N323 Care Plan

Hadley Jones

Lakeview College of Nursing

Mental and Behavioral Health

October 17, 2025

Demographics (3 points)

Date of Admission 10/13/2025	Patient Initials E.A	Age 54 years old	Biological Gender Female
Race/Ethnicity Hispanic	Occupation Manager for a corporate finance company	Marital Status Single	Gender Identity Female
Code Status Not on file	Height and Weight 5'3 and 175lbs	Allergies No known allergies stated	Pronouns She/her

Medical History (5 Points)

Past Medical History: Client has a history of hypertension

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): Mid-sternal chest pain following a productive cough, green phlegm, and difficulty breathing.

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable): The client began an onset of pain over the last 24 hours, with the location of the pain in her mid-sternal chest area. The client called 911 and**

came directly to the hospital, describing her pain as feeling "crummy and weak." Aggravating factors included the pain increasing when coughing, and the client did not do anything beforehand to try to alleviate or treat the pain. Client states that she drinks 4-5 cups of coffee a day, with 1-2 alcoholic beverages a day as well. Client is an active smoker but states she has cut down her amount to ½ pack a day.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal): Client states that she was doubtful to be admitted because she has an insurance plan with a substantial deductible and is unsure about how she will pay for it. Along with that, the client describes her job as "quite stressful."**

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?	**N/A**
Do you have a history of trauma secondary to military service?	**N/A**
Have you experienced a loss of family or friends that affected your emotional well-being?	**Client lost their father over a year ago. Client reported trouble sleeping and increased alcohol intake since.**
Have you experienced any other scary or stressful event in the past that continues to bother you today?	**N/A**
(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?	**N/A**	**N/A**	
Do you feel tired or have little energy?	**Client stated difficulty sleeping.**	**Client stated they're having trouble sleeping for over a year and uses "poorly" to describe as a characteristic. Client did not state if this occurs every night.**	
Do you avoid social situations?	**N/A**	**N/A**	
Do you have difficulties with home, school, work, relationships, or responsibilities	**Client stated that their job was stressful.**	**Client stated that her job causes stress to her, but not did mention how long this has been occurring or when this started.**	
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	**N/A**	**N/A**	

sleep each night?		
Do you have difficulty falling asleep?	**N/A**	**N/A**
Do you frequently awaken during the night?	**N/A**	**N/A**
Do you have nightmares?	**N/A**	**N/A**
Are you satisfied with your sleep?	**Client stated that they have been having trouble sleeping.**	**Client stated they're having trouble sleeping for over a year and uses "poorly" to describe as a characteristic. Client did not state if this occurs every night.**
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?	**N/A**	**N/A**
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	**N/A**	**N/A**
Do you have not eat enough or have a loss of appetite?	**The client stated that they have no appetite along with an upset stomach and nausea.**	**The loss of appetite started on day two of their stay.**
Have you recently experienced unexplained weight	**N/A**	**N/A**

loss? **Amount of weight change: N/A**		
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?	**Tremors**	**The client showed moderate hand tremors** **when asked to stick both arms out completely.**
Do you experience panic attacks?	**N/A**	**N/A**
Do you have obsessive or compulsive thoughts?	**N/A**	**N/A**
Do you have obsessive or compulsive behaviors?	**N/A**	**N/A**
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**	**N/A**
Have you ever tried to kill yourself?	**No**	**N/A**
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)**	**N/A**	**N/A**
Rating Scale		

How would you rate your depression on a scale of 1-10?	**N/A**
How would you rate your anxiety on a scale of 1-10?	**N/A**

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: N/A
Family Medical History: N/A
Family Psychiatric History (including suicide): N/A
Family alcohol or drug use (not covered by those client lives with): N/A
Do you have children? If yes, what are their ages? N/A **Who are your children with now? N/A**
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? Yes, loss and death of a family member. **If yes, please tell me more about that: The client lost their father to death over a year ago.**
Are you currently having relationship problems? N/A

