N323 Care Plan

Lakeview College of Nursing

Ngoc Trinh

Professor Brittany Lawson

Approved: 01/02/2024

Demographics (3 points)

Date of Admission 10/6/25	**Patient Initials** EA	**Age** 54	**Biological Gender** Female
Race/Ethnicity Hispanic	**Occupation** Corporate finance company	**Marital Status** Divorced	**Gender Identity** Female
Code Status Full code	**Height and Weight** 6'3 (160.2 cm) and 175 lbs (79.3kg)	**Allergies** Penicillin	**Pronouns** She/ her.

Medical History (5 Points)

Past Medical History: Hypertension, Anxiety, Tonsillitis, Broken right arm at 13.

Psychiatric Diagnosis: Alcohol withdrawal Syndrome.

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

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 patient states she felt crummy and weaker for the last 24 hrs, and chest pain, coughing.
- **Chief Complaint Impact on Life:** The patient states her job was quiet and stressful, and she lost her father a year ago.

The 54-year-old Hispanic female presented at Lakeview on October 6, 2025, complaining of chest pain. The patient reported coughing with green phlegm, with difficulty breathing, and felt pain in her mid-ternal area; the location of the pain was in her chest. The patient also states that the symptoms have been continuous since they began and are described as an aching discomfort that worsens with coughing. The patient describes the pain as aching and rates the pain a 5/10 on a numerical scale. The patient states that she called 911 for evaluation and treatment when the symptoms became severe.

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?		The patient states her father abuse her mom when she was a child.	
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?		The patient states she lost her father year ago.	
Have you experienced any other scary or stressful event in the past that continues to bother you today?		The patient states her father death.	
(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			
Sexual Abuse			

Emotional Abuse			
Verbal Abuse			
Military			
Other			
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		
Do you avoid social situations?	Yes	The patient states she feels like they are uncomfortable.	
Do you have difficulties with home, school, work, relationships, or responsibilities	Yes		
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		
Do you have difficulty falling asleep?	Yes	The patient states she was sleeping poorly.	
Do you frequently awaken during the night?	Yes		
Do you have nightmares?	No		
Are you satisfied with your sleep?	No		
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	The patient states she loss of appetite due to stress.
Have you recently experienced unexplained weight loss? **Amount of weight change:**	Yes	
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 symptoms of anxiety?	Yes	
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	No	

kill yourself?		
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

If yes to any alcohol or drug use, explain:

Family Medical History: Mom (Breast cancer and Heart Failed), Father (Hypothyroidism).

Family Psychiatric History (including suicide): Mom 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? Yes **If yes, please tell me more about that:** The patient states her dad pass away year ago.
Are you currently having relationship problems? No

What is your sexual orientation: N/a	**Are you sexually active?** No	**Do you practice safe sex?** No

Please describe your religious values, beliefs, spirituality and/or preference: The patient states she don't eat pork.
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? The patient states she uses to be Buddhist but now she's Muslim.
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? The patient states 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.) The patient states she drinks a couple of Martine and couple of beers.
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) The patient states her work make her stress worse.
Client raised by: Natural parents.
Self-Care: Independent.

Education History: High school
Reading Skills: Yes
Primary Language: English.

Personal History of Substance Use

Screening Questions:

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

(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-year-old **Last Use:** Continue	Everyday
Alcohol	**First Use:** 13-year-old **Last Use:** Continue	Everyday
Prescription Medications (Recreational Use)	**First Use:** No **Last Use:**	
Marijuana	**First Use:** Don't know **Last Use:** Don't remember	4 Months
Heroin	**First Use:** No **Last Use:**	
Methamphetamine	**First Use:** No **Last Use:**	
Other: Specify	**First Use:** No	

	Last Use:	

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

Brand/Generic	Hydrochlorothiazide/ HYDRODUIRIL	Alprazolam/ NIRAVAM			
Dose	12.5 mg	0.25 mg			
Frequency	Once daily	Once PRN			
Route	PO	Oral			
Classification	Thiazide diuretic (Jones & Bartlett, 2024).	Benzodiazepine (Jones & Bartlett, 2024).			
Mechanism of Action	Inhibits sodium reabsorption in distal renal tubules, causing excretion of sodium, potassium, hydrogen ions, water (Jones & Bartlett, 2024).	Enhances the inhibitory effects of the neurotransmitter GABA at GABA-A receptors in the brains (Jones & Bartlett, 2024).			
Therapeutic Uses	Treatment of mild to moderate hypertension (Jones & Bartlett, 2024).	Produces anxiolytic effect due to CNS depressant actions (Jones & Bartlett, 2024).			
Therapeutic	N/a	Produces anxiolytic			

