N323 Care Plan

Lakeview College of Nursing

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Professor Lenard

Demographics (3 points)

Date of Admission	Patient Initials	Age	Biological Gender
02/13/2026	M.L	50	Male
Race/Ethnicity	**Occupation**	**Marital Status**	**Gender Identity**
White	Farmer	Divorced	Male
Code Status	**Height and Weight**	**Allergies**	**Pronouns**
Full	6'2" 81.6 kg	No known	He/Him

Medical History (5 Points)

Past Medical History: Alcohol abuse. Pancreatitis, duodenitis, Jejunitis

Psychiatric Diagnosis: **Depression, Anxiety, Bipolar disorder**

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
02/13/26	Inpatient.	Bipolar disorder, current episode depressed, severe without psychotic thoughts.
NO OTHER PRIORS		

Admission Assessment

Chief Complaint (2 points): "I had relapsed on alcohol after a breakup."

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable)**: Patient has struggled with depression for many years. The patient stated that his ex-girlfriend and him had a traumatic event where he accidentally cut her finger off while working with wood. Patient verbalized that she knew it was an accident. A couple weeks later the patient and ex-girlfriend broke up. This sent him into a spiral with his depression. The patient then went on to drink for a week straight and called the ambulance due to not feeling good.
- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal)**: The patient stated that balancing life, work, and drinking was hard. The patient was getting into arguments with his ex-girlfriend. The client was experiencing sad moods, low motivation, sleeping and eating poorly, easy fatigue, poor concentration, and feeling overwhelmed.

Primary Diagnosis on Admission (2 points): Bipolar disorder, depression episode

Psychosocial Assessment (30 points)

History of Trauma	
Screening Questions:	**Client Answer**
Do you have a history of physical, sexual,	No

emotional, or verbal abuse?	
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, Mom and dad had passed.
Have you experienced any other scary or stressful event in the past that continues to bother you today?	Yes, cutting his ex-girlfriend's finger accidently.
(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		
Sexual Abuse	N/A		
Emotional Abuse	N/A		
Verbal Abuse	N/A		
Military	N/A		
Other	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?	No	
Do you avoid social situations?	Yes	Reports feeling this way when drinking; patient does not like being out and about. When the alcohol wears off, the patient no longer feels this way.
Do you have difficulties with home, school, work, relationships, or responsibilities	Yes	When drinking, the patient has a hard time keeping up with work and family. The patient stated that he secludes himself. The patient does not feel this way when sober.
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	No	

hours that you sleep each night?		
Do you have difficulty falling asleep?	Yes	When the patient drinks for many days straight he reports not being able to fall asleep. The patient reports that he tries to stay sober but drinks when he is feeling depressed.
Do you frequently awaken during the night?	Yes	About once a night every night. Patient reports being able to go back to sleep quickly.
Do you have nightmares?	No	
Are you satisfied with your sleep?	Yes	The patient stated that he gets 5-6 hours of sleep and that is normal for him. The patient feels full of energy throughout the entire day.
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?	Yes	The patient reports overeating on holidays only. Patient reported eating until he feels like he is about to burst. Patient reports not feeling this way any other time.
Do you purge after	No	

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?	Yes	Patient reports feeling this way when he is drinking. The patient does not want to eat food at all. When the client sobers back up, his appetite does come back with no problems.
Have you recently experienced unexplained weight loss? **Amount of weight change:**	No	
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	Yes	The patient reports feeling an ache in his chest and feeling hot on his face. The patient feels this way

other symptoms of anxiety?		when worried about something. When the patient deals with the problem, the patient feels back to normal.
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	**N/A**	

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?	3 when sober, 8 when drinking.
How would you rate your anxiety on a scale of 1-10?	2 or 3 when sober, 7 when drinking.

Personal/Family History

Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs**?
N/A			

If yes to any alcohol or drug use, explain: N/A

Family Medical History: Mom: Melanoma Cancer Dad: Prostate cancer

Family Psychiatric History (including suicide): **Sister:** Depression

Family alcohol or drug use (not covered by those client lives with): Sister: Had a pill problem (not specified due to being unknown by patient) but sister has been clean for 35 years.

