dizzy, easy to lose balance when walking Limbs independent</p>
<p>NEUROLOGICAL (2 points): MAEW: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input checked="" type="checkbox"/> Strength Equal: Y <input checked="" 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:</p>	<p>Alert, oriented when awake No focal weakness, cranial nerves normal No seizures, or numbness Complain of headache and dizzy Can communicate clearly</p>

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):	Alcohol abuse Stay alone Express loneliness in voice and speech Non religious

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0745	84	156/86	18	99.5 F Axillary	96
1105	81	150/90	18	96.9 F Oral	97

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0825	None				
1045	8	Head	Strong	Sharp/persistent	Give tylenol

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 22 Location of IV: radial Date on IV: 9/8/2021 1300 Patency of IV: Signs of erythema, drainage, etc.: None IV dressing assessment: dry/new/clean	5% dextrose

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
360 p.o.	100

Nursing Care

Summary of Care (2 points)

Overview of care: alcohol withdrawal care

Procedures/testing done: CBC, covid, magnesium

Complaints/Issues: head, neck, abdominal pain

Vital signs (stable/unstable): hypertension

Tolerating diet, activity, etc.: diabetic diet

Physician notifications: none

Future plans for patient: prevent fall, skin injury

Discharge Planning (2 points)

Discharge location: home

Home health needs (if applicable): none

Equipment needs (if applicable): none

Follow up plan: alcohol rehab

Education needs: mobility impairment education, joint strength; home safety

Nursing Diagnosis (15 points)

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full	• Explain why		• How did the

nursing diagnosis with “related to” and “as evidenced by” components	the nursing diagnosis was chosen		<p>patient/family respond to the nurse’s actions?</p> <ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
1. Risk of fall related to alcohol withdrawal as evidence by losing balance when walking	Patient has unsteady gait	1.gait belt 2.bed and chair alarm	Patient cooperates, goal partial met as patient did not fall
2. Risk of skin injury related to alcohol withdrawal as evidence by losing balance when walking and unsteady gait	Patient thinks that she can be independent yet her balance when walking is off	1. one person assists in transferring 2.using walker	Patient cooperates, goal partial met as patient did not fall
3. Electrolyte and fluid imbalance related to alcohol consumption as evidence by imbalance electrolytes in lab result	Patient lab result	1. monitor intake and output 2 educate patient in excessive alcohol consumption	Patient cooperates, goal partial met as patient did listen to the education

Other References (APA):

Pamela, Swearingen L. and Jacqueline, Wright D, “All-in-One Nursing Care Planning Resource”

(2019). *Faculty Bookshelf* 75.

Concept Map (20 Points):

Subjective Data

The patient had drunk 3 bottles of wine then fell and hit her head. Patient complained of head, neck, and abdominal pain that worsen with movement.

Nursing Diagnosis/Outcomes

Risk of fall related to alcohol withdrawal as evidence by losing balance when walking/ Patient cooperates, goal partial met as patient did not fall
Risk of skin injury related to alcohol withdrawal as evidence by losing balance when walking and unsteady gait/ Patient cooperates, goal partial met as patient did not fall
Electrolyte and fluid imbalance related to alcohol consumption as evidence by imbalance electrolytes in lab result / Patient cooperates, goal partial met as patient did listen to the education

Objective Data

CT scan show no acute injury
Lab result shows electrolyte imbalance
Hypoglycemic episode upon arriving
BP 156/86
P 84
R 18
T 99.5
O2 96

Patient Information

History of alcohol abuse,
anxiety, back pain, diabetes
mellitus, hypertension
Living alone, depress, lonely
Had been to hospital several
times due to alcohol
withdrawal

Nursing Interventions