Range (if applicable)		effect due to CNS depressant action (Jones & Bartlett, 2024).			
Reason Client Taking	Hypertension	Help the patient for sleep or feel anxious.			
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	N/a	Fall precautions (Jones & Bartlett, 2024).			
Contraindications (2)	1.Anuria (Jones & Bartlett, 2024) 2.Electrolyte Imbalance (Jones & Bartlett, 2024)	1.Alcohol use (Jones & Bartlett, 2024). 2. Respirations issue (Jones & Bartlett, 2024).			
Side Effects/Adverse Reactions (2)	1.Headed (Jones & Bartlett, 2024) 2.GI disturbances (Jones & Bartlett, 2024)	1.Dizziness (Jones & Bartlett, 2024). 2.Unsteadiness (Jones & Bartlett, 2024).			
Medication/Food Interactions	Can interact with digoxin, lithium and NSAIDs (Jones & Bartlett, 2024).	Grapefruit (Jones & Bartlett, 2024).			
Nursing Considerations (2)	1.Mornitor the patient electrolyte levels and blood pressure (Jones & Bartlett, 2024). 2.Encourage the patient to change position slowly to prevent dizziness or orthostatic hypotension (Jones & Bartlett, 2024).	1.Monitor for signs of CNS depression and fall risk, especially in elderly patients' pressure (Jones & Bartlett, 2024). 2. Educate patient on short term use and withdrawal symptoms pressure (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:**	**Appearance (i.e.: positioning, posture, dress, grooming):** The patient looks older than stated age, well groom. **Alertness:** Patient was alert. **Orientation:** Oriented x3 person, place, and situation, knew year, but wrong day of week. **Behavior:** Normal **Speech:** Normal **Eye Contact:** Make eye contact **Attentiveness:** Full Attentiveness
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	**How is your mood today?** The patient states she's normal **Affect:** No
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	**Alertness:** The patient was alertness. **Orientation:** Alert & oriented to person, place, and situation (x3), knew year, but wrong day of week **Memory Impairment:** No **Attention:** Full attention
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	**Homicidal Ideations or Suicidal Ideation:** No **Delusions:** No **Hallucinations:** No **Obsessions:** No **Compulsions:** No **Paranoia:** No **Flight of Ideas:** No **Perseveration:** No **Loose Association:** No
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	Pick it up, look wallet, depend on how much money is this.

MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	 **Assistive Devices:** No **Gait:** No **Abnormal Motor Activities:** No

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
1135	96 bpm	138/88 mmHg	28 Respirations per minute.	101.2 F (Oral)	92 % room air

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
1350	Numerical scale (1-10)	Chest	5/10	Ache	Nothing

Nursing Care (6 points)

Overview of care provided today: The patient was monitored for vital signs, oxygen saturation, and pain level throughout the shift. Administered prescribed medications and provided education on fall precautions when taking the medication, used CAM techniques before sleep, and encouraged deep breathing exercises to support recovery from pneumonia.

Client complaints: The patient reported chest pain rated 5/10, described as an aching sensation.

Participation in therapy/groups: The patient attended group therapy but was quiet and didn't pay attention.

Medication compliance today: The patient demonstrated understanding of their purpose and schedule.

Behaviors exhibited today: The patient was calm, cooperative, and oriented x3, but appeared fatigued and mildly anxious.

Discharge Planning

Discharge location: The patient will be discharged home.

Follow-up plan: The patient will follow up with her primary care provider within one week for blood pressure and pneumonia reassessment.

Education needs: The patient was educated on medication adherence, avoiding alcohol while taking prescribed medication, recognizing early signs of pneumonia, maintaining a sodium diet, and stress management techniques.

