N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	**Patient Initials**	**Age**	**Biological Gender**
10/13/25	E.A.	54	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Gender Identity**
Hispanic	Manager at a corporate finance company	Single	Female
Code Status	**Height and Weight**	**Allergies**	**Pronouns**
Full code	63” and 175lbs	No known allergies	She/her

Medical History (5 Points)

Past Medical History: 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 with productive cough, green phlegm, with difficulty breathing

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** The patient stated that she felt “crummy” and weaker. She also started to have some mid-sternal chest pain and a productive cough that had green phlegm with difficulty breathing.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** She is having a stressful time at work and drinks about 4-5 coffees and at least 1-2 alcoholic drinks per day. She also stated that she hasn't been able to get much sleep due to her father's death, which was a little over a year ago.

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?		"Yes, I lost my father a little over a year ago."	
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?	"Yes."	"I just feel so anxious sometimes throughout the day."
Do you feel tired or have little energy?	"Yes."	"Since I don't sleep much, I always have no energy at work."
Do you avoid social situations?	"Yes."	"I get so stressed out during work that I don't have the energy at times to talk to people."
Do you have difficulties with home, school, work, relationships, or responsibilities	"Yes, sometimes."	"Work is the only thing that really stresses me out."
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?	N/A	N/A
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?	"No, I am not."	"I have a hard time sleeping."
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."	N/A
Do you purge after	"No."	N/A

eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**		
Do you have not eat enough or have a loss of appetite?	"No."	N/A
Have you recently experienced unexplained weight loss? **Amount of weight change:**	"No."	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?	"Yes."	"I tend to bite my fingernails a lot."
Do you experience panic attacks?	"No."	N/A
Do you have obsessive or compulsive thoughts?	"No."	N/A
Do you have obsessive or compulsive behaviors?	"No."	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**	"No."	N/A

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?	"I would say maybe like a 4-5."

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
Alone	54	Patient	Use alcohol and smoke ½ pack a day.

If yes to any alcohol or drug use, explain: "I drink about 1-2 alcoholic drinks every day."

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."

If yes, please tell me more about that:"My father died recently."

Are you currently having relationship problems? "No."

What is your sexual orientation: Heterosexual	**Are you sexually active?** "No."	**Do you practice safe sex?** N/A
Please describe your religious values, beliefs, spirituality and/or preference: "I am not religious."		
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? "No."		
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? "I am alone." **How can your family/support system participate in your treatment and care?** "I don't really have family or any support system near me."		
What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) "I drink and I smoke."		
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) "Anything related to my father or work."		
Client raised by: **Natural parents** **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Self-Care: **Independent** **Assisted** **Total Care**		
Education History: **Grade school** **High school** **College** **Other:**		
Reading Skills:		

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:** A little over a year ago **Last Use:** Yesterday	Patient smokes ½ pack a day.
Alcohol	**First Use:** A little over a year ago **Last Use:** Yesterday	Patient drinks at least 1-2 alcoholic drinks a day.
Prescription Medications (Recreational Use)	**First Use:** 3 years ago **Last Use:** Yesterday	Patient takes hydrochlorothiazide for their hypertension.
Marijuana	**First Use:** N/A **Last Use:** N/A	N/A
Heroin	**First Use:** N/A **Last Use:** N/A	N/A
Methamphetamine	**First Use:** N/A **Last Use:** N/A	N/A
Other: Specify	**First Use:** N/A	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	Microzide/ hydrochlorothiazide	Xanax/ alprazolam	Ativan/ lorazepam	Vitamin B1/thiamine	Folvite/ Folic acid
Dose	12.5mg	0.25 mg	1mg	100 mg	1 tab
Frequency	Daily	PRN (as needed)	Daily Q4 for 2 days	Daily	Daily
Route	PO (by mouth)	PO (by mouth)	PO (by mouth)	PO (by mouth)	PO (by mouth)
Classification	Thiazide diuretic, diuretic	Benzodiazepine, anxiolytic, antipanic	Benzodiazepine, an anxiolytic	Vitamins and minerals	Vitamins and minerals
Mechanism of Action	This medication helps lower blood pressure and reduce swelling by excreting through urine. The distal convoluted tubule in the kidneys decreases cardiac output, extracellular fluid volume, or plasma volume, resulting in a decrease in	This medication inhibits the GABA receptors in the brain, which helps calm brain activity. It binds to specific receptors that help control emotional behavior (Jones & Bartlett Learning, 2024).	This medication inhibits the GABA receptors in the brain, which helps calm brain activity. It binds to specific receptors that help control emotional behavior(Jones & Bartlett Learning, 2024).	This medication helps the body convert carbohydrates from food into energy and other essential substances it needs for proper bodily function (Jones & Bartlett Learning, 2024).	This medication helps the body make and keep new cells, especially when the patient is on their period, those who have anemia or are pregnant. After it is absorbed and converted into an active form, it spreads

