

N323 Care Plan

Lakeview College of Nursing

Name: Caite Blakeney

Demographics (3 points)

Date of Admission 11/9/21	Patient Initials CW	Age 50	Gender Female
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Single	Allergies None
Code Status Full	Observation Status 15-minute checks	Height 5'7"	Weight 100.4lbs

Medical History (5 Points)

Past Medical History: The patient has denied any past medical history other than being in a mental health facility for the attempt of suicide.

Significant Psychiatric History: The patient has consulted with a psychiatrist in the past. She was never hospitalized, and patient has history of 1 suicide attempt. The patient has previous psychiatric history of suicide attempts. Pt states "I attempted suicide a couple times".

Pt is a 58 y/o female presenting as a walking seeking rehab services for alcohol use. Pt reports that her memory is bad, so she struggles with remembering certain details. When asked how much she drinks she was unable to identify. Pt reports she has been drinking heavily for the past year and the amount often depends on how much money she has. Pt reports that her stresses and triggers involve almost everything and so it causes her to drink to cope. Pt identified that she was previously in rehab at this facility and she successfully completed it. With a period, sobriety to following the completion. Patient denied any still S1, H1, or psychosis features. No medical concerns. No prescribed medications. Pt covid returned negative.

Family History: The patient's family history includes his biological father had issues with alcoholism. That her brother/sister have a history of anxiety and depression. Her sister also has a history or multiple suicide attempts.

Social History (tobacco/alcohol/drugs): The patient was living alone in her apartment but was evicted due to her chronic alcohol abuse. She stated once she was evicted, she had moved in with her new male friend. She is currently unemployed. She is unknown to how much alcohol she used to consume. She stated “I have been drinking since I was 15-16 years old”. Upon arrival the patient’s withdrawal symptoms included cramping, sweating, nausea, diarrhea, and tremors.

Living Situation: Patient is homeless, she was recently evicted from her apartment but was living with a male friend.

Strengths: The patient stated she is literate, hardworking, quick learner when shown appropriately. Patient has been cooperative, and willing to participate in her treatment. She was willing to answer any questions that were asked.

Support System: The patient states, "My daughter from a distance, she is 23 but has her own family to worry about".

Admission Assessment

Chief Complaint (2 points): “Before I didn’t think I had alcohol problems, now I believe I have alcohol problems”. “I am a chronic alcoholic”

Contributing Factors (10 points): This is a 50-year-old female with a history of alcohol use disorder. She was willingly admitted for detox after speaking with her male friend who stated she needed help. Patient states, “I have been drinking since I was 15-16 years old”. She states, “Losing her apartment, car due to driving on a suspended license, financial problems, relationship issues, and negative consequences due to alcohol use”.

Factors that lead to admission: She states, “I lost my apartment, I didn’t have anywhere to live so I had to move in with a male friend.”.

History of suicide attempts: She had suicide intentions and plans in January 2021.

Primary Diagnosis on Admission (2 points): Alcohol use with detox.

Secondary Diagnosis: Patient has been diagnosed with anxiety, depression, bipolar type 1, concentration loss, and memory loss.

Psychosocial Assessment (30 points)

History of Trauma				
<p>No lifetime experience: Patient states he has a history related to trauma physical, sexual and mental abuse.</p> <p>Witness of trauma/abuse: N/A</p>				
	Current	Past (what age)	Secondary Trauma (response that comes from caring for another person with trauma)	Describe
Physical Abuse	No	Yes 2017	Daughter Never care	Significant other fractured her cheek, blackened her eyes, Bloody lip. Pushed down in June and broke

				her L wrist.
Sexual Abuse	No	Yes as a child	N/A	Inappropriately touched, raped and molested.
Emotional Abuse	No	Yes Up bringing and adult	N/A	Pt stated she has been Insulted, belittled, and degraded.
Neglect	N/A	N/A	N/A	N/A
Exploitation	N/A	N/A	N/A	N/A
Crime	No	2018		Patient's chart states, "DUI, DAR, Destruction of property, multiple car accidents". Pt was intoxicated with alcohol didn't possess a legal license.
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	N/A	Just family members that she	N/A	Patient did not elaborate on

