

N311 Care Plan #1

Lakeview College of Nursing

Name Berich Mpoy

Demographics (5 points)

Date of Admission 12/9/21	Client Initials DB	Age 62	Gender M
Race/Ethnicity Caucasian	Occupation Construction worker	Marital Status single	Allergies None
Code Status Full	Height 73.0 inches	Weight 132.2 lbs.	

Medical History (5 Points)

Past Medical History: Toxic encephalopathy, alcohol dependence, altered mental status, acute kidney failure, rhabdomyolysis, hypokalemia, hypermagnesemia, thrombocytopenia unspecified, elevated white blood cells unspecified, acidosis, fatty change of liver, urinary tract infection, constipation, essential primary hypotension, retention of urine, mild cognitive impairment, alcohol abuse with other alcohol induced disorder, sedative, hypnotic, anxiolytic dependence uncomplicated.

Past Surgical History: Not Available

Family History: Not available

Social History (tobacco/alcohol/drugs including frequency, quantity, and duration of use):

The patient smoked 1 pack of smokes every day for 15 years. The patient drank 2 bottles of beer every day for 18 years. Patient denies use of drugs.

Admission Assessment

Chief Complaint (2 points): Difficulty hearing or hearing loss.

History of Present Illness – OLD CARTS (10 points): The patient started experiencing gradual hearing loss four years ago. Prior to admission the patient was in a motor vehicle accident that caused partial hearing loss in both ears. The patient's left ear has 18 percent hearing

loss while the right has 80 percent hearing loss. The patient has hearing loss located in both ears. The patient is hearing impaired all day. The patient has no aggravating factor or relieving factors. The patient has no treatments but is provided with assistive listening devices from time to time.

Primary Diagnosis

Primary Diagnosis on Admission (3 points): Upon admission the patient was diagnosed with alcohol overdose and was provided with Ambien.

Secondary Diagnosis (if applicable):

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

Alcohol intoxication occurs when alcohol is absorbed through the proximal GI tract. The alcohol is metabolized in the liver by alcohol dehydrogenase to acetaldehyde. In acute toxicity the primary site is the central nervous system, acute toxicity increases inhibition and decreases excitation in the central nervous system. The primary inhibitory neurotransmitter in the central nervous system is Gamma aminobutyric acid. Cellular excitability is decreased when GABA binds to receptors allowing chloride to enter the cell. Some signs and symptoms like sedation, cognitive dysfunction, decreased coordination occurs when alcohol binds to GABA receptors causing an inhibitory cascade. Other signs and symptoms associated with alcohol intoxication are disorientation, restlessness, irritability, visual and auditory distortions, or hallucinations.

Risk factors associated with alcohol intoxication are electrolyte imbalances, sleep deprivation, psychological stress, decreased cardiac output, presence of dysrhythmias, liver disease, alcohol hepatitis and Wernicke syndrome. There are no treatments for alcohol intoxication instead they are supportive groups for patients. "Patients with alcohol use disorder may benefit from IV fluids, and considerations must be made for alcoholic cardiomyopathy in

this patient population before administering fluids” (Doenges, M. & Moorhouse, M. & Murr, A. (2019). Alcohol intoxication is treated by treating hypoglycemia and replacing vitamins through IV routes. depending on the severity of the intoxication and the complications some patients may need further treatments to treat disorder such as alcoholic hepatitis, Wernicke encephalopathy, hypoxia, and metabolic disorders. Patients are sometimes provided with education on alcohol intoxication and supportive groups at rehab center.

My patient was diagnosed with alcohol overdosed and presented with the same signs and symptoms as above. my patient presented with altered mental status, sedative, cognitive impairment, auditory impairment. there are no treatments for alcohol intoxication, but my patient is being provided with care and education on the dangers of alcohol intoxication at the rehab facility to prevent any further alcohol intoxication.