Do you have children? **If yes, what are their ages?** The client has a daughter that is 20 years old.

Who are your children with now? She is currently in Effingham with her biological mother. Patient stated he hopes she is coming to pick him up 02/16/26 after release.		
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? N/A **If yes, please tell me more about that:**		
Are you currently having relationship problems? Yes, the patient and his ex-girlfriend broke up after being together for three years.		
What is your sexual orientation: Straight	**Are you sexually active?** Yes	**Do you practice safe sex?** No
Please describe your religious values, beliefs, spirituality and/or preference: Agnostic, the patient reported that he believes in higher ups but doesn't know exactly what/who he believes in. Not sure if God is what he would term it.		
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? The patient was unable to identify anything.		
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? Daughter, Sister, Aunt **How can your family/support system participate in your treatment and care?** The patient's aunt		

offered to let him live with her until he is able to get back up on his own feet.

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.)

The patient was able to provide healthy coping by saying, taking walks, being outside, taking hot baths, and reading books.

What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.)

The patient reports feeling triggered by thinking about the bills while he was getting treatment. The client was worried about how he would be paying for his house due to needing to pay payments using his phone but was unable to do so while getting treatment. The client was also triggered by not sure what to do about finances due to not working at the moment.

Client raised by: Natural Parents

Natural parents

Grandparents

Adoptive parents

Foster parents

Other (describe):

Self-Care: Independent

Independent

Assisted

Total Care

Education History: College

Grade school

High school

College, Got a bachelor's degree in Ag. Engineering

Other:

Reading Skills: Yes

Yes

No

Limited

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: N/A** **Last Use: N/A**	N/A

Alcohol	**First Use:** 22 years old **Last Use:** 1 week ago	The patient reported drinking almost daily. He reported before his relapse that he was 16 months sober. The patient said there are times where he doesn't drink, then he does. Reported it was like a “rollercoaster”.
Prescription Medications (Recreational Use)	**First Use: N/A** **Last Use: N/A**	**N/A**
Marijuana	**First Use: 20 years old** **Last Use: 2 weeks ago**	Patient reported doing this at night to help him sleep every night.
Heroin	**First Use: N/A** **Last Use: N/A**	**N/A**
Methamphetamine	**First Use: N/A** **Last Use: N/A**	**N/A**
Mushrooms	**First Use: 19-20 years old** **Last Use: 20 years ago**	The patient reported stopping after his daughter was born. The patient reported doing this occasionally.
LSD	**First Use: 21 years old** **Last Use: 25 years ago**	Patient reported stopping a couple years before his daughter was born. The patient reported using it on rare occasions.
Cocaine	**First use: 22 years old**	Patient reported stopping after his

	Last use: Over 20 years ago	daughter was born. Patient reported not doing this often when he was using it.

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	Acetaminophen	Ariprazole	Benztropine mesylate	Calcium carbonate	Chlordiazepoxide
Dose	650 mg	10 mg	2 mg	500 mg	25 mg
Frequency	4 hrs. PRN	Once daily	2 times daily PRN	3 times daily PRN	6 hrs. PRN
Route	Oral	Oral	Injection	Oral	oral
Classification	NSAID	Second generation antipsychotic	Anticholinergic	Antacid	Benzodiazepine
Mechanism of Action	Inhibition of brain-specific	Partial agonist at dopamine	Blocks acetylcholine receptors in	Neutralizes gastric acid by reacting	Enhances the effect of GABA.

