N323 Care Plan

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Biological Gender**
10/06/2025	EA	54	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Gender Identity**
Hispanic	Management at a corporate finance company	Divorced	Female
Code Status	**Height and Weight**	**Allergies**	**Pronouns**
Full Code	160.2cm and 175 lbs	Penicillin's	She/Her

Medical History (5 Points)

Past Medical History: Hypertension, Anxiety, Tonsillectomy.

Psychiatric Diagnosis: Alcohol withdrawal Syndrome

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
N/A	N/A	N/A
N/A	N/A	N/A
N/A	N/A	N/A

Admission Assessment

Chief Complaint (2 points): Chest Pain

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** The client is alert and oriented to person place time and situation, client does appears a little restless. Client stated that she felt "crummy and weaker" in the past 24 hours. Client describes having midsternal chest pain that increased with a harsh productive cough with green phlegm with difficulty of

breathing. Client is coherent with speech. The clients' reports taking alprazolam to help her sleep or when she feels anxious. Client reports drinking more and having poor sleep. Client states that nothing has help to alleviate the pain.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** Client describes her job "quite stressful". Client also has lost her father over a year ago. Client did not talk about her mom. Client doesn't have a social life, client stated "I don't like to leave my house, I like to stay inside and spend time with my cat".

Primary Diagnosis on Admission (2 points): Pneumonia

Psychosocial Assessment (30 points)

History of Trauma			
Screening Questions:		**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?		NO	
Do you have a history of trauma secondary to military service?		NO	
Have you experienced a loss of family or friends that affected your emotional well-being?		Yes, father died in the past year.	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		Passing of her father.	
(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)		**(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)**	
	Current?	**Past? (what age)**	**By whom?**
Physical Abuse	N/A	N/A	N/A

Sexual Abuse	N/A	N/A	N/A
Emotional Abuse	N/A	N/A	N/A
Verbal Abuse	N/A	N/A	N/A
Military	N/A	N/A	N/A
Other	N/A	N/A	N/A
Presenting Problems			
Problematic Areas	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**	
Do you feel down, depressed or hopeless?	No		
Do you feel tired or have little energy?	Yes	Client does look tired, client is forming bags under her eyes, the way she sits, sloughing.	
Do you avoid social situations?	Yes	Client stated that going to places makes them uncomfortable.	
Do you have difficulties with home, school, work, relationships, or responsibilities	Yes	Client states that her job is stressful. Client is single, doesn't go to school. Client states that she just go to work and then goes home to her cat.	
Sleeping Patterns	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**	
Have you experienced a change in numbers of hours that you sleep each night?	Yes	She states that she gets about 4 hours of sleep each night.	
Do you have difficulty falling asleep?	Yes	Client states that it's hard for her to sleep at night. She seems to be lying in bed with her eyes open	

		majority of the time.
Do you frequently awaken during the night?	Yes	Client states that it seems like when she's feels like she about to go to sleep she gets a spirts of energy to stay awake.
Do you have nightmares?	No	
Are you satisfied with your sleep?	No.	Client believes if she could get more sleep, she probably would be less cranky.
Eating Habits	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you overeat?	No	
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	No	
Do you have not eat enough or have a loss of appetite?	Yes	Client does not have an appetite and haven't been able to eat much lately.
Have you recently experienced unexplained weight loss? **Amount of weight change: 10 pounds in 3 weeks**	Yes	Client states she hasn't been eating and notice a weight change.
Anxiety Symptoms	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you pace, have tremors, or experience other	Yes	Client was asked to place her hand out and when doing so client hand was not steady, it was quite

symptoms of anxiety?		shaky.	
Do you experience panic attacks?	No		
Do you have obsessive or compulsive thoughts?	No		
Do you have obsessive or compulsive behaviors?	No		
Suicidal Ideation	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**	
In the past week have you wished that you were dead?	No		
Have you ever tried to kill yourself?	No		
If the client answered either of the previous questions "yes", you must ask the client: **Are you having thoughts of killing yourself right know?** **(If the client says yes, you must ensure facility staff are aware)**			
Rating Scale			
How would you rate your depression on a scale of 1-10?		0	
How would you rate your anxiety on a scale of 1-10?		7	
Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**

N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A

If yes to any alcohol or drug use, explain: No.

