N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 12/05/22	**Patient Initials** A.M.	**Age** 12	**Gender** Female
Race/Ethnicity African American	**Occupation** N/A	**Marital Status** Single	**Allergies** Peanut
Code Status Full Code	**Observation Status** Inpatient	**Height** 5'1"	**Weight** 141 lbs

Medical History (5 Points)

Past Medical History: Asthma

Significant Psychiatric History: disruptive mood dysregulation disorder, attention deficit hyperactivity disorder, major depressive disorder without psychosis

Family History: mental health issues run in the family, patient unable to specify

Social History (tobacco/alcohol/drugs): The patient has never used tobacco, smokeless tobacco, alcohol, or drugs

Living Situation: Patient lives with her mother

Strengths: The patient is motivated to get better, she likes music, and watching sports, and coloring/drawing

Support System: The patient's mother is her support system, but they are currently having issues

Admission Assessment

Chief Complaint (2 points): HI and physical aggression towards mother, impulsiveness

Contributing Factors (10 points):

Factors that lead to admission: anger and homicidal thinking

History of suicide attempts: held scissors to throat, banging head against wall

Primary Diagnosis on Admission (2 points): aggression

Psychosocial Assessment (30 points)

History of Trauma				
No lifetime experience: Pt is emotionally/physically abused by her mother. **Witness of trauma/abuse:** Yes				
	Current	**Past (what age)**	**Secondary Trauma (response that comes from caring for another person with trauma)**	**Describe**
Physical Abuse	**Yes**	**Current**	**Anger**	**Patient gets physical with her mother.**
Sexual Abuse	N/A	N/A	N/A	N/A
Emotional Abuse	**Yes**	**Current**	**Anger**	**Patient gets physical with her mother.**
Neglect	N/A	N/A	N/A	N/A
Exploitation	N/A	N/A	N/A	N/A
Crime	N/A	N/A	N/A	N/A
Military	N/A	N/A	N/A	N/A
Natural Disaster	N/A	N/A	N/A	N/A
Loss	N/A	N/A	N/A	N/A
Other	N/A	N/A	N/A	N/A
Presenting Problems				
Problematic Areas	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**	

Depressed or sad mood	**Yes**	No	**Patient stated she is sad often.**
Loss of energy or interest in activities/school	Yes	**No**	Denies
Deterioration in hygiene and/or grooming	Yes	**No**	Denies
Social withdrawal or isolation	Yes	**No**	Denies
Difficulties with home, school, work, relationships, or responsibilities	**Yes**	No	**Patient has relationship difficulties with her mother.**
Sleeping Patterns	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Change in numbers of hours/night	Yes	**No**	Denies
Difficulty falling asleep	**Yes**	No	**Patient stated she has a hard time falling asleep at night.**
Frequently awakening during night	Yes	**No**	Denies
Early morning awakenings	Yes	**No**	Denies
Nightmares/dreams	Yes	**No**	Denies
Other	Yes	**No**	Denies
Eating Habits	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Changes in eating habits: overeating/loss of appetite	Yes	**No**	Denies
Binge eating and/or purging	Yes	**No**	Denies
Unexplained weight loss? **Amount of weight change:**	Yes	**No**	Denies
Use of laxatives or excessive exercise	Yes	**No**	Denies

Anxiety Symptoms	Presenting?		Describe (frequency, intensity, duration, occurrence)
Anxiety behaviors (pacing, tremors, etc.)	**Yes**	**No**	Denies
Panic attacks	**Yes**	**No**	Denies
Obsessive/compulsive thoughts	**Yes**	**No**	Denies
Obsessive/compulsive behaviors	**Yes**	**No**	Denies
Impact on daily living or avoidance of situations/objects due to levels of anxiety	**Yes**	**No**	Denies
Rating Scale			
How would you rate your depression on a scale of 1-10?			**3/10**
How would you rate your anxiety on a scale of 1-10?			**0/10**
Current Stressors of Areas of Life Affected by Presenting Problem (work, school, family, legal, social, financial)			
Problematic Area	**Presenting?**		**Describe (frequency, intensity, duration, occurrence)**
Work	Yes	**No**	Denies
School	Yes	**No**	Denies
Family	**Yes**	**No**	**The patient and her mother fight with one another frequently.**
Legal	Yes	**No**	Denies
Social	Yes	**No**	Denies
Financial	Yes	**No**	Denies
Other	Yes	**No**	Denies