		would not like to speak about.		patient's death stated she did not want to speak about them.
Other	N/A	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	Presenting?		Describe (frequency, intensity, duration, occurrence)	
Depressed or sad mood	Yes	No	Patient stated she is sad more often than not, just all around sad. Her chart stated, "I only drink and use because these are the only people I want to be around".	
Loss of energy or interest in activities/school	Yes	No	Patient stated no at this time however, Patient stated she was having a hard time doing daily activities, she stated "I always feel tired and exhausted."	
Deterioration in hygiene and/or grooming	Yes	No	Patient stated no at this time however, Patient stated she was having a hard time wanting to shower and do normal hygiene. "I went 5 days without showering,	

			I even started doing sponge baths because all I wanted to do was drink.”
Social withdrawal or isolation	Yes	No	Patient stated no at this time however, “I only wanted to hang out with people who were actively using/abusing substances.”
Difficulties with home, school, work, relationships, or responsibilities	Yes	No	Even though patient stated no, chart stated, “I used to work however was fired due to substance abuse and not being able to quit drinking”.
Sleeping Patterns	Presenting?		Describe (frequency, intensity, duration, occurrence)
Change in numbers of hours/night	Yes	No	Even though patient stated no, that the doctor just put her on Hydroxine. Her chart stated, “I get about 3-4 hours of sleep every night” for the past 30 days.
Difficulty falling asleep	Yes	No	Even though patient stated no, his chart stated, the doctor put her on hydroxyzine.
Frequently awakening during	Yes	No	

night			
Early morning awakenings	Yes	No	
Nightmares/dreams	Yes	No	Patient states “I have horrific nightmares, horrific. However I do not want to go into detail.”
Other	Yes	No	
Eating Habits	Presenting?		Describe (frequency, intensity, duration, occurrence)
Changes in eating habits: overeating/loss of appetite	Yes	No	Even though patient stated no, she stated “I had not eaten a lot in the past few days, but once I got here I have been eating 3x a day”.
Binge eating and/or purging	Yes	No	
Unexplained weight loss? Amount of weight change:	Yes	No	Patient states “due to the substance abuse in 2014 I was a size 14 and went to a junior size 0 in a 6 month period”.
Use of laxatives or excessive exercise	Yes	No	
Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	Yes	No	Patient stated no at this time however, “I have the shakes from being a chronic alcoholic, I also shake from anxiety if I am

			in some sort of trouble”.
Panic attacks	Yes	No	Patient stated no at this time however, “The last DUI I had a panic attack because I thought I was going to prison”.
Obsessive/ compulsive thoughts	Yes	No	Patient stated no at this time however, “when I was under the influence, I would become Obsessive and compulsive”
Obsessive/ compulsive behaviors	Yes	No	Patient stated no at this time however, “when I was under the influence, I would become Obsessive and compulsive”
Impact on daily living or avoidance of situations/objects due to levels of anxiety	Yes	No	Patient stated no at this time however, “ sometimes I do have social anxiety”.
Rating Scale			
How would you rate your depression on a scale of 1-10?		Patient stated, “I would rate it a 1, because I am not depressed”.	
How would you rate your anxiety on a scale of 1-10?		Patient stated, “I would rate it a 1, because I do not have anxiety right now”	
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	Presenting?		Describe (frequency, intensity, duration, occurrence)

Work	Yes	No	Even though patient stated no, his chart stated, “Patient is here by choice and just recently lost her job due to intoxication”.	
School	Yes	No		
Family	Yes	No	Even though patient stated no, her chart stated, “my daughter is supportive from a distance”.	
Legal	Yes	No	Even though patient stated no, she stated she has had legal problems in the past.	
Social	Yes	No		
Financial	Yes	No	Patient stated she is only receiving spouse support at this time.	
Other	Yes	No		
Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	Facility/ MD/ Therapist	Inpatient/ Outpatient	Reason for Treatment	Response/ Outcome
January 2021	Inpatient	Inpatient.	Suicide	No improvement