Family Medical History: Mother- Breast Cancer, Heart failure

Father- Hypothyroidism

Family Psychiatric History (including suicide): Mom had anxiety.

Family alcohol or drug use (not covered by those client lives with): No.

Do you have children? If yes, what are their ages? No.

Who are your children with now?

Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? Dad died last year.
If yes, please tell me more about that: Client did state that the dad used to beat her mom. Client feels like ever since her father has passed her life has been going downhill.

Are you currently having relationship problems? No

What is your sexual orientation: Straight.	**Are you sexually active?** No.	**Do you practice safe sex?** Doesn't have sex.

Please describe your religious values, beliefs, spirituality and/or preference:

Client stated "use to be Baptist" she learning about muslin but not a Muslim.

Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? She stopped eating pork.

Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): No.

Whom would you consider your support system? Her cat. **How can your family/support system participate in your treatment and care?** N/A
What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) Client states that she drinks a couple of Martinis or a couple of beers to cope.
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) Work
Client raised by: Client was raised by both parents. Dad used to beat on the mother. **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Self-Care: Client lives at home alone with her cat, she takes care of herself with no help from others. **Independent** **Assisted** **Total Care**
Education History: Client highest education level is High school. **Grade school** **High school** **College** **Other:**
Reading Skills: Client can read. Client reading level is appropriate for her age. **Yes** **No** **Limited**
Primary Language: Spanish and English.

Personal History of Substance Use

Screening Questions:

1. **Have you ever used drugs, alcohol, or nicotine?**

(If no, you may skip to "psychiatric medications".
If yes, complete all sections of this chart. Type N/A if not applicable.)

Substance	First Use and Last Use	Frequency of Use
Nicotine Products (including smoking, chewing, vaping)	**First Use:** 18 years old **Last Use:** Yesterday	She use to smoke a pack a day now she smokes half a pack a day.
Alcohol	**First Use:** 13 years old **Last Use:** Yesterday	Client states that she "drinks everyday".
Prescription Medications (Recreational Use)	**First Use:** N/A **Last Use:** N/A	
Marijuana	**First Use:** Don't remember **Last Use:** Doesn't remember	Client states "only did it for about 4 months".
Heroin	**First Use:** N/A **Last Use:** N/A	
Methamphetamine	**First Use:** N/A **Last Use:** N/A	
Other: Specify	**First Use:** N/A **Last Use:** N/A	

Current Psychiatric Medications (10 points)
Complete all of your client's psychiatric medications
All information listed in this section must be pertinent to your patient.

Brand/Generic	Hydrochlorothiazide (HYDRODUIRIL) (Jones &Bartlett, 2024).	Alprazolam (XANAX) (Jones &Bartlett, 2024).			
Dose	12.5–50 mg once daily (Jones &Bartlett, 2024).	0.25 mg- 0.5 mg (Jones &Bartlett, 2024).			
Frequency	(Once daily (typically in the morning to avoid nocturia) Jones &Bartlett, 2024).	2-3 times daily, PRN or scheduled (Jones &Bartlett, 2024).			
Route	Oral (Jones &Bartlett, 2024).	Oral (Jones &Bartlett, 2024).			
Classification	Thiazide diuretic, Antihypertensive	Benzodiazepine			

	(Jones &Bartlett, 2024).	(Jones &Bartlett, 2024).			
Mechanism of Action	Inhibits sodium reabsorption in the distal convoluted tubule of the nephron, promoting excretion of sodium, water, potassium, and hydrogen ions, resulting in decreased blood volume and pressure, (Jones &Bartlett, 2024).	Enhances the inhibitory effects of the neurotransmitter GABA at GABA-A receptors in the brain, (Jones &Bartlett, 2024).			
Therapeutic Uses	Hypertension, (Jones &Bartlett, 2024).	Produces anxiolytic effect due to CNS depressant action, (Jones &Bartlett, 2024).			
Therapeutic Range (if applicable)	Monitor by blood pressure weight and electrolytes, (Jones &Bartlett, 2024).	Max dose 4mg/for anxiety, (Jones &Bartlett, 2024).			
Reason Client Taking	Hypertension (Jones &Bartlett, 2024).	For acute anxiety or panic attacks, (Jones &Bartlett, 2024).			