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient				
Dates	**Facility/MD/ Therapist**	**Inpatient/ Outpatient**	**Reason for Treatment**	**Response/Outcome**
Garfield 2020	**Inpatient Outpatient Other:**	**Inpatient**	**Aggression**	**No improvement** **Some improvement** **Significant improvement**
Riverside 2020	**Inpatient Outpatient Other:**	**Inpatient**	**Aggression**	**No improvement** **Some improvement** **Significant improvement**
Residential at Rice May 2020	**Inpatient Outpatient Other:**	**Inpatient**	**Aggression**	**No improvement** **Some improvement** **Significant improvement**
Personal/Family History				
Who lives with you?	**Age**	**Relationship**	**Do they use substances?**	
Angela	N/A	Mother	Yes	**No**
			Yes	No
			Yes	No
			Yes	No
			Yes	No
If yes to any substance use, explain: Denies substance abuse				

Children (age and gender): N/A

Who are children with now?

Household dysfunction, including separation/divorce/death/incarceration:

Emotional and physical abuse from mother

Current relationship problems: Mother

Number of marriages: N/A

Sexual Orientation:	**Is client sexually active?**	**Does client practice safe sex?**
Straight	**Yes** **No**	**Yes** **No**

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

Patient is not religious

Ethnic/cultural factors/traditions/current activity: N/A

Describe:

Current/Past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): N/A

How can your family/support system participate in your treatment and care?

Patient stated she just wants her mom to be there for her throughout her time at the Pavillion.

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Significant childhood issues impacting current illness:

Emotional and physical abuse from mother.

Atmosphere of childhood home:

Loving
Comfortable
Chaotic

Abusive: emotional and physical abuse **Supportive** **Other:**
Self-Care: **Independent** **Assisted** **Total Care**
Family History of Mental Illness (diagnosis/suicide/relation/etc.) Mental health disorders run in the family, but the patient is unable to specify which kinds.
History of Substance Use: No history of substance use
Education History: **Grade school** **High school** **College** **Other:**
Reading Skills: **Yes** **No** **Limited**
Primary Language: English
Problems in school: Patient said she had no problems at school.
Discharge
Client goals for treatment: Decrease aggression and increase her overall mood
Where will client go when discharged? Home

Outpatient Resources (15 points)

Resource	Rationale
1. Behavioral Therapy	**1.** Patient has aggression problems.

2. Family Counseling	**2.** Patient and mother have relationship problems d/t the emotional/physical abuse.
3. Psychiatrist	**3.** Pt has HI and MDD.

Current Medications (10 points)
Complete all of your client's psychiatric medications

Brand/ Generic	**Risperidone (Risperdal)**	**Clonidine (Catapres)**	**Dexmethylphenidate LA (Focalin XR)**	**Melatonin (Syncrodin)**	**Fluoxetine (Prozac)**
Dose	1mg	0.05 mg	20 mg	9 mg	10 mg
Frequency	Twice a day	3 times a day	Once a day	Before bed	Once a day
Route	PO	PO	PO	PO	PO
Classification	Atypical Antipsychotics	Antihypertensives	Schedule two controlled substance	Endogenous hormone	SSRI
Mechanism of Action	Serotonin and norepinephrine reuptake inhibition (Jones & Bartlett Learning, 2022).	stimulating the pre-synaptic alpha 2 adrenoceptors, thereby decreasing noradrenaline release from both central and peripheral sympathetic nerve terminals (Jones & Bartlett Learning, 2022).	block the reuptake of norepinephrine and dopamine into the presynaptic neuron and increase the release of these monoamines into the extraneuronal space (Jones & Bartlett Learning, 2022).	binds to melatonin receptor type 1A, which then acts on adenylate cylcase and the inhibition of a cAMP signal transduction pathway (Jones & Bartlett Learning, 2022).	blocking the reuptake of serotonin into presynaptic serotonin neurons by blocking the reuptake transporter protein located in the presynaptic terminal (Jones & Bartlett Learning, 2022).
Therapeutic Uses	Used to treat schizophrenia, bipolar disorder,	Treating high blood pressure	Used to treat ADHD	treat delayed sleep phase	depression, obsessive-compulsive