	Outpatient Other: Terre Haute Psych Unit			Some improvement Significant improvement Patient stated she has improved significantly and has not had any suicidal thoughts.
Early 2014	Inpatient Outpatient Other: Psych Unit	Outpatient	Anxiety, Depression , Bipolar Type 1	No improvement Some improvement Patient states she has some improvement that she still gets anxiety and she still gets depressed time to time. Significant improvement
November 2021	Inpatient Outpatient Other: Pavilion	Inpatient/ Outpatient (patient can leave if she chooses)	Substance use/abuse. Mental Health	No improvement Some improvement Patient stated she feels much better that she is in here getting sober because she knows that she has the strength to do it. Significant improvement
Personal/Family History				
Who lives with you?	Age	Relationship	Do they use substances?	
Patient did live her male friend but she is homeless.	54	Male Friend	Yes	No

			<p>Patient male friend uses alcohol. However she also suspects he uses meth.</p>	
			Yes	No
<p>If yes to any substance use, explain:</p>				
<p>Children (age and gender): Patient has a 23 year old daughter that she has a relationship with. However she has a 33 year old daughter and a 35 year old daughter that she has no relationship with.</p> <p>Who are children with now? Patient's daughters are adults.</p>				
<p>Household dysfunction, including separation/divorce/death/incarceration: Patient states she was divorced after 17 years of marriage.</p>				
<p>Current relationship problems: Patient states she doesn't really have a stable relationship with her new male friend.</p>				

Number of marriages: 1		
Sexual Orientation: Male	Is client sexually active? Yes No	Does client practice safe sex? Yes No
Please describe your religious values, beliefs, spirituality and/or preference: Patient states, "I am Protestant".		
Ethnic/cultural factors/traditions/current activity: Patient does not practice in traditions. Describe: Stated above.		
Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Patient does not have any current legal issues. She stated she has been arrested for child abandonment, public intoxication. She stated she surrendered her parent rights over when her daughter was 1 years old. Eldest daughter got taken from DCFS. She lost custody of her second daughter when her daughter was 5 years old, she left her home alone while she was under the influence.		
How can your family/support system participate in your treatment and care? Patients states, "My one daughter is supportive from a distance, but she has her own family".		
Client raised by: Natural parents Grandparents Adoptive parents Foster parents Other (describe): Patient was raised by her natural parents.		
Significant childhood issues impacting current illness: Patient states, " I was grown up in a domestic violence home, mental and emotional abuse, and substance abuse".		
Atmosphere of childhood home: Loving Comfortable Chaotic Abusive Supportive Other: Patient stated " I believe my parents did the best that they could with what they had".		
Self-Care: Independent		

<p>Assisted Total Care</p>
<p>Family History of Mental Illness (diagnosis/suicide/relation/etc.)</p> <p>Patient stated her sister/brother both have depression. She stated her mother could have possibly also had depression. She stated her Middle sister has a history of suicide attempts.</p>
<p>History of Substance Use: Patient states, “My biological father had alcohol abuse problems as well”. Patient also states “In the past I have used Alcohol, Meth, Marijuana, speed and cigarettes”.</p>
<p>Education History:</p> <p>Grade school High school College: Other: Patient has her GED.</p>
<p>Reading Skills:</p> <p>Yes - Fluently No Limited</p>
<p>Primary Language: English, patient denies being fluent in any other languages.</p>
<p>Problems in school: Patient denies having difficulties in school. He states, “I have no learning disability, I just used drug and alcohol in high school”.</p>
<p>Discharge</p>
<p>Client goals for treatment: Patient stated, “I hope to work on my anxiety and depression and have that under control”. Patient also stated “ I hope to work on grieving/loss, self-forgiveness and to be able to control myself without any medications”.</p>
<p>Where will client go when discharged? Patient stated “It is up in the air right now, I believe the man I was living with is not a good influence for me. I am thinking about sober living”.</p>

Outpatient Resources (15 points)