What is your sexual orientation: N/A	**Are you sexually active? N/A**	**Do you practice safe sex? N/A**
Please describe your religious values, beliefs, spirituality and/or preference: N/A		

Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? N/A
Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): **N/A**
Whom would you consider your support system? N/A **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 client stated that she has been drinking more since the death of her father. Alcohol is a coping method that she uses.**
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) **The death of her father and her stressful job are factors that the client stated that can be identified as triggers.**
Client raised by: N/A **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**
Self-Care: N/A **Independent** **Assisted** **Total Care**
Education History: N/A **Grade school** **High school** **College** **Other:**
Reading Skills: N/A **Yes** **No** **Limited**
Primary Language: 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: N/A** **Last Use: N/A**	**Client states that she has cut down to a ½ pack a day, but it is not known if she smoked the day of her admission or not.**
Alcohol	**First Use: N/A** **Last Use: Admission date (10/13/2025)**	**Client states that she has 1-2 alcoholic beverages a day, and her last one was the day of her admission. The amount is unknown, but evidenced by the smell of alcohol on her breathe and her blood alcohol level.**
Prescription Medications (Recreational Use)	**First Use: N/A** **Last Use: N/A**	
Marijuana	**First Use: N/A** **Last Use: N/A**	
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 <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	**Xanax/ alprazolam**	**Vitamin B1/ thiamine**	**Microzide/ hydrochlorothiazide**	**Ativan/ lorazepam**	**Folvite/ folic acid**
Dose	**0.25mg tablet**	**1100mg IV/IM** **100mg tablet**	**12.5mg tablet**	**1mg tablet**	**1mg tablet**
Frequency	**PRN at night**	**Q8H/TID x3 days** **PO daily**	**QD**	**Q4H x2 days**	**QD**
Route	**Oral**	**IV/IM** **Oral**	**Oral**	**Oral**	**Oral**
Classification	**Pharmacologic class: Benzodiazepine** **Therapeutic class: Anxiolytic, antipanic**	**Pharmacological: Water-soluble vitamin (Vitamin B complex)** **Therapeutic: Vitamin supplement/ Nutritional deficiency agent**	**Pharmacological: Thiazide diuretic** **Therapeutic: Diuretic**	**Pharmacological: Benzodiazepine** **Therapeutic: Anxiolytic**	**Pharmacological: Water-soluble vitamin (Vitamin B complex)** **Therapeutic: Vitamin supplement**
Mechanism of Action	**By attaching to certain benzodiazepine receptors in the limbic and cortical regions of the central nervous system, it may intensify the effects of gamma-**	**Engages in physiological functions; it is a crucial coenzyme for the metabolism of carbohydrates.**	**HCTZ is a thiazide diuretic, or water pill that is used to treat edema, or fluid retention, in patients with renal disease, liver cirrhosis, congestive heart failure, or edema brought on by estrogen or steroids. Additionally, HCTZ is used to treat**	**By attaching to certain benzodiazepine receptors in the limbic and cortical regions of the central nervous system, it may intensify the effects of gamma-**	**The body transforms folic acid into its active form, tetrahydrofolate (THF).** **The creation of DNA, RNA, and amino acids are all necessary for cell division and growth,**

	aminobutyric acid and other inhibitory neurotransmitters. GABA helps regulate emotional behavior by blocking excitatory stimuli. The anti-anxiety effects of medicines may be explained by the many benzodiazepine receptors found in the limbic system.		**hypertension, or elevated blood pressure. Blood pressure decline can be explained by a decrease in cardiac output, extracellular fluid volume, or plasma volume.**	**aminobutyric acid and other inhibitory neurotransmitters. GABA helps regulate emotional behavior by blocking excitatory stimuli. The anti-anxiety effects of medicines may be explained by the many benzodiazepine receptors found in the limbic system. Lorazepam hyperpolarizes neuronal cells thereby interfering with their ability to generate seizures.**	**require THF as a coenzyme. The body uses folic acid to create and repair DNA, encourages the bone marrow to produce red blood cells, and keeps low folate levels from causing megaloblastic (macrocytic) anemia.**
Therapeutic Uses	**To treat anxiety associated with depression.**	**To help reduce the risk of developing Wernicke-Korsakoff syndrome.**	**To treat client's hypertension.**	**To treat anxiety and insomnia.**	**Long-term alcohol consumption affects the metabolism and absorption of folate; folic acid helps to make up for deficiencies and enhance nutritional status.**
Therapeutic	**20–100 ng/mL**	**N/A**	**12.5-50mg**	**20-100ng/mL**	**N/A**