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

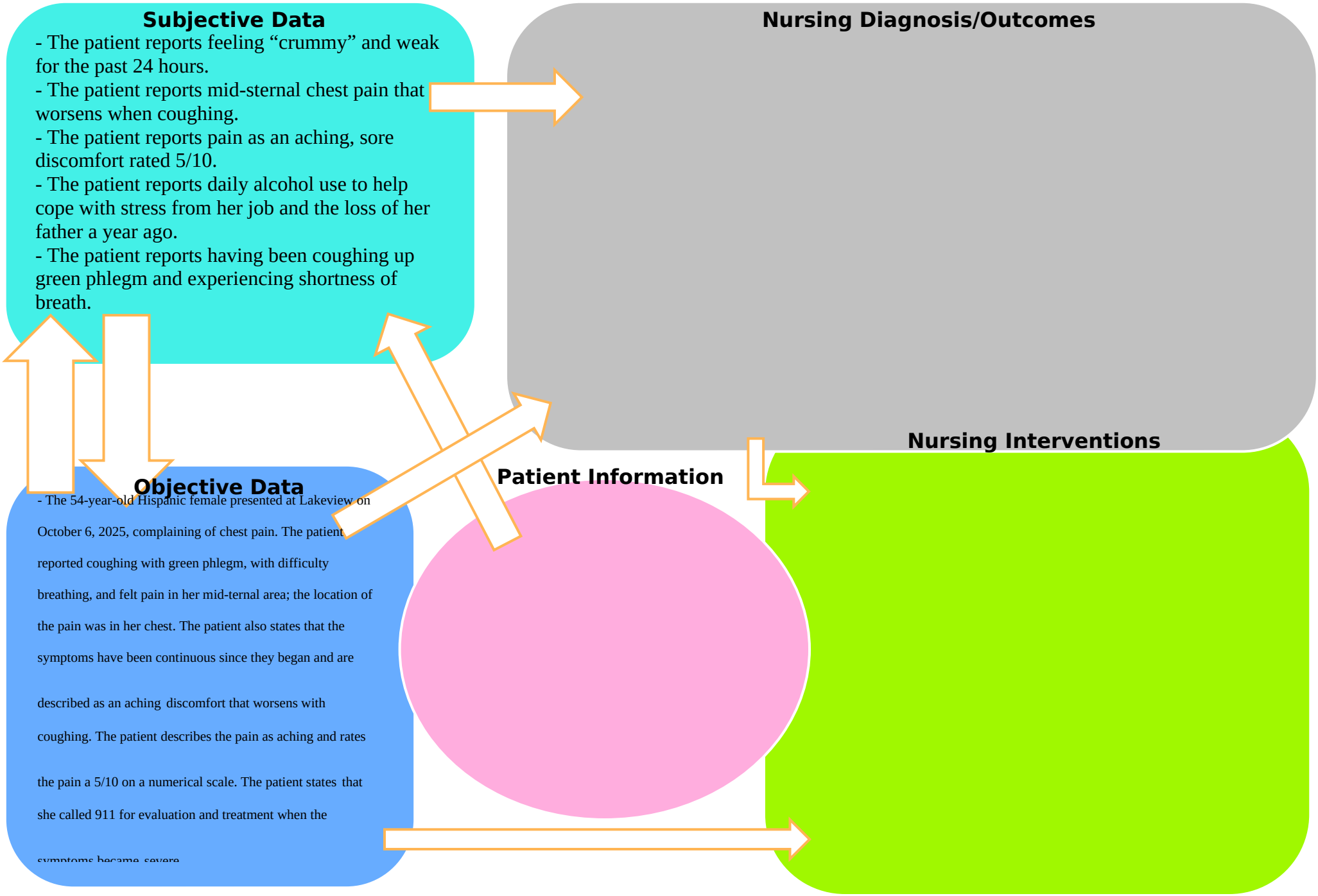
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**
1.Impaired gas exchange related to	This diagnosis was chosen because the	**1.**Patient will display appropriate oxygen	**1.**Encourage rest and limit exertion (Phelps, 2020).	1. American Lung Association – Pulmonary Rehabilitation

fluid and mucus in the alveoli as evidenced by restlessness (Phelps, 2020).	patient has taken ondansetron due to nausea and vomiting.		**2.** Administer oxygen (Phelps, 2020). **3.** Reposition if need (Phelps, 2020).	Program. **Rationale**: This program provides education about breathing exercise to help the patient improve lung function.
1.Risk for falls related to impaired balance, tremor as evidenced by unsteady gait and history of alcohol withdrawal symptoms (Phelps, 2020).	This diagnosis was chosen because the patient has drink 1-2 alcoholic most days.	1. The patient will remain free from falls.	1.Keep the bed in a low position (Phelps, 2020). 2.Encourage the patient to call before ambulating (Phelps, 2020). 3.Monitor the level of consciousness and gait frequently (Phelps, 2020).	1. Alcoholics Anonymous (AA). **Rationale:** These programs provide support, education, and coping strategies to help prevent relapse, reducing the long-term risk of falls.
1.Ineffective coping related to maladaptive use of alcohol to manage as evidence by daily alcohol consumption and verbalization to using alcohol to relax and reduce stress (Phelps, 2020).	This diagnosis was chosen because the patient was reports using alcohol daily to cope with emotional distress.	1. The patient will begin using healthy coping strategies to manage stress without using alcohol.	1. Encourage the patient to verbalize feelings (Phelps, 2020). 2.Teach relaxation techniques such as CAM and deep breathing (Phelps, 2020). 3. Provide education about the effect of alcohol on physical health (Phelps, 2020).	1. Substance Abuse and Mental Health Services Administration (SAMHSA) National Helpline. **Rationale**: This program provides confidential counseling, referrals to local treatment programs.