	blood pressure (Jones & Bartlett Learning, 2024).				throughout the body where it is needed. Following this process, the creation of red blood cells and the prevention of megaloblastic anemia occur, which is crucial for individuals in early pregnancy (Jones & Bartlett Learning, 2024).
Therapeutic Uses	Manage hypertension	Treat generalized anxiety disorder	Treat anxiety	Treat or prevent vitamin B1 deficiency	Prevent and treat folate deficiency that can cause megaloblastic anemia, and prevent serious birth defects in pregnant women
Therapeutic Range (if applicable)	12.5mg-25mg for hypertension	10-100 ng/mL	10-20 ng/mL	N/A	N/A
Reason Client	Patient is	Patient is	Patient is	The patient	Patient is

Taking	taking this medication due to hypertension.	taking this medication due to anxiety.	taking this medication due to anxiety.	is taking this medication to prevent vitamin B1 deficiency, also known as beriberi.	taking this medication to prevent rolate deficiency
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	N/A	The nurse can check the patient's vital signs and assess the current anxiety level.	N/A	N/A	N/A
Contraindications (2)	Anuria; hypersensitivity to hydrochlorothiazide, other thiazides, sulfonamide derivatives, or their components	Acute angle closure glaucoma; pregnancy	Acute angle closure glaucoma, severe respiratory insufficiency	Kidney disease, pregnancy	Alcoholism, kidney disease, or being on dialysis
Side Effects/Adverse Reactions (2)	Hypotension, pancreatitis	Seizures, respiratory depression	Seizures, suicidal ideation	Chest pain, shortness of breath, blue lips	Insomnia, feeling tired, fatigue
Medication/Food Interactions	Corticosteroids - increase electrolyte depletion, especially potassium NSAIDS: decreased the diuretic effect and increased the risk for renal failure Alcohol use: possible	Opioids: increased risk of significant respiratory depression Anticonvulsants, antidepressants, antihistamines; other benzodiazepines, CNS depressants,	Aminophylline, theophylline: possible reduced sedative effects Antidepressants: increased risk of profound respiratory depression, sedation, and	Patiromer: decreases the effectiveness of thiamine Alcohol: It can cause malabsorption if taken with alcohol.	Sulfasalazine: may decrease the body's ability to absorb folate Alcohol: reduces the absorption and increases the eliminatio n of folic

	orthostatic hypotension	psychotropics: possible CNS depressant effects	somnolence Alcohol use: increased CNS depression and severe respiratory depression		acid
Nursing Considerations (2)	Monitor blood pressure, daily weight, intake and output, and assess for any evidence of hypokalemia	Monitor for signs and symptoms of dependence, assess mental status, and monitor signs and symptoms of depression	Be careful for those who have an alcohol or drug abuse history because there is an increased risk of physical and psychological dependence. Make sure that the patient who has depression is receiving an antidepressant before starting because untreated depression could lead to suicidal ideation.	Monitor patients at risk for thiamine deficiency, and monitor creatinine and BUN levels	Assess and monitor individuals at risk for folate deficiency. Monitor the patients who are pregnant

Medications Reference (1) (APA):

Drugs.com, Thiamine Uses, Side Effects & Warnings. (2024).

https://www.drugs.com/mtm/thiamine.html

Drugs.com. Folic acid: uses, dosage, side effects, warnings. (2024).

https://www.drugs.com/folic_acid.html

Jones & Bartlett Learning. (2024). *2024 Nurse's Drug Handbook* (23rd ed.).

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	The patient was sitting down in her chair, frowning. She was wearing comfortable pants and a t-shirt. She is alert and oriented to person, place, time, and situation, and knows why she is being admitted. Patient is well-groomed. Speech is clear and appropriate for the age. Eye contact was maintained throughout the conversation, but I also occasionally looked down at the ground. Behavior was cooperative, calm, and very attentive.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	Patient stated that she was in a gloomy mood.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	The patient is alert and oriented to person, place, time, and situation. The patient showed no signs of memory impairment. The patient was attentive throughout the interview, but showed little enthusiasm for anything.
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** ● **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	The patient stated that she is not having any ideation of homicidal or suicidal ideation. No hallucinations and delusions. She states that she has no compulsions, obsessions, or paranoia. Also stated that she has no idea of flight, perseveration, or loose association.
REASONING: **Judgment (Assess by asking: If you found**	The patient stated that she could take it to the police station and give it to them to see if they

a wallet on the side of the road, what would you do?): **Insight into Illness:**	could track the owner and return it.
MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	The patient is currently independent with all daily living activities. The gait is balanced. There are no abnormal motor activities.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0100	110	154/92	20	99.0 degrees Fahrenheit	95% Room air