Resource	Rationale
<p>1. A & A Accredited Alcohol & Drug located in Danville, IL. 217-655-7004</p>	<p>1. Due to patient living close to Danville, AA meetings will help keep patient accountable and hopefully be able to find a sponsor to help her with her alcoholism. AA is a great source of group counseling and know that she is not alone.</p>
<p>2. SAMHSA'S National Hotline, 1-800-662-HELP (4357).</p>	<p>2. This hotline is a free number he can call at anytime of the day. Someone will always answer and be supportive. They can also help with treatment referrals and information about their services.</p>
<p>3. Lionrock Recovery, 1-800-495-2282 or lionrockrecovery.com.</p>	<p>3. Lionrock in an online substance abuse counseling. They have individual, group, and family sessions. Everything is confidential when talking, and it is an accredited outpatient treatment. This would be beneficial due to patient having difficulties with her daughters. They are available at all times as well and their hotline is free as well.</p>

Current Medications (10 points)

Complete all of your client's psychiatric medications

Brand: Generic:	Multivitamin	Hydroxyzine	Vitamin B-1, thiamine	Valium, diazepam	No other Medications.
Dose	1 tablet	100 mg	100mg	5-10mg	
Frequency	Daily	Daily	Daily	Depends on patients CIWA-AR score	
Route	PO	PO	PO	PO	
Classification	Vitamin and mineral combination (Wisdom Jobs, 2019).	Piperazine derivative	Vitamin B1 supplement (Wikipedia contributors, 2021).	Benzodiazepine	
Mechanism of Action	Provide vitamins and minerals not obtained through diet (Wisdom Jobs, 2019).	Competes with histamine for histamin1 receptor sites on surface of effector cells. This suppresses results of histaminic activity, including edema, flare, and pruritus. Sedative actions occur at subcortical level of CNS and are dose related. (Jones & Bartlett Learning, 2020).	Aids pyruvic acid in the conversion to acetyl-CoA so that it can enter the Krebs cycle (Wikipedia contributors, 2021).	May potentiate effects of gamma- aminobutyric acid (GABA) and other inhibitory neurotransmitters by binding specific benzodiazepine receptors in cortical and limbic areas of CNS (Jones & Bartlett Learning, 2020).	
Therapeutic Uses	vitamin deficiency replacement due to illness	Helps control	Replace vitamin B1 deficiency due to illness	Anticonvulsant	

	and poor nutrition (Wisdom Jobs, 2019).		or nutritional deficiency (Wikipedia contributors, 2021).		
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Detox Protocol	As adjunct to permit reduction in preoperative and postoperative opioid dosage.	Detox Protocol	Detox Protocol	
Contraindications (2)	hypersensitivity to any of its components, use with other vitamins or multivitamins. Too much can lead to toxicity (Wisdom Jobs, 2019).	Breastfeeding ; early pregnancy; hypersensitivity to cetirizine, hydroxyzine or their components; prolonged QT interval. (Jones & Bartlett Learning, 2020).	hypersensitivity to thiamine, kidney impairment (Wikipedia contributors, 2021).	Acute angle-closure glaucoma, hypersensitivity to diazepam or its components, untreated open-angle glaucoma.	
Side Effects/Adverse Reactions (2)	upset stomach, headache (Wisdom Jobs, 2019).	Drowsiness, hallucination, headaches, seizures, tremor.	Restlessness, itching (Wikipedia contributors, 2021).	Respiratory depression, depression, or libido changes.	
Medication/Food Interactions	Antacids, diuretic, and Sulfa drugs may affect the absorption and distribution (Drugs.com, n.d.).	Acetaminophen, tricyclic antidepressants, caffeine, or acidic beverages.	Azithromycin, Erythromycin (Wikipedia contributors, 2021).	Antacids, fluoxetine, CNS depressants, antidepressants, opioids, and alcohol use.	.

