N323 Care Plan

Lakeview College of Nursing

Jessica Runde

Demographics (3 points)

Date of Admission 2/24/2024	Patient Initials AT	Age 13	Biological Gender female
Race/Ethnicity white	Occupation n/a	Marital Status single	Gender Identity female
Code Status full	Height and Weight 5-foot 3 inch & 135 pounds	Allergies Amoxicillin; penicillin	Pronouns She/her

Medical History (5 Points)

Past Medical History: N/A

Psychiatric Diagnosis: Major Depressive Disorder

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
N/A – Patient has not been a patient at this facility before this		

Admission Assessment

Chief Complaint (2 points): Hallucinations- voices talking to her, feels like something is kicking her or trying to physically hurt her

Contributing Factors (10 points):

o **Factors that lead to admission (address triggers and coping mechanisms if applicable):** The patient said the hallucinations have been happening "for a long time." She said that she will hear voices and "it feels like something is kicking me or trying to physically hurt me." The patient said that the voices will come and go

and that they do not last very long. When I asked how long the hallucinations last, she said they last for "only a minute or two." The patient says that school is what triggers the hallucinations. The patient said, "I try to block them out by thinking of something that makes me happy" to help cope with the hallucinations. The patient said that medications help with hallucinations.

- o **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** The patient says that it makes it hard for her to go to school because the hallucinations typically happen at school. The patient said, "it makes schoolwork hard to do."

Primary Diagnosis on Admission (2 points): Major Depressive Disorder

Psychosocial Assessment (30 points)

History of Trauma		
Screening Questions:	**Client Answer**	
Do you have a history of physical, sexual, emotional, or verbal abuse?	**No**	
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?	Brother, father, and grandpa all passed away. Patient said she was very close with all of them and it makes her sad.	
Have you experienced any other scary or stressful event in the past that continues to bother you today?	Stepdad used to physically abuse her mother	
(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	Patient said that school, homework, the people at school all make her feel depressed and stressed. Patient said it "happens almost every day I go to school." Patient also said that it could last all day.	
Do you feel tired or have little energy?	Yes	Patient said that "I feel the most tired at nighttime."	
Do you avoid social situations?	"Sometimes"	Patient said that "I do not always feel like talking to people."	
Do you have difficulties with home, school, work, relationships, or responsibilities	"I have difficulties at home and school"	The patient said that she is the oldest kid in her family, so she has to do "more than anyone else." The patient also said that she has difficulties at school because of "some people and bad grades."	
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	Yes	Client just claims that she does not get a lot of hours of sleep at night and that she usually wakes	

sleep each night?		up tired in the morning.
Do you have difficulty falling asleep?	Yes	Patient said "I have trouble falling back asleep" after she wakes up.
Do you frequently awaken during the night?	Yes	The patient says that she will "toss and turn" and wake up in the middle of the night.
Do you have nightmares?	No	No
Are you satisfied with your sleep?	No	The patient just wishes she would get more sleep at 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?	No	n/a
Do you purge after eating? Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.	No	n/a
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?	"I sometimes pace."	Patient said that she will sometimes catch herself pacing at home because she is nervous, mad, or

		upset.
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 yourself right know?** **(If the client says yes, you must ensure facility staff are aware)**	no	n/a

Rating Scale		
How would you rate your depression on a scale of 1-10?	"right now a 0"	
How would you rate your anxiety on a scale of 1-10?	"right now a 0"	

Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**

Brooke	31	mother	No
Jonah	12	Brother	no
Sophia	6	Sister	no
Hailey	6	sister	no

If yes to any alcohol or drug use, explain:

Family Medical History: n/a

Family Psychiatric History (including suicide): mother-depression/anxiety; father-

depression

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: The patient's father died when she was young, her mother got remarried and divorced her stepdad. Also the patient said that her brother and grandfather also passed away.

Are you currently having relationship problems? No

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: Patient has no

religion but believes in God and heaven.

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?

"my mom and friends"

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

Patient said my mom "takes me to the doctor for my appointments and will talk to me when I

need someone to talk to."

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.)
Patient said that she is "still learning some coping skills." Patient also said that sometimes she will play with her fidgets or focus on her breathing.