	and irritability			and circadian rhythm sleep disorders in the blind and provide some insomnia relief	disorder (OCD), bulimia nervosa, premenstrual dysphoric disorder (PMDD), and panic disorder
Therapeutic Range (if applicable)	2-3 mg once a day	0.2-0.6 mg per day	10 mg once daily for a max of 40 mg a day	0.5 to 5 mg	20-60 mg a day
Reason Client Taking	To improve thinking, mood, and behavior	To treat hypertension	The patient has ADHD	delayed sleep-wake phase disorder, some sleep disorders in children	To treat the patient's depression
Contraindications (2)	Anaphylaxis Opioids	Anticoagulant therapy Bleeding diathesis	Glaucoma Tourette's syndrome	Autoimmune conditions Pregnancy	MAOI therapy Bipolar disorder
Side Effects/ Adverse Reactions (2)	Anxiety Difficulty concentrating	Anxiety Chest pain	Trouble sleeping Nervousness	Irritability constipation	Anxiety Difficult falling asleep or staying asleep
Medication/ Food Interactions	Should not be mixed with tea or cola	Don't have with caffeine Melatonin	Caffeine Clonidine	Caffeine Anticonvulsants	Anticonvulsants Calcium channel blockers
Nursing Considerations (2)	Monitor for AMS Monitor for changes in BP (Jones & Bartlett Learning, 2022).	Monitor blood pressure frequently Monitor pulse frequently (Jones & Bartlett Learning, 2022).	Monitor heart rate Monitor for seizures (Jones & Bartlett Learning, 2022).	Caution patient to not drive and avoid alcohol (Jones & Bartlett	Discontinue if GI upset occurs and keep out of reach of young children (Jones & Bartlett

				Learning, 2022).	Learning, 2022).

Brand/Generic	Albuterol (Proventil HFA)	N/A Patient is only taking 6 medications	N/A Patient is only taking 6 medications	N/A Patient is only taking 6 medications	N/A Patient is only taking 6 medications
Dose	90 mcg	N/A	N/A	N/A	N/A
Frequency	prn	N/A	N/A	N/A	N/A
Route	PO	N/A	N/A	N/A	N/A
Classification	Adrenergic bronchodilators	N/A	N/A	N/A	N/A
Mechanism of Action	acts on beta-2 adrenergic receptors to relax the bronchial smooth muscle. (Jones & Bartlett Learning, 2022).	N/A	N/A	N/A	N/A
Therapeutic Uses	to treat or prevent bronchospasm in patients with asthma, bronchitis, emphysema, and other lung diseases	N/A	N/A	N/A	N/A
Therapeutic Range (if applicable)	2.5 mg in nebulizer 3-4 times per day prn	N/A	N/A	N/A	N/A
Reason Client Taking	Patient has asthma	N/A	N/A	N/A	N/A
Contraindications (2)	Diabetes Overactive thyroid gland	N/A	N/A	N/A	N/A
Side Effects/Adverse Reactions (2)	Nervousness Headache	N/A	N/A	N/A	N/A
Medication/Food Interactions	Coffee MAOIs	N/A	N/A	N/A	N/A

Nursing Considerations (2)	Monitor respiratory rate Monitor lung sounds (Jones & Bartlett Learning, 2022).	N/A	N/A	N/A	N/A

Medications Reference (1) (APA):

Jones & Bartlett Learning, LLC. (2022). 2022 Nurse's Drug Handbook (20th ed.).