	enzymes.	D2 and serotonin 5-HT1A receptors.	the central nervous system.	with hydrochloric acid in the stomach.	
Therapeutic Uses	Mild to moderate pain.	Bipolar, Schizophrenia.	Treatment of drug induced movement disorders .	Relief of heartburn, acid indigestion, upset stomach.	Alcohol withdrawal management .
Therapeutic Range (if applicable)	Serum level 10-20 mcg/mL	Plasma range 150-210 ng/mL	N/A	Serum calcium 8.6-10.2 mg/dL	N/A
Reason Client Taking	Pain management	Client treated for bipolar disorder	Client treated for tremors	Client reported heartburn	Alcohol withdrawal management
For PRN Medications ONLY: One Nursing Intervention That Could Be	Ice packs	N/A	Reposition the client	Do not eat 3-4 hours before bed	Get a fan and cooling blanket

Attempted Prior to Use of this Medication					
Contraindications (2)	1. Liver disease 2. Hypersensitivity	1. Treatment of dementia related psychosis 2. Hypersensitivity	1. Urinary retention 2. Glaucoma	1. Hypercalcemia 2. Kidney stones	1. Monitor LOC 2. Put on seizure precautions
Side Effects/Adverse Reactions (2)	1. Hepatotoxicity 2. Hypersensitivit	1. Restlessness 2. Nausea/ vomi	1. Dry mouth 2. Confusion	1. Hypercalcemia 2. Constipation	1. Respiratory depression

	y reactions	ting			2. Drowsiness
Medication/Food Interactions	Alcohol. Warfarin can increase bleeding risk	CNS depressants, increase sedation	Alcohol, increased sedation/dizziness	Best absorbed with food but can decrease absorption of certain medications	Alcohol, increased respiratory depression Other opioids, increases risk of overdose
Nursing Considerations (2)	1. Monitor liver function 2. Monitor daily intake	1. Monitor mental status 2. Monitor for restlessness	1. Monitor patients gait for falls 2. Monitor for dry	1. Monitor calcium levels 2. Encourage fluid intak	1. Monitor LOC and O2 sat 2. Implement fall and

			mouth, confusion, urinary retention	e	seizure precautions
Brand/Generic	Diphenhydramine	Folic Acid	Gabapentin	Haloperidol	Hydroxyzine
Dose	50 mg	1 mg	300 mg	5 mg	25 mg
Frequency	2 times daily PRN	Daily	3 times daily	6 hrs. PRN	3 times daily
Route	Injection	Oral	Oral	Oral	Oral
Classification	First-generation antihistamine	Vitamin	Anticonvulsant	First-generation antipsychotic	Antihistamine
Mechanism of Action	Blocks histamine	Required for DNA	Modulates voltage-	Blocks dopamine	Blocks histamine

	H1 receptors	synthesis and red blood cell production	gated calcium channels in the CNS	receptors in the brain	receptors in the CNS
Therapeutic Uses	Client treated for tremors	Extra therapy in alcohol use disorder	Neuropathic pain	Acute psychosis, Delirium	Anxiety, pruritus
Therapeutic Range (if applicable)	N/A	Serum folate 2-20 ng/mL	N/A	N/A	N/A
Reason Client Taking	Client experiencing tremors	Client with chronic alcohol use	Client undergoing alcohol withdrawal	Client treated for tremors	Reduce anxiety
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this	Deep breathing techniques	N/A	N/A	Reposition the client and elevate head of bed	N/A

Medication					
Contraindications (2)	1. Glaucoma 2. Acute asthma attack	1. B12 deficiency 2. Hypersensitivity	1. Hypersensitivity 2. Renal impairment	1. Parkinson's 2. CNS depression	1. Hypersensitivity 2. Pregnancy
Side Effects/Adverse Reactions (2)	1. Dizziness 2. Dry mouth	1. Abdominal discomfort 2. Nausea	1. Dizziness 2. Unsteady gait	1. Restlessness 2. Altered mental status	1. Sedation 2. Constipation
Medication/Food Interactions	Other anticholinergic medications, increased	Alcohol, lower absorption	Antacids, lowers absorption, take 2 hours	Alcohol, increases sedative affects	Alcohol, CNS depression

	risk for toxicity		apart		
Nursing Considerations (2)	1. Monitor fall risk 2. Monitor LOC	1. Assess for B12 vitamin deficiency 2. Monitor CBC levels	1. Do not stop taking abruptly 2. Put on fall risk	1. Fall precautions 2. Use the lowest does you can	1. Encourage lots of fluids 2. Monitor levels of sedation
Brand/Generic	Levofloxacin	Lorazepam	Metronidazole	Multivitamin minerals	Naltrexone
Dose	750 mg	1 mg	500 mg	1 tablet	50 mg
Frequency	Once daily	6 hrs. PRN	Every 8 hours	Once daily	Once daily
Route	Oral	Oral	Oral	Oral	Oral