<p>Nursing Considerations (2)</p>	<p>Administer with food to promote absorption. Some GI disorders may affect the absorption of multivitamin (Wisdom Jobs, 2019).</p>	<p>Don't give hydroxyzine by subcutaneous or IV route because tissue necrosis may occur. Observe for over sedation if patient takes another CNS depressant. (Jones & Bartlett Learning, 2020).</p>	<p>Parenteral production may contain aluminum, used in caution with patients with renal failure. GI disorders may affect the absorption of Thiamine (Wikipedia contributors, 2021).</p>	<p>Use diazepam with extreme caution in patients with history of alcohol or drug abuse because it can cause physical and psychological dependence. Avoid abrupt withdrawal of diazepam, as ordered, when used as part of the patient's seizure control regimen because a transient increase in frequency or severity of seizures may occur (Jones & Bartlett Learning, 2020).</p>	
--	---	--	---	---	--

<p>Brand: Generic:</p>	<p>Atarax, hydroxyzine pamoate</p>	<p>Advil, ibuprofen</p>	<p>Imodium, loperamide</p>	<p>Melatonin</p>	<p>Zofran, ondansetron</p>
<p>Dose</p>	<p>25mg</p>	<p>400mg</p>	<p>2mg</p>	<p>3mg</p>	<p>8mg</p>
<p>Frequency</p>	<p>Every 6 hours PRN</p>	<p>Every 6 hours PRN</p>	<p>4x daily PRN</p>	<p>PRN at bedtime</p>	<p>Every 8 hours PRN</p>
<p>Route</p>	<p>PO</p>	<p>PO</p>	<p>PO</p>	<p>PO</p>	<p>PO</p>
<p>Classification</p>	<p>Anxiolytic, antiemetic, antihistamine , sedative-</p>	<p>NSAID</p>	<p>Antidiarrheal s</p>	<p>Hormone</p>	<p>Antiemetic (Jones & Bartlett Learning,</p>

	hypnotic (Jones & Bartlett Learning, 2019).				2019)
Mechanism of Action	Anxiolytic, antiemetic, antihistamine, sedative-hypnotic (Jones & Bartlett Learning, 2019).	Block's activity of cyclooxygenase, the enzyme needed to synthesize prostaglandins, which mediate inflammatory response and cause local pain, swelling, and vasodilation (Jones & Bartlett Learning, 2019).	Slows down the intestinal motility to allow for more water and electrolyte absorption (Jones & Bartlett Learning, 2019).	Regulate night and day cycles or sleep-wake cycles (Jones & Bartlett Learning, 2019).	Block's serotonin receptors centrally in the chemoreceptor trigger zone and peripherally at vagal nerve terminals in the intestines (Jones & Bartlett Learning, 2019).
Therapeutic Uses	Relieve anxiety (Jones & Bartlett Learning, 2019).	Analgesic, anti-inflammatory, antipyretic.	Diarrhea	Insomnia, cancer, endometriosis, high blood pressure, jet lag, migraines, anxiety before surgery, and sunburns (Jones & Bartlett Learning, 2019).	Prevent nausea and vomiting (Jones & Bartlett Learning, 2019).
Therapeutic Range (if applicable)	50-100mg 4 times daily (Jones & Bartlett Learning, 2019).	N/A	N/A	N/A	8mg (Jones & Bartlett Learning, 2019).

	Learning, 2019).				2019).
Reason Client Taking	Anxiety	Moderate Pain	Loose Stool	Insomnia	Nausea
Contraindications (2)	Prolonged QT interval, hypersensitivity to cetirizine, hydroxyzine, or its components (Jones & Bartlett Learning, 2019).	Hypersensitivity to ibuprofen or its components, known or suspected infection or necrotizing enterocolitis (Jones & Bartlett Learning, 2019).	Hypersensitivity to loperamide and bowel obstruction (Jones & Bartlett Learning, 2019).	Depression and seizure disorders (Jones & Bartlett Learning, 2019).	Concomitant use of apomorphine, congenital long QT syndrome (Jones & Bartlett Learning, 2019).
Side Effects/Adverse Reactions (2)	Drowsiness, hallucinations (Jones & Bartlett Learning, 2019).	Seizures, abdominal cramps, and nausea (Jones & Bartlett Learning, 2019).	Dizziness and constipation.	Headache and daytime sleepiness (Jones & Bartlett Learning, 2019).	Hypotension, serotonin syndrome (Jones & Bartlett Learning, 2019).
Medication/Food Interactions	Alcohol use may increase CNS depression, ondansetron may increase risk of QT prolongation (Jones & Bartlett Learning, 2019).	ACE inhibitors, alcohol use, lithium, aspirin, and digoxin (Jones & Bartlett Learning, 2019).	Pramlintide recent or current antibiotic use, and drugs that can cause constipation (Jones & Bartlett Learning, 2019).	CNS depressants, caffeine, anticoagulants, and antidiabetic drugs (Jones & Bartlett Learning, 2019).	Alcohol may cause increased stimulant and sedative effects.
Nursing Considerations (2)	Do not give subcutaneously or IV due to tissue necrosis. Observe for oversedation if a patient takes another	Urge patient not to take higher doses of drug or for longer time than prescribed and advise patient to	Do not drive, use machinery, or do anything that needs alertness until you can do it safely and avoid alcohol	Should not be used as long-term treatment and monitor the other drugs the patients taking to not	Monitor patient closely for serotonin syndrome. Ondansetron may mask symptoms of adynamic