Pathophysiology References (2) (APA):

Doenges, M. & Moorhouse, M. & Murr, A. (2019). Delirium tremens. Nursing Diagnosis Manual (6th ed.). F.A. Davis Company.

<https://www.r2library.com/Resource/Title/0803676778/ch0006s2759>

LaHood AJ, Kok SJ. Ethanol Toxicity. [Updated 2021 Mar 28]. In: StatPearls [Internet].

Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from:

<https://www.ncbi.nlm.nih.gov/books/NBK557381/>

Laboratory Data (20 points)

If laboratory data is unavailable, values will be assigned by the clinical instructor

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				
Hgb				
Hct				
Platelets				
WBC				
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-				
K+				
Cl-				
CO2				
Glucose				
BUN				
Creatinine				

Albumin				
Calcium				
Mag				
Phosphate				
Bilirubin				
Alk Phos				

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				
pH				
Specific Gravity				
Glucose				
Protein				
Ketones				
WBC				
RBC				
Leukoesterase				

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):

Diagnostic Imaging

All Other Diagnostic Tests (10 points):

Diagnostic Imaging Reference (1) (APA):

**Current Medications (10 points, 2 points per completed med)
*5 different medications must be completed***

Medications (5 required)

Brand/Generic					
Dose					
Frequency					
Route					
Classification					
Mechanism of Action					
Reason Client Taking					
Contraindications (2)					
Side Effects/Adverse Reactions (2)					

Medications Reference (1) (APA):

Assessment

Physical Exam (18 points) – **HIGHLIGHT ALL PERTINENT ABNORMAL FINDINGS**

<p>GENERAL: Alertness: Orientation: Distress: Overall appearance:</p>	
<p>INTEGUMENTARY: Skin color: Character: Temperature: Turgor: Rashes: Bruises: Wounds: . Braden Score: Drains present: Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	
<p>HEENT: Head/Neck: Ears: Eyes: Nose: Teeth:</p>	
<p>CARDIOVASCULAR: 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 type="checkbox"/> Edema Y <input type="checkbox"/> N <input type="checkbox"/> Location of Edema:</p>	
<p>RESPIRATORY: Accessory muscle use: Y <input type="checkbox"/> N <input type="checkbox"/> Breath Sounds: Location, character</p>	
<p>GASTROINTESTINAL: Diet at home: Current Diet Height: Weight:</p>	

<p>Auscultation Bowel sounds: Last BM: Palpation: Pain, Mass etc.: Inspection: Distention: Incisions: Scars: Drains: Wounds: Ostomy: Y <input type="checkbox"/> N <input type="checkbox"/> Nasogastric: Y <input type="checkbox"/> N <input type="checkbox"/> Size: Feeding tubes/PEG tube Y <input type="checkbox"/> N <input type="checkbox"/> Type:</p>	
<p>GENITOURINARY: Color: Character: Quantity of urine: Pain with urination: Y <input type="checkbox"/> N <input type="checkbox"/> Dialysis: Y <input type="checkbox"/> N <input type="checkbox"/> Inspection of genitals: Catheter: Y <input type="checkbox"/> N <input type="checkbox"/> Type: Size:</p>	
<p>MUSCULOSKELETAL: Neurovascular status: ROM: Supportive devices: Strength: ADL Assistance: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Risk: Y <input type="checkbox"/> N <input type="checkbox"/> Fall Score: 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>NEUROLOGICAL: MAEW: Y <input type="checkbox"/> N <input type="checkbox"/> PERLA: Y <input type="checkbox"/> N <input type="checkbox"/> Strength Equal: Y <input type="checkbox"/> N <input type="checkbox"/> if no - Legs <input type="checkbox"/> Arms <input type="checkbox"/> Both <input type="checkbox"/> Orientation: Mental Status: Speech:</p>	

Sensory: LOC:	
PSYCHOSOCIAL/CULTURAL: Coping method(s): Developmental level: Religion & what it means to pt.: Personal/Family Data (Think about home environment, family structure, and available family support):	