Mental Status Exam Findings (20 points)

APPEARANCE: **Behavior:** **Build:** **Attitude:** **Speech:** **Interpersonal style:** **Mood:** **Affect:**	Appears alert and oriented x person, place, and time, well groomed, no acute distress. Patient is cooperative and calm. Patients' mood was anxious, and her mood was congruent. Speech was coherent. The patient was engaged, oriented, and talkative. The patient had a hard time focusing but was easily redirectable.
MAIN THOUGHT CONTENT: **Ideations:** **Delusions:** **Illusions:** **Obsessions:** **Compulsions:** **Phobias:**	Patient denies have any delusions, illusions, obsessions, compulsions, or phobias currently. Patient has a history of suicide ideations and is depressed.
ORIENTATION: **Sensorium:** **Thought Content:**	Patient was A& O x4 but had a hard time focusing. Sensorium was not assessed. Thought content is realistic logical.
MEMORY: **Remote:**	Long and short memory intact.
REASONING: **Judgment:** **Calculations:** **Intelligence:** **Abstraction:** **Impulse Control:**	Pts judgment was intact. Impulse control was observed to be average besides whenever she is angry and gets aggressive with others. Calculation and abstraction were not assessed.

INSIGHT:	The insight was poor.
GAIT: **Assistive Devices:** **Posture:** **Muscle Tone:** **Strength:** **Motor Movements:**	The patient had no assistive devices. The posture was relaxed and slouched during the conversations. Muscle tone, strength, and motor movement was appropriate for age and height.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0900	105	131/87	18	98.3	99%
1300	92	129/68	16	98.0	97%

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0900	Numeric Scale	N/A	0	N/A	N/A
1300	Numeric Scale	N/A	0	N/A	N/A

Dietary Data (2 points)

Dietary Intake	
Percentage of Meal Consumed: **Breakfast:** 75% **Lunch:** 100% **Dinner:** 100%	**Oral Fluid Intake with Meals (in mL)** **Breakfast:** 120 mL of milk **Lunch:** 260 mL of milk and water **Dinner:** 240 of milk

Discharge Planning (4 points)

Discharge Plans (Yours for the client): Patient will go home with mother if DCFS clears it.

They will have to have therapy together. The patient will also see a behavioral psychiatrist.

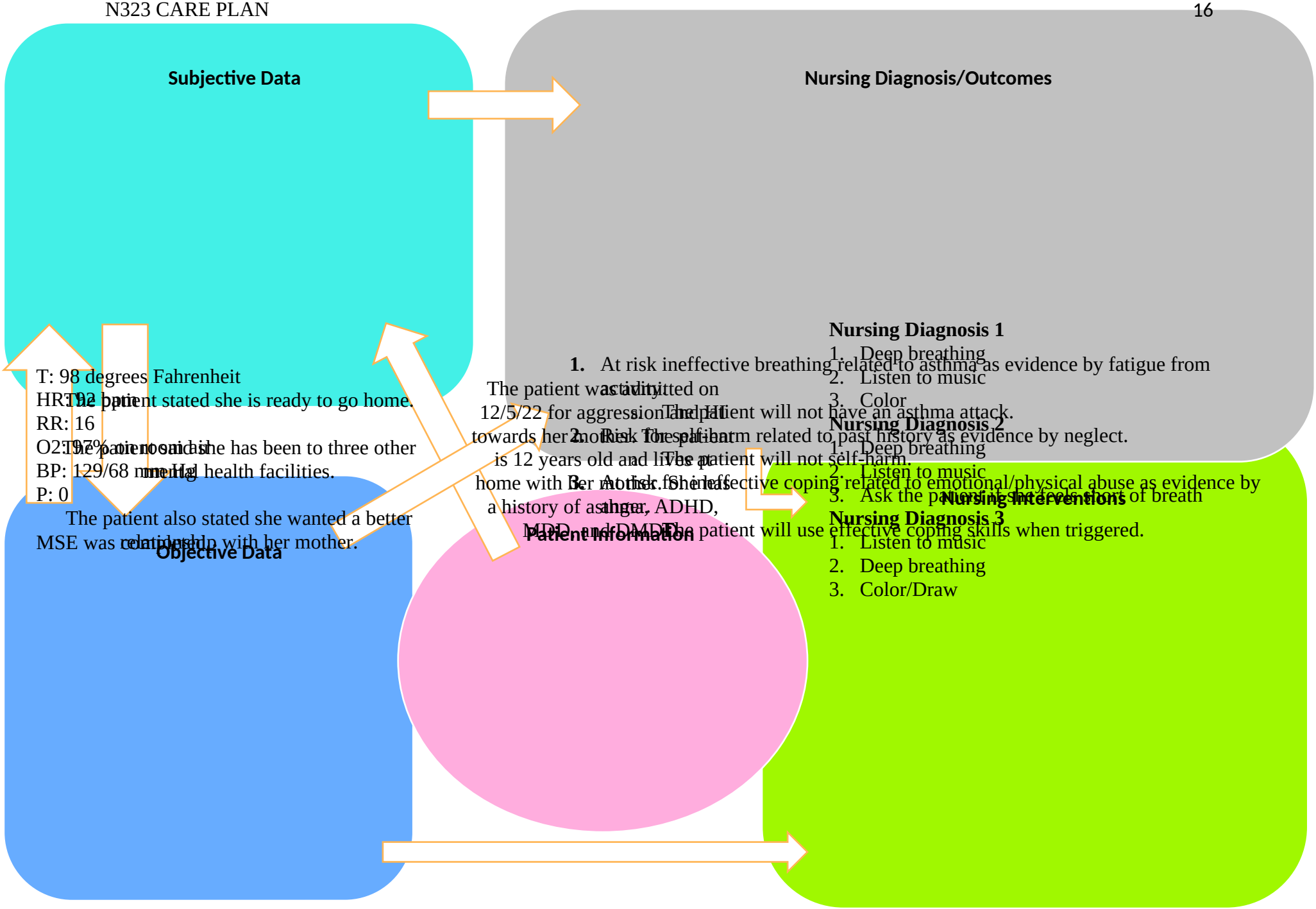
Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Immediate Interventions (At admission)**	**Intermediate Interventions (During hospitalization)**	**Community Interventions (Prior to discharge)**
1. At risk ineffective breathing related to asthma as evidence by fatigue from activity.	Patient has a history of asthma and gets asthma attacks when fatigued from activity.	**1.**Deep breathing **2**. listening to music **3.** Coloring	**1.** Deep breathing **2.** Drawing **3.** Playing with cards	**1.** Educate the patient on how to use her inhaler. **2.** Educate the patient for when to use the inhaler. **3.** Educate the patient on when to call for help.
2. Risk for self-harm related to past history as evidence by neglect.	Patient has a history of self-harming.	**1.** Inhaler **2.** Deep breathing **3.** Ask the patient if she feels short of breath.	**1.** Inhaler **2.** Deep breathing **3.** Drawing	**1.** Provide the patient resources. **2.** Offer the patient a safe place. **3.** Educate the patient on how to handle intrusive thoughts.