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

Client raised by:

  <mark>Natural parents</mark>
  Grandparents
  Adoptive parents
  Foster parents
  Other (describe):

Self-Care:

  <mark>Independent</mark>
  Assisted
  Total Care

Education History:

  <mark>Grade school</mark>
  High school
  College
  Other:

Reading Skills:

<mark>Yes</mark> **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	N/A
Alcohol	**First Use:** N/A **Last Use:** N/A	N/A
Prescription Medications (Recreational Use)	**First Use:** N/A **Last Use:** N/A	N/A
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 **Last Use:** N/A	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	fluoxetine hydrochloride; Prozac	aripiprazole; Ablify	acetaminophen	calcium carbonate; Titralac	
Dose	20 mg	5 mg	325 mg	750 mg	
Frequency	Every morning	HS	Every 6 hours	Every 6 hours	
Route	Oral	Oral	Oral	Oral	
Classification	*Pharmacologic class:* Selective serotonin reuptake inhibitors (Jones & Bartlett Learning, 2022, p. 571) *Therapeutic class:* Antidepressant (Jones & Bartlett Learning, 2022, p. 571)	*Pharmacologic Class:* Atypical antipsychotic (Jones & Bartlett Learning, 2022, p. 93) *Therapeutic Class:* Antipsychotic (Jones & Bartlett Learning, 2022, p. 93)	*Pharmacologic Class:* Nonsalicylate, para-aminophenol derivative (Jones & Bartlett Learning, 2022, p. 9) *Therapeutic Class:* Antipyretic, nonopioid analgesic (Jones & Bartlett Learning, 2022, p. 9)	*Pharmacologic Class:* Calcium salts (Jones & Bartlett Learning, 2022, p. 191) *Therapeutic Class:* Antacid, antihypermagnesemic, antihyperphosphatemic, antihypocalcemic, calcium replacement, cardiotonic (Jones & Bartlett Learning, 2022, p. 191)	
Mechanism of Action	"Selectively inhibits reuptake of the neurotransmitter	"Aripiprazole acts as a partial agonist at dopamine	"Inhibits the enzyme cyclooxygenase, blocking	"Oral forms also neutralize or buffer stomach acid to relieve discomfort caused by	

	serotonin by CNS neurons and increases the amount of serotonin available in nerve synapses" (Jones & Bartlett Learning, 2022, p. 572).	receptors and serotonin receptors" (Jones & Bartlett Learning, 2022, p. 97).	prostaglandin production and interfering with pain impulse generation in peripheral nervous system" (Jones & Bartlett Learning, 2022, p. 11).	hyperacidity" (Jones & Bartlett Learning, 2022, p. 191).	
Therapeutic Uses	The therapeutic use of this medication is to treat acute depression (Jones & Bartlett Learning, 2022, p. 571).	The therapeutic use of this medication for this patient could be used to "treat depression in patients already taking an antidepressant" (Jones & Bartlett Learning, 2022, p. 95).	The therapeutic use of this medication is to relieve the patient's pain.	The therapeutic use of this medication is to help the patient with any GI upset from their other medications.	
Therapeutic Range (if applicable)	n/a	n/a	n/a	n/a	
Reason Client Taking	This medication is used for the patient's major depressive disorder.	This medication is used for the patient's mood.	This medication is used if the patient has any pain.	This medication is used for when the patient has GI upset.	
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	n/a	n/a	n/a	n/a	
Contraindications (2)	1.hypersensitivity to fluoxetine (Jones & Bartlett Learning, 2022, p. 572) 2.other selective serotonin reuptake inhibitors (Jones & Bartlett Learning, 2022, p.572)	1. hypersensitivity to aripiprazole (Jones & Bartlett Learning, 2022, p. 97) 2. hypersensitivity to the components of aripiprazole (Jones & Bartlett	1. hypersensitivity to acetaminophen (Jones & Bartlett Learning, 2022, p. 11) 2. severe hepatic impairment (Jones & Bartlett	1. "concurrent use of calcium supplements" (Jones & Bartlett Learning, 2022, p. 193) 2. hypersensitivity to calcium salts (Jones & Bartlett Learning, 2022, p. 193)	