Classification	Broad-spectrum antibacterial	Benzodiazepine	Antibiotic	Vitamin supplement	Opioid antagonist
Mechanism of Action	Prevents DNA replication which causes bacterial cell death	Enhances the effect of GABA in the CN	Disrupts DNA synthesis in anaerobic bacteria and protozoa	Replaces essential vitamins and minerals	Blocks opioid receptors in the brain
Therapeutic Uses	Skin and soft tissue infections	Acute anxiety disorders	Bacterial infections	Treatment of vitamin deficiencies	Alcohol/ Opioid use disorder
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	Bacterial infection due to open wound on the chin	Reduce acute anxiety	Bacterial infection due to open wound on the chin	Treat/ prevent nutritional deficiencies	Help with abstinence from alcohol
For PRN	N/A	Go to a quiet	N/A	N/A	N/A

Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication		room to relax			
Contraindications (2)	1. History of tendon disorders 2. Hypersensitivity	1. Sleep apnea 2. Respiratory insufficiency	1. Alcohol use 2. Hypersensitivity to metronidazole	1. Excess vitamin levels 2. High levels or iron	1. Opioid dependence 2. Liver failure
Side Effects/Adverse Reactions (2)	1. Tendon ruptu re	1. Respiratory depre	1. Metallic tastes.	1. Upset GI. 2. Dark stool	1. Upset GI. 2. Hepatoxic

	2. Dysrhythmias.	ssion. 2. Sedation.	2. Peripheral neuropathy.	s.	ity.
Medication/Food Interactions	Corticosteroids, risk of tendon rupture.	Alcohol, increased respiratory depression. Opioids, risk of fatal respiratory depression.	Warfarin, increased bleeding risk Lithium, could cause toxic levels .	Warfarin, increased bleeding risk.	Alcohol, increases liver toxicity Opioid medication, blocks the effect of the medication.
Nursing Considerations (2)	1. Asses to make sure there are no prior cardiac	1. Keep oxygen close by. 2. Monitor O2 and	1. Teach to avoid alcohol until 72 hours after dosin	1. Eat food with medication to reduce the risk of	1. Assess liver function by doing labs.

	issues. 2. Monitor tendon inflammation.	LOC.	g. 2. Monitor for any tingling in the arms/ legs.	upsetting GI. 2. Monitor iron levels with labs,	2. Confirm that the client is not using opioids.

Medications Reference (1) (APA):

Frandsen, G., & Pennington, S. S. (2025). *Abrams' clinical drug therapy: Rationales for Nursing Practice*. Wolters Kluwer Health.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming)**: **Alertness:**	The patient is A&Ox4 well-groomed with no signs of distress. The patient is relaxed and not tense. Speech is normal and steady, not broken, and not slurred. The patient holds conversation and makes jokes. The patient is very well

Orientation: **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	tempered and not angry or upset. The patient maintains eye contact when speaking and being spoken to.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	The patient reports being excited for discharge tomorrow and in a good mood. The patient reports being overstimulated at times due to other people on the floor. The patient's affect seems to be high in spirits. The patient was seen laughing and giving high fives to nurses. The mood reported and affect seem to correlate very well.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	The patient was A&Ox4. The client was aware of person, time, place, and situation. The client had no memory impairment and was able to remember all past life events easily. The client's attention was focused on our conversation the entire time and never veered off.
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation**:	The patient reported no homicidal or suicidal

