Alcohol Withdrawal Nursing Care Plan Template

Patient Information and Assessment			
Name:	Michael De Santa	**Gender:**	Male
Age:	48	**Date of Admission:**	11/15/2023
History of Alcohol Use:	Heavy alcohol consumption for over 15 years		
Previous Withdrawal Episodes and Stages - Last known dates and their stages			
One documented withdrawal episode three years ago			
Co-ingestions or Comorbidities:	Smoker, Overweight, Hypertensive, Liver Problems (elevated liver enzymes), Arthritis, Gout		
CIWA-Ar Score:	63		
Other Findings, Additional Notes, Differential Diagnosis (if any)			

Symptom Assessment		
Stage I – Hyperactivity:	**Stage II – Hallucinations and Seizure Activity:**	**Stage III – Delirium Tremens (DTs), Confusion, Fever, and Anxiety:**
☑ Tremors ☑ Anxiety ☑ Nausea ☑ Headaches	☑ Agitation ☑ Increased heart rate ☑ High blood pressure ☑ Visual, auditory, or tactile hallucinations ☑ Tonic-clonic seizures	☑ Prolonged, vivid hallucinations ☑ Severe agitation ☑ Extreme confusion ☑ High fever ☑ Tachycardia ☑ Hypertension

Interventions

- General intervention:
  - Regular monitoring of vital signs
  - Ensure a quiet and calm environment
  - Adequate hydration
  - Nutritional support
  - Regular documentation of symptom progression
- Monitoring Progress:
  - Regular assessment of symptom severity
  - Document any adverse reactions to medications
- Follow-up Plan:
  - Schedule follow-up assessments post-discharge
  - Collaborate with other healthcare providers for ongoing care

Stage-Specific Interventions

Stage I:

- Medications for anxiety and nausea as prescribed
- Provide emotional support and reassurance

Stage II:

- Seizure precautions
- Medications for seizure control as prescribed
- Monitor and manage hallucinations
- Continuous cardiac monitoring
- **Stage III (DTs):**
  Immediate medical intervention
- Administer medications to control severe symptoms
- Continuous monitoring in an intensive care setting

Treatment Plan, Detoxification Method, Supportive Care

detoxification using diazepam. Initial 20mg IV, followed by 20mg orally every 2 hours till CIWA-Ar scores are below ten to avoid seizure. Supportive care includes managing comorbidities, addressing liver enzymes, and vitamins (thiamine, multivitamins). Monitor blood pressure and fluids due to hypertension. Pain management for arthritis and gout is included.

Medication, Dosage, and Administration Schedule

Medication	Time	Dosage	Administration Method
Diazepam	Initial Dose	20 mg	IV
Diazepam	Every 2 hours until CIWA-AR score goes under 10	20 mg	Orally
Multivitamin	Once a day, 3-5 days	See composition in addtl notes	IV
NSAIDs for gout and arthritis	as needed	as needed	

Additional notes:

multivitamin composition below:
Thiamine: 250mg - Once a day
Riboflavin: 10 mg - Once a day
Pyridoxine (B6): 50 mg - Once a day
Nicotinamide: 20 mg - Once a day
Vitamin C: 500 mg - Once a day

Monitoring and Assessment

CIWA-Ar Monitoring Schedule:

Start CIWA-Ar assessment upon admission.
Repeat every 4 hours, adjusting frequency based on symptoms.
If scores consistently below 10 for two consecutive assessments, shift to every 8 hours.
Continue until withdrawal symptoms stabilize.

Vital Signs Monitoring:

Hourly checks for the first 24 hours, then every 4 hours if stable.
If severe withdrawal, more frequent monitoring.

Neurological Assessment:

Detailed assessment on admission.
Check every 2 hours initially, then every 4-8 hours once stable.

Complications and Contingency Plans	
Seizure Prophylaxis:	Use 2 mg of lorazepam via IV to prevent seizures during withdrawal. If seizures go on, give additional diazepam in symptom-monitored doses, up to 60-80 mg
Management of Delirium Tremens:	IV diazepam in 10 mg doses, increasing to 20 mg if needed for calmness. Transition to symptom-monitored doses once sedated. If DT is tough to manage (ongoing agitation with high diazepam needs), consider phenobarbital 100-200 mg/h and, if necessary, haloperidol or newer antipsychotics
Referral to Specialist (if needed):	Consult a neurologist or intensivist if there are over six seizures lasting more than 6 hours despite benzodiazepine treatment, or if neurological complications are suspected. For stubborn DT cases, involve an addiction medicine or psychiatry specialist for alternative treatments and comprehensive care

Care Team Notes
Day 1: Patient responsive to initial diazepam. Monitor for signs of excessive sedation/respiratory depression Day 2: Some reduction in agitation, but symptoms persist. Consider adding phenobarbital if needed

Discharge Planning	
Medication Instructions (if applicable):	- Take Chlordiazepoxide 25mg orally every 6 hours as prescribed. Follow the tapering schedule provided to gradually reduce the dosage. - Continue Thiamine 100mg, Multivitamin, and Folate supplements as directed for overall health support. - Do not self-adjust medication without consulting healthcare
Abstinence Support Resources:	- Attend local Alcoholics Anonymous (AA) meetings on Mondays and Wednesdays at the church - Explore counseling services at Community Counseling Center - Connect with family and friends for emotional assistance
Follow-up Appointment Schedule:	- Follow up appointment in 1 month - In case of any immediate issues, call our office at (555) 123-4567 - Emergency support is available via our emergency helpline (555) 765-4321 or call 911