	CNS depressant (Jones & Bartlett Learning, 2019).	take drug with food or after meals to reduce GI distress (Jones & Bartlett Learning, 2019).	use (Jones & Bartlett Learning, 2019).	cause too much sleepiness (Jones & Bartlett Learning, 2019).	progressive ileus or gastric distention after abdominal surgery (Jones & Bartlett Learning, 2019).
--	---	---	--	--	--

Medications Reference (1) (APA):

Drugs.com. (n.d.). *Multivitamins*. Drugs.Com. Retrieved July 2021, from

<https://www.drugs.com/mtm/multivitamins.html>

Jones & Bartlett Learning. (2019). *2020 Nurse’s drug handbook* (19th ed.). Jones & Bartlett Learning.

Wikipedia contributors. (2021, June 29). *Thiamine*. Wikipedia.

<https://en.wikipedia.org/wiki/Thiamine>

Mental Status Exam Findings (20 points)

<p>APPEARANCE: Behavior: Build: Attitude: Speech: Interpersonal style: Mood: Affect:</p>	<p>Patient appears to be alert and oriented time 4. Patient is friendly, cooperative, maintains appropriate eye contact, appropriate height, and weight. Patient clothing is appropriate for the setting. Patient appears clean, neat, and tidy and no odor present. Patient’s attitude is open and pleasant. Patient’s speech is clear and normal liveliness and offers information. Patient’s mood a majority of the time was flat. Patient’s affect is appropriate to situation, normal and constricted.</p>
<p>MAIN THOUGHT CONTENT: Ideations: Delusions:</p>	<p>Patient denies hallucinations, paranoid, delusion, illusions. Patient’s thought process is good, relevant to the topic being discussed, coherent,</p>

<p>Illusions: Obsessions: Compulsions: Phobias:</p>	<p>logical. Patient denies delusions and ideations. Patient denies obsession and compulsive behaviors. Patient denies having phobias. Patient denies having suicidal and homicidal and agrees to remain safe. Patient did not express delusional content.</p>
<p>ORIENTATION: Sensorium: Thought Content:</p>	<p>Patient is oriented to time, place, person, and situation. Patients’ sensorium is normal, and patient’s level of consciousness is normal, alert.</p>
<p>MEMORY: Remote:</p>	<p>Patient’s memory is good for recent events but is average when it comes to past experiences. Patient’s attention and concentration is mostly sufficient. She is slow at concentrating. No acute, inattention, alerted LOC, or disorganized thinking.</p>
<p>REASONING: Judgment: Calculations: Intelligence: Abstraction: Impulse Control:</p>	<p>Patient’s judgement is good; able to come to appropriate conclusions; realistic decisions. Patient’s impulse control is good at the moment as well. Patient was attentive and has adequate concentration.</p>
<p>INSIGHT:</p>	<p>Patient’s insight is good; recognizes her problems; intellectual and emotional awareness; patient is hopeful things will get better and willing to try different things to improve.</p>
<p>GAIT: Assistive Devices: Posture: Muscle Tone: Strength: Motor Movements:</p>	<p>Patient denies use of assistive devices. Patient is independent with ADL assistance, up ad lib. Patient does not require assistance with equipment and support to stand and walk. Patient demonstrated active range of motion bilaterally throughout. Patient has a low fall risk score. Patient maintains good balance independently. Patient tolerated ambulation well and showed no signs of difficult breathing. Patient needed no cueing and set up assistance. Patient’s general motor response was normal. Patient’s hang grips and pedal pushes were strong and +2 bilaterally.</p>