		Learning, 2022, p. 97)	Learning, 2022, p. 11)		
Side Effects/Adverse Reactions (2)	1.anxiety (Jones & Bartlett Learning, 2022, p. 573) 2.insomnia (Jones & Bartlett Learning, 2022, p. 573)	1. hallucinations (Jones & Bartlett Learning, 2022, p. 97) 2. delusions (Jones & Bartlett Learning, 2022, p. 97)	1. anaphylaxis (Jones & Bartlett Learning, 2022, p. 11) 2. fatigue (Jones & Bartlett Learning, 2022, p. 11)	1. hypotension (Jones & Bartlett Learning, 2022, p. 193) 2. hypercalcemia (Jones & Bartlett Learning, 2022, p. 193)	
Medication/Food Interactions	Patient should not take this medication if they are also taking alprazolam, aspirin, NSAIDs, antidepressants (Jones & Bartlett Learning, 2022, p. 572).	Patient should not take this medication if they are also taking antihypertensives (Jones & Bartlett Learning, 2022, p. 97). Patient should also avoid this medication with alcohol use (Jones & Bartlett Learning, 2022, p.97).	Patient should avoid this medication if they are also taking propranolol, anticholinergics, barbiturates, warfarin (Jones & Bartlett Learning, 2022, p. 11).	Patient should avoid this medication if they are taking bisphosphonates, other calcium supplements, have an intake of caffeine, or eat high-fiber foods (Jones & Bartlett Learning, 2022, p. 193).	
Nursing Considerations (2)	1."Use fluoxetine cautiously in patients with history or seizures and in children, because of potential for adverse effects" (Jones & Bartlett Learning, 2022, p. 573). 2.Also people who have hypokalemia should be careful taking this medication (Jones & Bartlett Learning, 2022, p. 573).	1. "Monitor patient for difficulty swallowing or excessive somnolence" (Jones & Bartlett Learning, 2022, p. 99). 2. Also monitor patient's who are taking other medications that could worsen CNS effects (Jones & Bartlett Learning, 2022, p. 99).	1. Patient should take this medication with food to avoid an upset GI tract. 2. "Calculate total daily intake of acetaminophen including other products that may contain acetaminophen so maximum daily dosage is not exceeded (Jones & Bartlett Learning, 2022, p. 11).	1. "Monitor serum calcium level in all patients, as ordered" (Jones & Bartlett Learning, 2022, p. 194). 2. Have the patient chew the tablet and drink water after swallowing (Jones & Bartlett Learning, 2022, p. 194).	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2022). *2023 Nurse's drug handbook* (22nd ed.). Jones & Bartlett

Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	Patient's posture is appropriate, patient is in appropriate clothing for her age, patient did her morning hygiene. Patient is alert and oriented times 4. Patient behavior is appropriate. Patient has speech that is understandable and appropriate. Patient is making direct eye contact with me while having a conversation. Patient does not get distracted during our conversation.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	The patient said her mood is "good" today. The patient's affect was good spirits and happy. The patient's affect and mood were consistent with each other.
COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	The patient was alert and oriented, the patient had no memory impairment, and her attention span was good.
MAIN THOUGHT CONTENT: **Homicidal Ideations or Suicidal Ideation:** **Delusions:** **Hallucinations:** • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** **Compulsions:** **Paranoia:** **Flight of Ideas:** **Perseveration:** **Loose Association:**	None None Patient was having hallucinations prior to being admitted to the Pavilion. The patient was having auditory hallucinations. None None None None None None
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	"I would try looking for the person that lost their wallet then I would give it to the authorities." N/A

MOTOR ACTIVITY:	
Assistive Devices:	n/a
Gait:	n/a
Abnormal Motor Activities:	n/a

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0645	90	122/79	18	97.7 F	100%

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	0/10	n/a	n/a	n/a	n/a

Nursing Care (6 points)

Overview of care provided today: The care for the patient today was to make sure that their symptoms did not worsen. The patient was also supposed to be active in group to help them.

Client complaints: The patient had no complaints today. Her past complaints consisted of her hallucinations that she was having.

Participation in therapy / groups: The patient did participate in the group that was provided during the day. She also participated in the hours she spent learning school.

Medication compliance today: The patient agreed to take the medication in the morning at the appropriate time.

Behaviors exhibited today: The patient exhibited no inappropriate behavior and claimed she is in a "good mood today."

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Discharge Planning

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Discharge location: The patient is supposed to be discharged on March 4, 2024, from The Pavilion.

Follow up plan: There was no follow-up plan listed.

Education needs: The patient's education needs consisted of contacting her provider if any abnormal symptoms follow leaving the facility.