Delusions: **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	ideations, delusions, any hallucinations, obsessions, compulsions, paranoia, flight of ideas, perseveration, or loos association.
REASONING: **Judgment** (**Assess by asking: If you found a wallet on the side of the road, what would you do?)**: **Insight into Illness:**	The patient reported that he would investigate the wallet and see if there was an identification card to see if he knew who owned it. If he knew the person, he would return it to them whether he liked the person or not. If he did not know who the person was, he would try to find a way to get it to the owner. The client also noted that he would search through to be nosey to see what was in there. I think this is a normal thought process anyone would have. The one thing that stuck out to me is that he would surf through it, but I think that is just curiosity. I think

	the client had a great response.
MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	The patient has reading glasses for things that are up close. The patient's gait is steady/smooth and not wobbly. There were no abnormal motor activities. All motions were well coordinated.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
08:23	115	123/78	17	97.5	97

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
08:20	1-10 Said a 0	None	0	None	None

Nursing Care (6 points)

Overview of care provided today: Gave oral and IM medications, informed about side effects that could be experienced. A mental exam was completed as well.

Client complaints: The patient complains of no pain or any mental issues.

Participation in therapy / groups: Went to 9:30, 13:00, and 14:00 hour group therapies.

Medication compliance today: Was compliant to all medications except nicotine patches. The patient refused this medication due to never smoking.

Behaviors exhibited today: The patient was well mannered and had a good temperament. The patient was seen reading a book and sat in the lounge all day when not in groups.

Discharge Planning

Discharge location: The patient will be discharged to his own home.

Follow up plan: Start taking Levofloxacin and Metronidazole. Continue taking Calcium carbonate, Chlordiazepoxide, Gabapentin, Multivitamin minerals, and Trazodone. The patient will have to report with PCP in 1-2 weeks. The client will be discharged on 2/16/26.

Education needs: The client will need education about individual medication and their side effects/adverse reactions. Education about alcohol abuse complications should also be given due to relapse.

Nursing Diagnosis (25 points)

Must be NANDA approved nursing diagnosis and listed in order of priority

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

nursing diagnosis with "related to" and "as evidenced by" components	nursing diagnosis was chosen	**diagnosis)**		**(1 per diagnosis)**
1. Ineffective coping is related to mood instability as evidenced by the history of alcohol	The client stated that he uses alcohol to deal with problems.	1. The client will use healthy coping strategies instead of turning to alcoho	1.Determine five positive coping mechanisms. 2. Encourage the client to go to therapy. 3. Watch the client act out one of the positive coping mechanisms.	1. Go to AA support groups. This can help with the abuse of alcohol by talking in a group with other people who are going through similar experiences.

abuse.		l.		
2. Risk for self-harm related to mood instability as evidenced by feeling overwhelmed.	Before being on the floor, the client was feeling overwhelmed and very depressed.	1. If the client is feeling like self-harm, the client will tell a trusted person.	1. Educate the client on the effects of alcohol and mood. 2.Ask the client if they have any suicidal ideations. 3. Make a list of trusted people they can call if they are fighting with self-harm thoughts.	1. Provide the client with the 988 suicide and crisis lifeline. The client can call this number at any time of day or night, and someone will always answer to help with self-harm thoughts.
3. Impaired health maintenance related to substance	When using alcohol, it can impair your decision-making skills. This can cause	1. The client will stay on track with the treatment plan upon discharge and follow up with PCP in	1. Education on why it is important to take medications exactly when they should be taken. 2. Assess barriers to adherence to	1. Community Mental Health Center. They can help with medication adherence, therapy, and help with substance abuse.