For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	Encourage the patient to elevate legs and reduce sodium intake to help manage mild edema non-pharmacologically, (Jones &Bartlett, 2024).	Deep breathing exercises, (Jones &Bartlett, 2024).			
Contraindications (2)	1. Hypersensitivity to thiazides or sulfonamide-derived drugs, (Jones &Bartlett, 2024). 2. Severe electrolyte imbalance (Jones &Bartlett, 2024).	1. Using during pregnancy-fetal harm or congenital abnormalities, (Jones &Bartlett, 2024). 1. Lactation/ breastfeeding-the drug excretes in breast milk and may harm the infant, (Jones &Bartlett, 2024).			
Side Effects/Adverse Reactions (2)	1. Hypokalemia (Jones &Bartlett, 2024). 2. Orthostatic hypotension (Jones &Bartlett, 2024).	1. Drowsiness (Jones &Bartlett, 2024). 2. Hand tremors (Jones &Bartlett, 2024).			

Medication/Food Interactions	Increases lithium toxicity risk (Jones &Bartlett, 2024). NSAIDs may reduce diuretic and antihypertensive effectiveness, (Jones &Bartlett, 2024).	Avoid alcohol, increases sedation and respiratory depression. Grapefruit may increase alprazolam level, (Jones &Bartlett, 2024).			
Nursing Considerations (2)	1. Monitor the patient electrolyte levels and blood pressure, (Jones &Bartlett, 2024). 2. Educate patient to take medication in the morning to avoid nighttime urination and to rise slowly from sitting to prevent dizziness or falls, (Jones &Bartlett, 2024).	1. Monitor for signs of CNS depression and fall risk, especially in elderly patients, (Jones &Bartlett, 2024). 2. Educate patient on short term use and withdrawal symptoms, (Jones &Bartlett, 2024).			

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2024). *NDH: Nurse's Drug Handbook: Twenty-Four Edition*. World headquarters.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	The client looks older than stated age. Client is alerted, oriented x4 to person place time and situation. Client is well groomed and dressed casually. Client has no sign of distress. Client is pleasant. Client was cooperative in the interview. No agitation shown. Client appears to be getting enough rest. Speech is coherent and normal rate tone and volume. Client made eye contact during the interview, client was attentive and willing to answer questions.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	Question: How is your mood today? Client reports that "I'm in an okay mood today". Affect: Client seemed to be calm and relaxed. The client made eye contact when speaking, talking in a normal tone.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	Client is alert and was awake during interview. Client was fully oriented to place person time and situation. Client shows no memory impairment. Client was able to remember recent events. Client attention was focused, client asked questions about things when confused about something, client was able to focus but didn't know what a lot of things meant.
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	Client denies both homicidal and suicidal ideation. Client has no delusional thoughts. Client has no hallucinations. Denis auditory, denies seeing things. No tactile or Olfactory issues. Client denies obsessions thoughts. No compulsions, paranoia, flight of ideas. Client's thoughts are organized and coherent.
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	Client stated" pick it up, look in the wallet and it depends on how much money is in it" depends on what the client would do with it.

MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	Client does not use any assistive devices.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	96 (right wrist)	138/88 (on right arm)	28	101.2F Oral 38.4 C Oral	92 O2 room air.

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numeric Scale	Head	5	Ache, constant	Client was given pain meds.

Nursing Care (6 points)

Overview of care provided today: Client just showed up to the center. Client seemed calm and was willing to participate in the interview.

Client complaints: Chest pain

Participation in therapy / groups: Patient was just admitted today.

Medication compliance today: N/A.

Behaviors exhibited today: Client present calm and focused.

Discharge Planning

Discharge location: Home with some support.

Follow up plan: Patient is to follow up with primary care to talk about safety of medication and to check blood pressure.

Education needs: The patient will need to be educated on the signs and symptoms of withdrawal recurrences, medication regimen, avoiding alcohol triggers and high-risk situation, importance of nutrition and hydration, relapse prevention strategies and available community resources.