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

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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. Potential for suicide related to depressed mood as evidenced by the patient having major depressive disorder and the patient experiencing losses from close family	This is a very important nursing diagnosis because if the patient has thoughts of suicide, then they could possibly take their own life.	1.The goal of this outcome is for the patients to understand ways to cope with their depression, so they do not experience suicidal thoughts.	1.Complete a suicide assessment for the patient (Swaringen & Wright, 2019, p. 745). 2. Administer any antidepressant medications as ordered. 3. Teach the family members of the patient of the signs and symptoms of the	1. If my patient is having suicidal thoughts then I would have them admitted to a mental health facility, such as The Pavilion.

members at a young age.			patient's possible suicidal thoughts.	
2. Need for health teaching related to the patient being "unfamiliar wih the causes, signs and symptoms, and treatment of depression" as evidenced by the patient only being thirteen years old (Swaringen & Wright, 2019, p. 746).	This nursing diagnosis was chosen because it is important for people at any age to be aware of the possibility of depression. If a patient does not know that they have depression, they could go untreated, and the symptoms may worsen.	**1.** The outcome goal for this patient would be for them to understand the signs and symptoms of depression so that they know when to seek help.	**1.** Assess any barriers to learning that the patient may have. **2.** Assess the patient's present knowledge regarding any signs and symptoms of depression. **3.** Inform the patient of the suicidal effects the patients could receive from any antidepressant medications they are prescribed.	**1.** I could provide this patient with a brochure that shows all the signs, symptoms, treatment, and prevention of depression. I also would recommend that they see or call their provider if they have any questions.
3. Potential for hopelessness related to losses of loved ones as evidenced by the patient stating that she lost her father, brother and grandfather and was sad about it.	This is an important nursing diagnosis because if the patient experiences hopelessness for a long time, they could possibly not see the point of living any longer which could cause	**1.** The outcome goal for this patient would be to find the patient a good support system that they can talk to. This could help with their feelings of hopelessness.	**1.** Assess the patient's signs of hopelessness. **2.** Encourage the patient to verbalize their feelings. **3.** Assess the patient for possible signs of suicide.	**1.** If the patient has this diagnosis, then I would recommend cognitive behavioral therapy. This would be a good session for them to express and verbalize their feelings.

	suicidal thoughts.			

Other References (APA):

Swaringen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical*

    surgical, pediatric, maternity, and psychiatric-mental health. St. Louis, MO: Elsevier

Concept Map (20 Points):

Subjective Data

The patient said that she was in a good mood today.
The patient had no complaints of any pain.
The patient said that she was excited to get discharged.
The patient said that she was having auditory hallucinations prior to being admitted.
The patient said that she gets sad when she thinks about the loss of her loved ones.

Nursing Diagnosis/Outcomes

1. Potential for suicide related to depressed mood as evidenced by the patient having major depressive disorder and the patient experiencing losses from close family members at a young age. Outcome: This is a very important nursing diagnosis because if the patient has thoughts of suicide, then they could possibly take their own life.

2. Need for health teaching related to the patient being "unfamiliar with the causes, signs and symptoms, and treatment of depression" as evidenced by the patient only being thirteen years old (p. 746). Outcome: This nursing diagnosis was chosen because it is important for people at any age to be aware of the possibility of depression. If a patient does not know that they have depression they could go untreated, and the symptoms may worsen.

3. Potential for hopelessness related to losses of loved ones as evidenced by the patient stating that she lost her father, brother and grandfather and was sad about it. Outcome: This is an important nursing diagnosis because if the patient experiences hopelessness for a long time, they could possibly not see the point of living any longer which could cause suicidal thoughts.

Objective Data

The patient was not portraying any signs of pain.
The patient's vitals were in the normal range.
The patient seemed happy when she was talking to me.
The patient was interacting in group and with other patients.
The patient did her hygiene in the morning.
The patient was dressed and acted appropriately for her age.

Patient Information

A 13-year-old female was admitted to the facility on 2/24/2024. The patient's passed medical history is major depressive disorder; her chief complaint and reasoning for being admitted was her recent onset of hallucinations.

Nursing Interventions

Nursing Diagnosis 1: Complete a suicide assessment for the patient (p. 745). Administer any antidepressant medications as ordered. Teach the family members of the patient of the signs and symptoms of the patient's possible suicidal thoughts.
Nursing Diagnosis 2: Assess any barriers to learning that the patient may have. Assess the patient's present knowledge regarding any signs and symptoms of depression. Inform the patient of the suicidal effects the patients could receive from any antidepressant medications they are prescribed.
Nursing Diagnosis 3: Assess the patient's signs of hopelessness. Encourage the patient to verbalize their feelings. Assess the patient for possible signs of suicide.