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
------	-------	-----	-----------	------	--------

13:00	112 bpm (Right radial)	125/99 (Sitting; left upper arm)	20 breaths per minutes (unlabored)	98.7 (temporal)	96% (room air)
18:00	84 bpm (Right radial)	122/84 (Sitting; left upper arm)	17 breaths per minutes (unlabored)	97.8 (temporal)	98% (room air)

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
13:00	1-10	Patient denies any pain.	N/A	N/A	N/A
18:00	1-10	Patient denies any pain.	N/A	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: Breakfast: 100% Lunch: 75% Dinner: 100%	Oral Fluid Intake with Meals (in mL) Breakfast: 600mL Lunch: 450mL Dinner: 800mL

Discharge Planning (4 points)

Discharge Plans (Yours for the client):

Discharge plans for C.W. include:

1. Discuss who is going to be there for her when she finds a place to live.
2. Attend an AA meeting at least once a week to help develop effective coping skills.
3. Continue prescribed medications if applicable.
4. Follow up with primary doctor.
5. Educate patient on taking medications as prescribed.
6. Equip the patient with the following outpatient resources listed above.

Nursing Diagnosis (15 points)

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

<p>Nursing Diagnosis</p> <ul style="list-style-type: none"> • Include full nursing diagnosis with “related to” and “as evidenced by” components 	<p>Rational</p> <ul style="list-style-type: none"> • Explain why the nursing diagnosis was chosen 	<p>Immediate Interventions (At admission)</p>	<p>Intermediate Interventions (During hospitalization)</p>	<p>Community Interventions (Prior to discharge)</p>
<p>1. Imbalanced nutrition related to drinking alcohol instead of</p>	<p>I chose this diagnosis due to patient not eating much and that she came in not</p>	<p>1.Ascertain healthy body weight for age and height. 2. Provide</p>	<p>1.Provide companionship during mealtime. 2. Consider six small nutrient-</p>	<p>1. Encourage exercise. 2. Encourage patient to eat more meals</p>

<p>eating nourishing food (Phelps et al., 2017).</p>	<p>eating much.</p>	<p>pleasant environment. 3. Provide good oral hygiene and dentition.</p>	<p>dense meals instead of three larger meals. 3. Consider the use of seasoning for patients with changes in their sense of taste.</p>	<p>with family. 3. Offer protein supplements based on individual needs.</p>
<p>2. Ineffective denial related to alcohol use as evidence by patient stating, “I Believe that I didn’t have a problem before I came in here but I do now.” (Phelps et al., 2017).</p>	<p>Denial of alcohol use and failure to accept responsibility for behavior.</p>	<p>1. Give the client information about alcoholism in a matter-of-fact manner. 2. Avoid the client’s focus only on external problems without relating them to the problem of alcoholism. 3. encourage the client to identify behaviors that have caused problems in his life.</p>	<p>1. Do not allow the client to rationalize difficulties or to blame others or circumstances beyond the client’s control. 2.Consistently redirect the client’s focus to his own problems and to what he can do about them. 3. Positively reinforce the client when she identifies or expresses feelings or shows any insight into his or her behaviors or consequences.</p>	<p>1. Encourage other clients in the program to provide feedback for each other. 2. Identify community resources for the patient to be able to use. 3. The patient to be able to verbalize their acceptance of their responsibility.</p>
<p>3. Risk for injury related to substance intoxication as evidence by patient being in an accident while intoxicated (Phelps et</p>	<p>Patient was in a previous car accident due to being intoxicated.</p>	<p>1. Patient safety. 2. Monitor patient’s vitals. 4. Monitor patient’s seizure activity.</p>	<p>1. Assist with ambulation and self-care activities if needed. 2. Assess gait. 3. Monitor cardiac rate and rhythm.</p>	<p>1. Encourage the patient to report any type of abuse. 2. Patient will remain free of injury. 3. Patient will be able to identify the</p>

al., 2017).				different stages of alcohol withdrawal syndrome.
-------------	--	--	--	--