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0100	0-10 word scale	Headache	7/10	"It feels like it is throbbing like an elastic band around my head."	1. Assess and monitor pain using the 0-10 word scale every hour. 2. Administer pain meds 3. Give ice packs, dim the lights,

					and minimize sounds in the room

Nursing Care (6 points)

Overview of care provided today: Patient participated in group therapy.

Client complaints: The patient reported no complaints**.**

Participation in therapy/groups: The patient attended group therapy, where she shared her story and was able to relate to others in similar situations.

Medication compliance today: The patient was compliant with all medications.

Behaviors exhibited today: Patient was very cooperative and interactive with others.

Discharge Planning

Discharge location: To her house

Follow up plan: Patient will follow up with the psychiatrist and attend the therapy sessions.

Education needs: The patient needs to be educated on different kinds of coping mechanisms other than drinking and smoking.

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	**Rationale** ● Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**

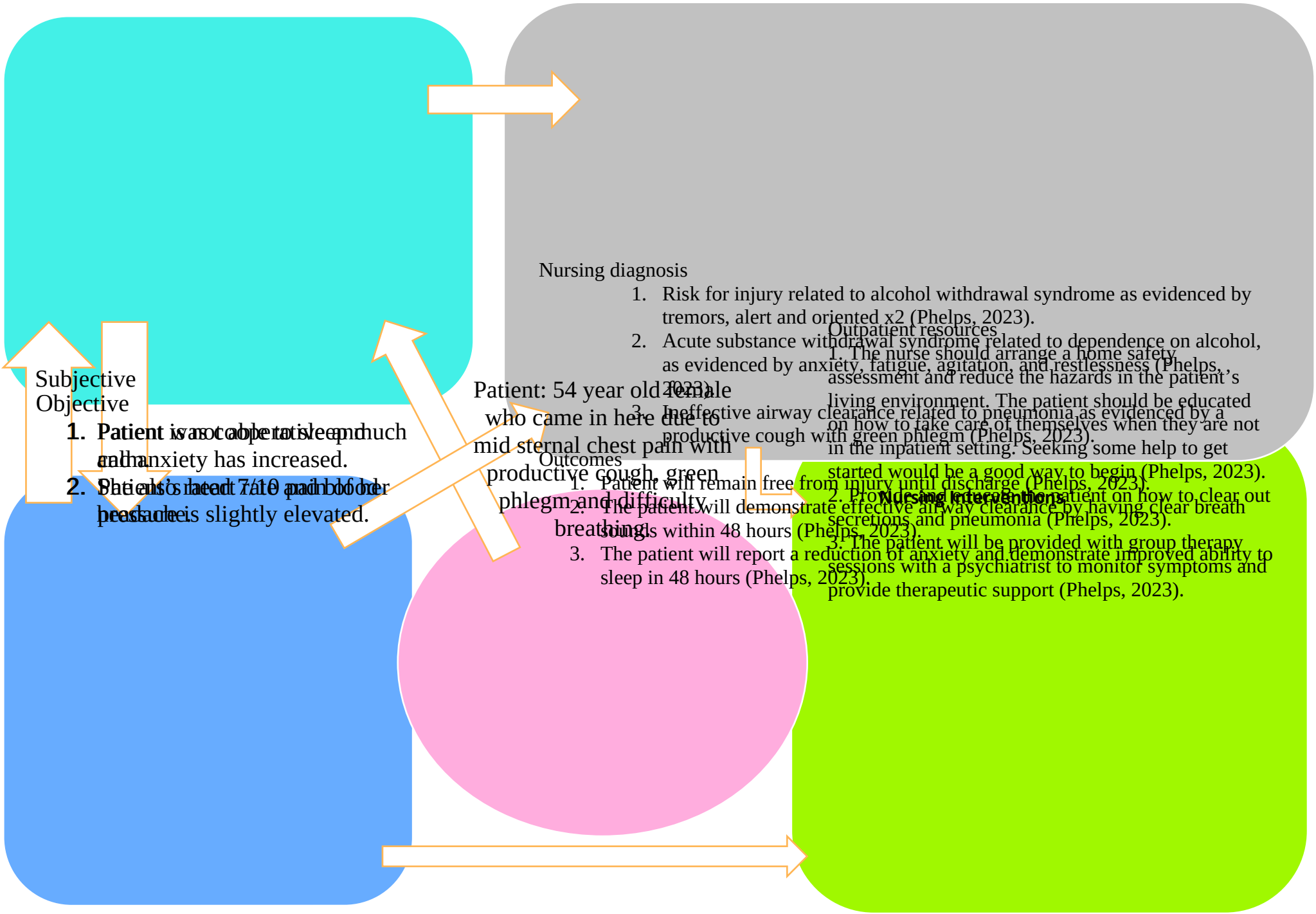
by" components				
1. Risk for injury related to alcohol withdrawal syndrome as evidenced by tremors, alert and oriented x2 (Phelps, 2023).	I chose this nursing diagnosis because she has mild confusion, so she might be able to make decisions physically or mentally in a state to make the right decisions (Phelps, 2023).	1. Patient will remain free from injury until discharge (Phelps, 2023).	1. Implement seizure and fall precautions (Phelps, 2023). 2. Assess neuro status and vital signs as facility protocol (Phelps, 2023). 3. Administer medications as ordered (Phelps, 2023).	1. The nurse should arrange a home safety assessment and reduce the hazards in the patient's living environment. The patient should be educated on how to take care of themselves when they are not in the inpatient setting. Seeking some help to get started would be a good way to begin (Phelps, 2023).
2. Ineffective airway clearance related to pneumonia as evidenced by a productive cough with green phlegm (Phelps, 2023).	I chose this nursing diagnosis because this is affecting her way of breathing.	1. The patient will demonstrate effective airway clearance by having clear breath sounds within 48 hours (Phelps, 2023).	1. Monitor respiratory status every 4 hours (Phelps, 2023). 2. Encourage coughing and deep breathing exercises (Phelps, 2023). 3. Administer bronchodilators as ordered (Phelps, 2023).	1. Provide and educate the patient on how to clear out secretions and pneumonia (Phelps, 2023).
3. Acute substance withdrawal syndrome	I chose this nursing diagnosis because this	1. The patient will report	1. Monitor withdrawal symptoms	2. The patient will be provided with