Range (if applicable)					
Reason Client Taking	**Trouble sleeping and anxiety**	**The client's alcohol intake could be interfering with the absorption and conservation of thiamine.**	**The client is taking this drug because they have hypertension.**	**The client is experiencing anxiety and difficulty sleeping.**	**To prevent a folate deficiency.**
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	**The client could practice deep breathing exercises to calm her anxiety and be more relaxed before bed to promote a better sleep.**	**N/A**	**N/A**	**N/A**	**N/A**
Contraindications (2)	**1. History of alcohol abuse 2. Severe hepatic impairment**	**1. Hypersensitivity to thiamine. 2. IV/IM administration should be done with caution.**	**1. Alcohol use 2. Dehydration**	**1. Hypersensitivity to lorazepam. 2. Severe respiratory insufficiency.**	**1. Undiagnosed anemia 2. Hypersensitivity to folic acid**
Side Effects/Adverse Reactions (2)	**1. Headache 2. Tremors**	**1. Pain or tenderness at IV site. 2. Restlessness**	**1. Muscle weakness 2. Headache**	**1. Confusion 2. Drowsiness**	**1. GI upset 2. Sleep disturbances**
Medication/Food Interactions	**If taking other CNS depressants, increased risk for respiratory depression or death. Do not take this medication with grapefruit**	**If taking and using alcohol, decreased absorption of thiamine and can cause deficiency. Foods like raw fish can break down thiamine.**	**If taking NSAIDs as well, may reduce antihypertensive effectiveness. Alcohol can increase risk of dehydration.**	**If taking other CNS depressants, increased risk for respiratory depression or death. Alcohol use increases the risk for drowsiness and slow**	**Long-term alcohol use affects the storage and absorption of folate. Providing folic acid during recovery helps avoid anemia, enhance nutritional**

	juice use. Alcohol use increases the risk for drowsiness and slow breathing.			**breathing.**	**status, and return RBC production to normal.**
Nursing Considerations (2)	**1. Monitor client's respiratory rate, blood pressure, and level of anxiety before and after administration.** **2. Administer this medication with food to prevent GI upset.**	**1. Assess the client for signs of confusion, muscle weakness, or fatigue.** **2. Monitor for eye movement inconsistencies; a possible sign of WKS.**	**1. Monitor the client's blood pressure regularly to assess effectiveness or abnormalities.** **2. Assess fluid status for abnormalities.**	**1. Administer this medication with food to prevent GI upset.** **2. Assess the client's level of anxiety and mental status prior to administration and during it.**	**1. Assess the patient for shortness of breath, fatigue, or pallor, which are signs of anemia.** **2. Assess the client's dietary intake and encourage folate-rich foods such as leafy greens.**

Medications Reference (1) (APA):

Drugs.com. (n.d.) (2025). *Prescription drug information*. Drugs.com. https://www.drugs.com/