Nursing Diagnosis (25 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**
1. Impaired gas exchange related to alveolar capillary membrane changes and buildup of fluid in alveoli which is the cause of the pneumonia evidence by O2 sat 92% on room air, crackles, dyspnea and a productive cough, (Phelps, 2023).	**This nursing diagnosis was chosen because pneumonia is a deadly disease-causing inflammation and fluid buildup in alveoli, which causes oxygen and carbon dioxide diffusion which can**	**1. The patient O2 saturation level will remain above 95 and patient will have absence of dyspnea for 3 days.**	**1.Give medication as order, the supplemental O2 to improve oxygenation (Phelps, 2023).** **2. Encourage use of incentive spirometer and position the patient in semi**	**1. Community Health Nurse to help teach the patient about how to monitor oxygenation and lung sounds at home.**

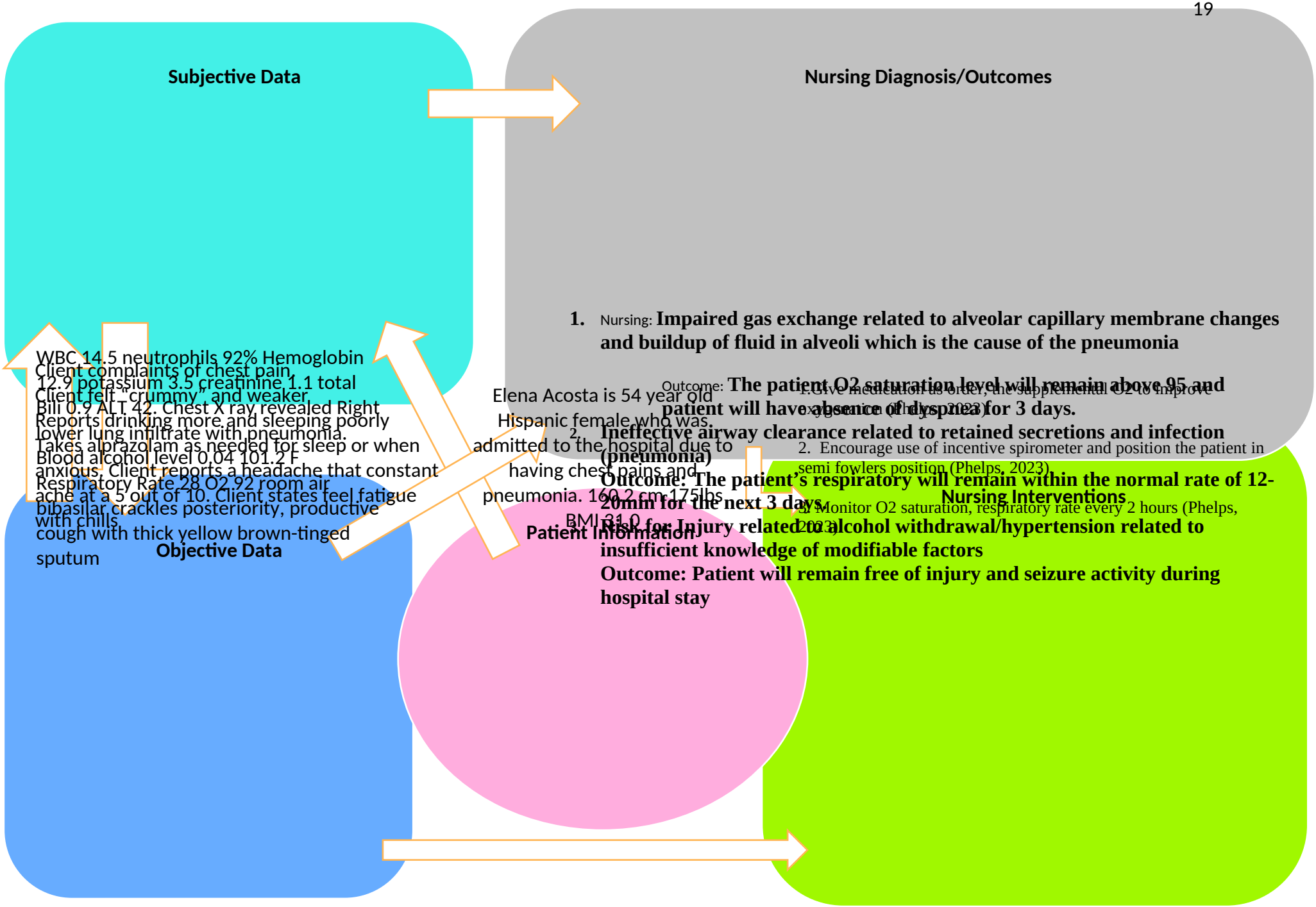
	lead to death if not treated.		**fowlers position (Phelps, 2023).** **3. Monitor O2 saturation, respiratory rate every 2 hours (Phelps, 2023).**	
1. Ineffective airway clearance related to retained secretions and infection (pneumonia) as evidence chest pain, increased respiratory rate and temperature 101.2F (Phelps, 2023). **2.**	**This nursing diagnosis was chosen because maintaining a clear airway for a patient is top priority. The client was admitted due to having pneumonia which is the cause of the low O2.**	**1. The patient's respirator y will remain within the normal rate of 12-20min for the next 3 days.**	**1.Encourage patients to intake at least 2-3 liters a day to help with the secretion, (Phelps, 2023).** **2. I will monitor the patient's vital signs: respiratory rate, heart rate, breath sounds, O2 every 4 hours, (Phelps, 2023).** **3. I will administer prescribed antibiotics and antipyretics to help manage the infection and**	**1. Alcohol Anonymou s recovery Support so the client can get the support they need to prevent damage to their lungs.**