Vital Signs, 1 set (5 points) – HIGHLIGHT ALL ABNORMAL VITAL SIGNS

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:00 AM	79	140 / 80	18	97.9	96

Pain Assessment, 1 set (5 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:00 AM	0 / 10	N/A	0	N/A	N/A

Intake and Output (2 points)

Intake (in mL)	Output (in mL)

Nursing Diagnosis (15 points)

Must be NANDA approved nursing diagnosis

Nursing Diagnosis	Rationale	Intervention s (2 per dx)	Outcome Goal (1 per dx)	Evaluation
<ul style="list-style-type: none"> Include full nursing diagnosis with “related to” and 	<ul style="list-style-type: none"> Explain why the nursing diagnosis was chosen 			<ul style="list-style-type: none"> How did the client/family respond to the nurse’s actions?

<p>“as evidenced by” components</p> <ul style="list-style-type: none"> Listed in order by priority – highest priority to lowest priority pertinent to this client 				<ul style="list-style-type: none"> Client response, status of goals and outcomes, modifications to plan.
<p>1. impaired verbal communication related to auditory impairment as evidenced by absent response to questions.</p>	<p>2. the patient indicated the need for hearing devices because of his auditory impairment or hearing loss.</p>	<p>1. Provide patient with assistive hearing devices, like hearing aids and others.</p> <p>2. Ensure appropriate use of assistive hearing aids as needed: Maintain batteries and cleanliness of equipment.</p>	<p>1. The patient will demonstrate appropriate use of assisting hearing devices such as hearing aids.</p>	<p>1. the patient and family members are satisfied with the assistive hearing devices given to the patient to reduce communication impairments.</p>
<p>3. Readiness for enhanced communication</p>	<p>The patient has difficulty understanding staff members and others due to hearing loss</p>	<p>1. Provide environment that diminishes physical space between nurse and patient to eliminate barriers communication such as noise and lack of privacy.</p> <p>2. Facilitate lip reading by facing the</p>	<p>1. The patient will be able to appropriately answer questions individually and in a group setting.</p>	<p>1. The patient expresses satisfaction with feedback received from caregivers and others. The family members expressed satisfaction with the patient’s improved communication</p>

		<p>patient directly in good lighting, allowing them to see your mouth while speaking. Use a low, deep voice when speaking.</p>		
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Other References (APA):

Concept Map (20 Points):

Subjective Data

The patient said "can you please repeat what you said"

The patient also said "I can't hear you"

The patient stated "I need hearing aids I've been asking for hearing aids for a while but they keep telling me that they will give them to me but they never do"

Nursing Diagnosis/Outcomes

impaired verbal communication related to auditory impairment as evidenced by absent response to questions and surrounding noise.

Outcome: The patient will demonstrate appropriate use of assisting hearing devices such as hearing aids.

Readiness for enhanced communication.

Outcome: The patient will be able to appropriately answer questions individually and in a group setting.

Objective Data

Vital signs: T 97.9, BP: 140/80, P: 79, R: 18, O2: 96%. Auditory impairment.

Client Information

DB

Age 62, Gender Male, Race Caucasian, Single, Full code, height 73inches, Weight 132.2.

Past medical history: toxic encephalopathy, Alcohol dependence, altered mental status, acute kidney failure, rhabdomyolysis, Hypokalemia, hyper magnesium, thrombocytopenia.

Nursing Interventions

Provide patient with assistive hearing devices, like hearing aids and others.

Ensure appropriate use of assistive hearing aids as needed: Maintain batteries and cleanliness of equipment.

Provide environment that diminishes physical space between nurse and patient to eliminate barriers to communications such as noise and lack of privacy.

Facilitate lip reading by facing the patient directly in good lighting, allowing them to see your mouth while speaking. Use a low, deep voice when speaking.