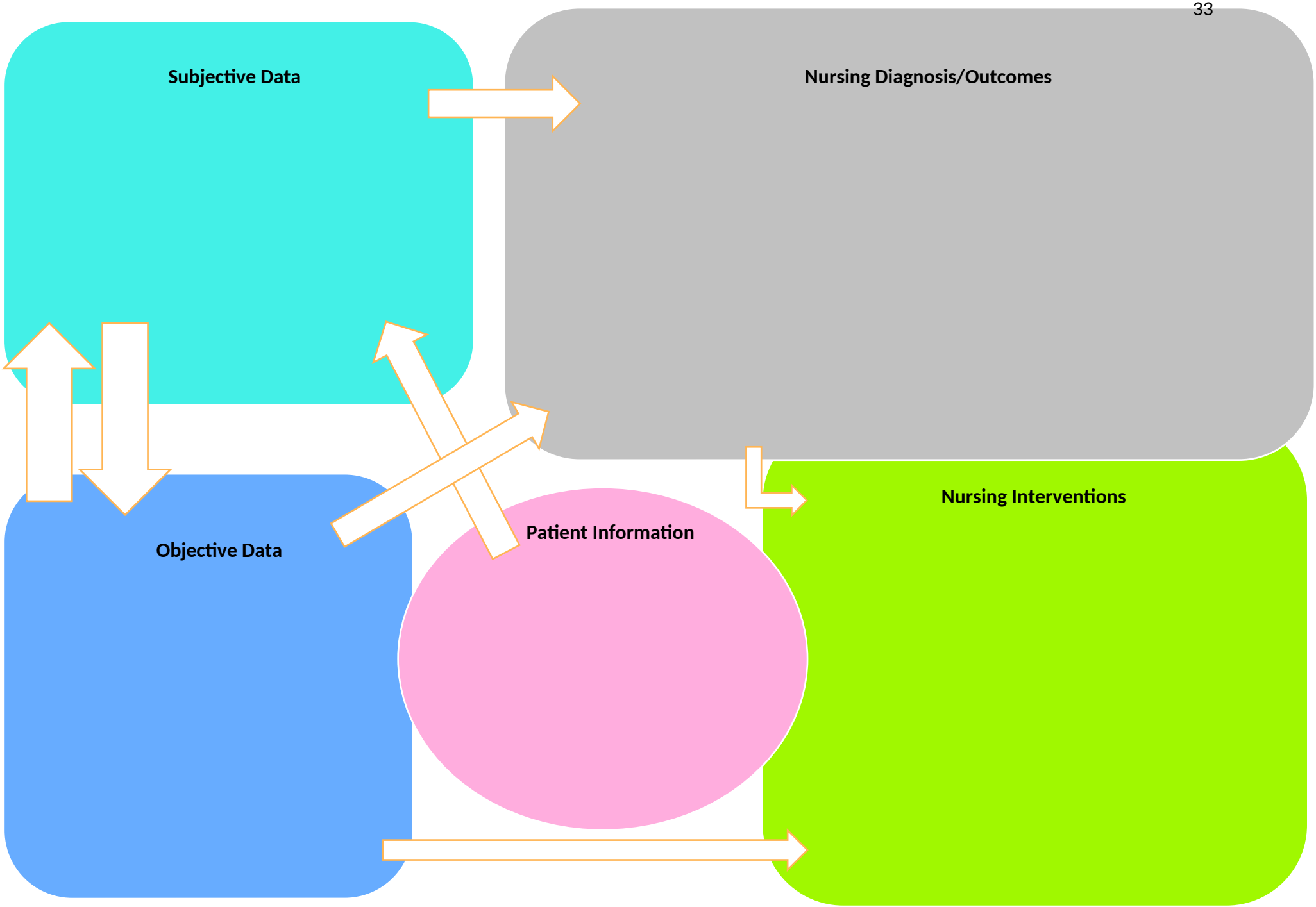
abuse as evidenced by the history of alcohol abuse.	the client to forget to take medications.	1-2 weeks.	medications. (side effects, motivation). 3. Collaborate with psychiatry team members.	

Other References (APA):

Videbeck, S. L. (2026). *Psychiatric-mental health nursing* (10th ed.). Wolters Kluwer.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2020). *Mosby's Diagnostic and Laboratory Test Reference*. Elsevier.

Concept Map (20 Points):


Subjective Data
Nursing Diagnosis/Outcomes
Nursing Interventions
Objective Data
Patient Information