Other References (APA):

Phelps, L. (2020). *Sparks and Taylor's Nursing Diagnosis Reference Manual: Eleventh Edition*. Wolter's Kluwer.

Concept Map (20 Points):


Subjective Data
- The patient reports feeling “crummy” and weak for the past 24 hours.
- The patient reports mid-sternal chest pain that worsens when coughing.
- The patient reports pain as an aching, sore discomfort rated 5/10.
- The patient reports daily alcohol use to help cope with stress from her job and the loss of her father a year ago.
- The patient reports having been coughing up green phlegm and experiencing shortness of breath.
Nursing Diagnosis/Outcomes
Nursing Interventions
Patient Information
Objective Data
- The 54-year-old Hispanic female presented at Lakeview on October 6, 2025, complaining of chest pain. The patient reported coughing with green phlegm, with difficulty breathing, and felt pain in her mid-ternal area; the location of the pain was in her chest. The patient also states that the symptoms have been continuous since they began and are described as an aching discomfort that worsens with coughing. The patient describes the pain as aching and rates the pain a 5/10 on a numerical scale. The patient states that she called 911 for evaluation and treatment when the symptoms became severe

Objective Data:

- The 54-year-old Hispanic female presented at Lakeview on October 6, 2025, complaining of chest pain. The patient reported coughing with green phlegm, with difficulty breathing, and felt pain in her mid-ternal area; the location of the pain was in her chest. The patient also states that the symptoms have been continuous since they began and are described as an aching discomfort that worsens with coughing. The patient describes the pain as aching and rates the pain a 5/10 on a numerical scale. The patient states that she called 911 for evaluation and treatment when the symptoms became severe.
- Appeared alert and oriented X3 but looked fatigued.
- Vital signs: BP 138/88 mmHg, pulse 96 bpm, respirations 28/min, temperature 101.2°F (oral), and oxygen saturation 92% on room air.
- Lung assessment revealed a harsh, productive cough with green sputum and labored breathing.
- The patient exhibited restlessness and mild anxiety but remained cooperative.
- Physical exam noted normal skin color, no edema, and an unsteady gait possibly related to alcohol withdrawal.

Nursing Diagnosis/Outcomes

- Impaired gas exchange related to fluid and mucus in the alveoli, as evidenced by restlessness

    Outcomes: Patient will display appropriate oxygen

- Risk for falls related to impaired balance, tremor, as evidenced by unsteady gait and a history of alcohol withdrawal symptoms.

    Outcomes: The patient will remain free from falls.

- Ineffective coping related to maladaptive use of alcohol to manage, as evidenced by daily alcohol consumption and verbalization of using alcohol to relax and reduce stress.

Outcomes: The patient will begin using healthy coping strategies to manage stress without using alcohol.

Patient Information:

Name: Elena Acosta, Age: 54 years old, Gender: Female, Ethnicity: Hispanic

Height/Weight: 63 inches (160.2 cm), 175 lbs (79.3 kg) — BMI 31.0 (obese category)

Date of Admission: October 6, 2025

Primary Diagnosis: Pneumonia

Past Medical History: Hypertension, Anxiety, Alcohol Withdrawal Syndrome

Allergies: Penicillin

Occupation: Works for a corporate finance company

Marital Status: Divorced

Code Status: Full Code

Primary Language: English

Religion/Cultural Considerations: Muslim — avoids pork

Living Situation: Lives alone with her cat

Support System: Limited; mainly her pet

Medication: Hydrochlorothiazide (for hypertension), Alprazolam (for anxiety)

Nursing Interventions

- Encourage rest and limit exertion, administer oxygen, and reposition if needed.

- Keep the bed in a low position, encourage the patient to call before ambulating, and monitor the level of consciousness and gait frequently.

- Encourage the patient to verbalize feelings, teach relaxation techniques such as CAM and deep breathing, and provide education about the effect of alcohol on physical health.