			to reduce the fever (Phelps, 2023).	
3. Risk for Injury related to alcohol withdrawal/hypertension related to insufficient knowledge of modifiable factors as evidence by the daily alcohol use and a use of CNS depressants (alprazolam) for sleep. (Phelps, 2023)	**I chose this nursing diagnosis because withdrawal from alcohol can lead to seizures and the patient safety is first.**	**1. Patient will remain free of injury and seizure activity during hospital stay.**	**1. Assess and document any motor, mental or sensory deficits, (Phelps, 2023).** **2. Implement seizure precautions, make sure the room is safe for the patient, (Phelps, 2023).** **3. Monitor for withdrawal symptoms such as tremors diaphoresis, tachycardia, (Phelps, 2023).**	**1. Primary Care Follow up to monitor patient medication safety.**

Other References (APA):

Phelps, L. L. (2023). *Nursing diagnosis reference manual*. Wolters Kluwer.

Concept Map (20 Points):


Subjective Data
Client complaints of chest pain, Client felt "crummy" and weaker Reports drinking more and sleeping poorly Takes alprazolam as needed for sleep or when anxious. Client reports a headache that constant ache at a 5 out of 10. Client states feel fatigue with chills cough with thick yellow brown-tinged sputum
Objective Data
WBC 14.5 neutrophils 92% Hemoglobin 12.9 potassium 3.5 creatinine 1.1 total Bili 0.9 ALT 42. Chest X ray revealed Right lower lung infiltrate with pneumonia. Blood alcohol level 0.04 101.2 F Respiratory Rate 28 O2 92 room air bibasilar crackles posteriority, productive
Elena Acosta is 54 year old Hispanic female who was admitted to the hospital due to having chest pains and pneumonia. 160.2 cm 175lbs BMI 31.0
Patient Information
Nursing Diagnosis/Outcomes
1. Nursing: Impaired gas exchange related to alveolar capillary membrane changes and buildup of fluid in alveoli which is the cause of the pneumonia
Outcome: The patient O2 saturation level will remain above 95 and patient will have absence of dyspnea for 3 days.
2. Ineffective airway clearance related to retained secretions and infection (pneumonia)
Outcome: The patient's respiratory will remain within the normal rate of 12-20mm for the next 3 days.
3. Risk for Injury related to alcohol withdrawal/hypertension related to insufficient knowledge of modifiable factors
Outcome: Patient will remain free of injury and seizure activity during hospital stay
Nursing Interventions
1. Give medication as order, the supplemental O2 to improve oxygenation (Phelps, 2023)
2. Encourage use of incentive spirometer and position the patient in semi fowlers position (Phelps, 2023)
3. Monitor O2 saturation, respiratory rate every 2 hours (Phelps, 2023)