2025 NDH: Nurse's Drug Handbook. Jones & Bartlett Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming): Dressed in a hospital gown and looks unkept.** **Alertness: Alert to person** **Orientation: A/O x1** **Behavior: Withdrawn, guarded** **Speech: Normal rate and rhythm, slow responses on some occasions.** **Eye Contact: N/A** **Attentiveness: Minimal**	**The most current assessment of the client showed that she seemed uneasy, anxious, and was frequently shifting self in bed.** **The client did not know where she was or what day of the week it was.** **The client was not cooperating when it came to answering questions. She stated, "Just leave me alone, please."** **The client showed minimal attentiveness and was irritable to conversation.**
MOOD: **How is your mood today? Tearful, apprehensive** **Affect: Flat** **Consistency between mood and affect? No**	**The client showed fatigue with mild depression and intense anxiety. The client was irritable and emotional at times. The client appeared to be in distress. The client rated her mild depression and intense anxiety levels a 7 out of a 0-10 scale.** **Client stated on day two that she is feeling a worse but in a "different way."**
COGNITION: **Alertness: Alert x1** **Orientation: Orientated x1** **Memory Impairment: N/A** **Attention: Inattentive**	**The client is alert and oriented to person. There were no signs of memory impairment. The client's attention was blunt and did not respond to questions in an appropriate manner.**
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions: N/A** **Hallucinations: N/A** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions: N/A** **Compulsions: N/A** **Paranoia: N/A** **Flight of Ideas: N/A** **Perseveration: N/A** **Loose Association: N/A**	

REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?): N/A** **Insight into Illness: N/A**	.
MOTOR ACTIVITY: **Assistive Devices: N/A** **Gait: N/A** **Abnormal Motor Activities: Tremors**	**The client showed a moderate effect of hand tremors when she extended both arms.**

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0100	**110**	**154/92; client has history of hypertension**	**20**	**99.0 degrees Fahrenheit**	**95% on room air**

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0100	**0-10**	**Headache**	**7**	**Client stated characteristics as a throbbing sensation and feels like an elastic band is around her head.**	**Client stated that bright light makes the pain worse, turning off the lights for a dim environment could help.**

Nursing Care (6 points)

Overview of care provided today: The client had vitals taken and medication administered per the provider's orders.

Client complaints: The client did not report any complaints about the care, just about her pain.

Participation in therapy / groups: N/A

Medication compliance today: The client was compliant with the ordered medications.

Behaviors exhibited today: The client appeared to be tense, guarded, and anxious. The client did not want to communicate and was very dry with her responses.

Discharge Planning

Discharge location: Undecided

Follow up plan: The follow-up plan for this client should be an inpatient stay due to their alcohol withdrawal symptoms and mild depression, in case of the worsening of either. The client should also speak with a therapist to further help with the loss and grief from her father's death.

Education needs: The client is given coping strategies on how to deal with the grief and depression she endures. Along with the stressed importance of stopping alcohol intake and smoking, with their explained effects on the body.

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

Nursing Diagnosis	**Rationale**	**Outcome Goal (1 per**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale**
• Include full nursing	• Explain why the			

diagnosis with "related to" and "as evidenced by" components	nursing diagnosis was chosen	**diagnosis)**		**(1 per diagnosis)**
1. Impaired Gas Exchange related to ineffective breathing pattern due to alveolar constriction from pneumonia as evidenced by bibasilar crackles posteriorly on auscultation (Phelps, 2023).	**This diagnosis was chosen because the client came in with a chief complaint of mid-sternal chest pain following a productive cough, green phlegm, and difficulty breathing. After being assessed, the client was diagnosed with pneumonia**	**1. Client's vital signs will remain stable, and breath sounds will return to normal before the patient is discharged from their stay.**	**1.Place the client in a comfortable, high-Fowler's position to allow the diaphragm to move more freely and encourage lung expansion and ventilation (Phelps, 2023).** **2. Encourage and educate the client on ways to use an incentive spirometer and/or deep breathing exercises to help enhance ventilation (Phelps, 2023).** **3. Monitor vital signs such as respiratory rate, lungs sounds, and oxygen saturation frequently (Phelps, 2023).**	**1. The client can attend a follow-up appointment to the pulmonary clinic with their primary care provider after discharge to monitor the recovery from the pneumonia, along with medication checks to ensure safe usage.**
2. Risk for Injury related to alcohol withdrawal as evidenced by tremors, restlessness, and altered mental status	**This diagnosis was chosen because the client is showing symptoms of alcohol withdrawal syndrome by her moderate**	**1. The client will remain free from injury throughout their stay.**	**1. Implement seizure and fall precautions that include a neat environment, bed rails, and call light within the client's reach to reduce the risk for injury (Phelps, 2023).**	**1. After discharge, the client can attend Alcoholics Anonymous (AA) meetings that are community-based and include peers going through alcohol withdrawal to form a sense of support and therapy to**