3. At risk for ineffective coping related to emotional/physical abuse as evidence by anger.	Patient gets aggressive when something triggers her.	**1.** Listen to music **2.** Deep breathing **3.** Coloring	**1.** Deep breathing **2.** Coloring **3.** Drawing	**1.** Educate the patient on how to handle intrusive thoughts. **2.** Ensure the patient has a therapist that specializes in intrusive thoughts and how to cope. **3.** Ensure the patient is referred to a psychiatrist.

Other References (APA):

Concept Map (20 Points):


Subjective Data
The patient stated she is ready to go home.
The patient stated she has been to three other mental health facilities.
The patient also stated she wanted a better relationship with her mother.
Objective Data
T: 98 degrees Fahrenheit
HR: 92 bpm
RR: 16
O2: 97% on room air
BP: 129/68 mmHg
P: 0
MSE was unremarkable.
Patient Information
The patient was admitted on 12/5/22 for aggression and HI towards her mother. She is 12 years old and lives at home with her mother. She has a history of asthma, ADHD, MDD, and DMDD.
Nursing Diagnosis/Outcomes
1. At risk ineffective breathing related to asthma as evidence by fatigue from activity
2. Risk for self-harm related to past history as evidence by neglect.
3. At risk for ineffective coping related to emotional/physical abuse as evidence by anger.
1. The patient will not have an asthma attack.
2. The patient will not self-harm.
3. The patient will use effective coping skills when triggered.
Nursing Interventions
Nursing Diagnosis 1
1. Deep breathing
2. Listen to music
3. Color
Nursing Diagnosis 2
1. Deep breathing
2. Listen to music
3. Ask the patient how she feels
Nursing Diagnosis 3
1. Listen to music
2. Deep breathing
3. Color/Draw