related to dependence on alcohol, as evidenced by anxiety, fatigue, agitation, and restlessness (Phelps, 2023).	is affecting her way of breathing. I chose this nursing diagnosis because the patient is actively experiencing alcohol withdrawal symptoms due to not drinking alcoholic drinks for the past few days (Phelps, 2023).	a reduction in anxiety and demonstrate an improved ability to sleep within 48 hours (Phelps, 2023).	(Phelps, 2023). 2. Provide a calm, low-stimulation environment (Phelps, 2023). 3. Provide adequate and appropriate emotional support (Phelps, 2023).	group therapy sessions with a psychiatrist to monitor symptoms and provide therapeutic support (Phelps, 2023).

Other References (APA):

Phelps, L.L., (2023). *Nursing diagnosis reference manual.* (12th ed.). Wolters Kluwer.

Concept Map (20 Points):


Subjective
Objective
1. Patient was able to sleep much and anxiety has increased.
2. Patient's heart rate and blood pressure is slightly elevated.
Patient: 54 year old female who came in here due to mid sternal chest pain with productive cough, green phlegm and difficulty breathing.
Nursing diagnosis
1. Risk for injury related to alcohol withdrawal syndrome as evidenced by tremors, alert and oriented x2 (Phelps, 2023).
2. Acute substance withdrawal syndrome related to dependence on alcohol, as evidenced by anxiety, fatigue, agitation, and restlessness (Phelps, 2023).
3. Ineffective airway clearance related to pneumonia as evidenced by a productive cough with green phlegm (Phelps, 2023).
Outcomes
1. Patient will remain free from injury until discharge (Phelps, 2023).
2. The patient will demonstrate effective airway clearance by having clear breath sounds within 48 hours (Phelps, 2023).
3. The patient will report a reduction of anxiety and demonstrate improved ability to sleep in 48 hours (Phelps, 2023).
Nursing interventions
1. Provide education to patient on how to clear out secretions and pneumonia (Phelps, 2023).
2. The patient will be provided with group therapy sessions with a psychiatrist to monitor symptoms and provide therapeutic support (Phelps, 2023).
Outpatient resources
1. The nurse should arrange a home safety assessment and reduce the hazards in the patient's living environment. The patient should be educated on how to take care of themselves when they are not in the inpatient setting. Seeking some help to get started would be a good way to begin (Phelps, 2023).