Other References (APA):

Phelps, L. L., Ralph, S. S., & Taylor, C. M. (2017). *Sparks and Taylor's Nursing Diagnosis Reference Manual* (10th ed.). Wolters Kluwer.

Concept Map (20 Points):

Subjective Data

Nursing Diagnosis/Outcomes

1. Imbalanced nutrition related to drinking alcohol instead of eating nourishing food (Phelps et al., 2017).
 - a. Patient will maintain a good weight according to patients height and age.
2. Ineffective denial related to alcohol use as evidence by patient stating, "I didn't believe I had an alcohol problem but I do now" (Phelps et al., 2017).
 - a. The patient will be accepting to her problem.
3. Risk for injury related to substance intoxication as evidence by patient being in an accident while intoxicated (Phelps et al., 2017).
 - a. The patient will abstain from alcohol to prevent injuries.

"I attempted suicide a couple times". "I have been thinking since I was 15-16 years old". "Losing her car due to driving on a suspended license, financial problems, relationship issues, and negative consequences due to alcohol use". "I was stressed out due to losing my car, and my apartment not knowing what to do. So, I started drinking a little too much".
 "I get about 3-4 hours of sleep every night". "I have trouble falling asleep every night". "In the past I have used Alcohol, Meth, Marijuana, speed, and stressers". "I had not eaten a lot in the past few days, but once I got here I have been eating 3x a day". "due to the substance abuse in 2014 I was a size 14 and went to a junior size 0 in a 6 month period".

Objective Data

Patient Information

50-year-old female that weighs 100.4lbs and is 5'7". Patient is on 15 min-check. She is a full code and was admitted on 11-9-2021. Patient has a history of chronic alcohol abuse. Patient was evicted from apartment and was living with male friend.

Date of Admission 11/9/21	Patient Initials C.W.	Age 50
Race/Ethnicity Caucasian	Occupation Unemployed	Marital Status Single
Code Status Full	Observation Status 15-minute	Height 5'7"

1. Ascertain healthy body weight for age and height.
2. Provide pleasant environment.
3. Provide good oral hygiene and dentition.
4. Provide companionship during mealtime.
5. Consider six small nutrient-dense meals instead of three larger meals.
6. Consider the use of seasoning for patients with changes in their sense of taste.
1. Encourage exercise.
2. Encourage patient to eat more meals with family.
3. Offer protein supplements based on lab results.

Nursing Interventions

Percentage of Meal Consumed:

- Breakfast: 100%
- Lunch: 75%
- Dinner: 100%

13:00 112 bpm (left radial)	125/99 (Sitting; left upper arm)	20 breaths per minutes (unlabored)	98.7 (temporal)	96% (room air)
18:00 84 bpm (Right radial)	122/84 (Sitting; left upper arm)	17 breaths per minutes (unlabored)	97.8 (temporal)	98% (room air)

1. Do not allow the client to rationalize difficulties or to blame others or circumstances beyond the client's control.
7. Consistently redirect the client's focus to his own problems and to what he can do about them.
8. Positively reinforce the client when he identifies or expresses feelings or shows any insight into his or her behaviors or consequences.
1. Encourage other clients in the program to provide feedback for each other.
9. Identify community resources for the patient to be able to use.
10. The patient to be able to verbalize their acceptance of their responsibility.
11. Patient safety.
12. Monitor patient's vitals.
13. Monitor patient's seizure activity.
14. Assist with ambulation and self-care activities if needed.
15. Assess gait.
16. Monitor cardiac rate and rhythm.
17. Encourage the patient to report any type of abuse.
18. Patient will remain free of injury.
19. Patient will be able to identify the different stages of alcohol withdrawal syndrome.