(Phelps, 2023).	**hand tremors, altered mental status, and restlessness.**		**2.Assess and monitor the client's vital signs and neurological status to check for abnormalities that could encourage the risk for injury (Phelps, 2023).** **3. Administer the ordered lorazepam medication and monitor the client after to promote safety and prevent worsening withdrawal symptoms that could lead to the risk for injury.**	**promote cessation.**
3. Deficient Fluid Volume related to fever and poor oral intake as evidenced by altered mental status (Phelps, 2023).	**This diagnosis was chosen because the client had a fever and later on developed a loss of appetite and altered mental status.**	**1. The client will consume an adequate fluid volume amount with a balanced intake and output during their stay.**	**1. Monitor the client's intake and output along with their daily weight to assess the fluid balance levels (Phelps, 2023).** **2. Encourage fluid intake and offer small meals to help prevent symptoms of nausea and dehydration (Phelps, 2023).** **3. Assess the client's mucous membranes and skin turgor to**	**1. The client can attend a follow-up appointment with their primary care provider one week after discharge to assess their hydration status and if needed, receive education on proper nutritional information.**

			confirm hydration status and see effects of treatment with fluid replenishment (Phelps, 2023).	

Other References (APA):

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

Substance abuse and mental health services administration. SAMHSA. (n.d.).

https://www.samhsa.gov/

Concept Map (20 Points):

Subjective Data

- Feeling "crummy and weaker" the last 24 hours.
- Chest pain that increases with coughing
- Difficulty breathing
- "Quite stressful" job
- "Drinking more and sleeping poorly."
- "Shouldn't smoke and has cut down to about ½ pack per day."
- "Doesn't know how she will be able to afford this."
- Stomach upset, no appetite, nausea

Nursing Diagnosis/Outcomes

3. Impaired Gas Exchange related to ineffective breathing pattern due to alveolar constriction from pneumonia as evidenced by bibasilar crackles posteriorly on auscultation (Phelps, 2023).
   - Client's vital signs will remain stable, and breath sounds will return to normal before the patient is discharged from their stay.
2. Risk for Injury related to alcohol withdrawal as evidenced by tremors, restlessness, and altered mental status (Phelps, 2023).
   - The client will remain free from injury throughout their stay.
1. Deficient Fluid Volume related to fever and poor oral intake as evidenced by altered mental status (Phelps, 2023).
   - The client will consume an adequate fluid volume amount with a balanced intake and output during their stay.

Objective Data

- Client's alert and oriented status
- Vital signs: pulse 110, B/P 154/92, RR 20, Temp 99.0 degrees Fahrenheit, SPO2 95% on room air
- The client looks distressed and unkept
- Moderate hand tremors
- Repositioning oneself in bed constantly
- Overweight

Patient Information

A 54-year-old female came in complaining of chest pain, productive cough with green sputum, and difficulty breathing. Upon further assessment, client stated difficulty sleeping, excessive alcohol intake, and showed mild depression, and intense anxiety. Client is grieving the loss of her father for over a year and has no support system.

Nursing Interventions

- Encourage the client to do deep breathing and coughing exercises every hour.
- Monitor the client's respiratory rate and lung sounds every 2 hours.
- Educate the client on the importance of getting up and changing positions slowly.
- Assess adequate lighting in the client's room.
- Provide IV fluids to restore hydration until not needed.
- Monitor the client's blood pressure and heart rate every 2 hours.