N323 Care Plan

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission 9/20/2025	**Patient Initials** AZ	**Age** 11 years old	**Biological Gender** Female
Race/Ethnicity African American	**Occupation Student**	**Marital Status**	**Gender Identity**
Code Status Full code	**Height and Weight 5ft and 94lb**	**Allergies N/A**	**Pronouns She/her**

Medical History (5 Points)

Past Medical History: Asthma

Psychiatric Diagnosis: ADHD, Anxiety, Depression, Disruptive Mood Dysregulation Disorder (DMDD)

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
1 year ago	**inpatient**	**ADHD**

Admission Assessment

Chief Complaint (2 points): Brought to hospital by father after recent fight at school; reported fire-setting of bed, self-harm (cutting), increased sadness/hopelessness. Patient stated: "I ran away, I had thoughts of wanting to die."

Contributing Factors (10 points):

Onset**:** Symptoms have worsened over the past several weeks.

Location**:** Emotional, behavioral, and psychosocial functioning.

Duration: Ongoing for more than a year, with recent escalation in severity.

Characteristics: Sadness, hopelessness, suicidal ideation, self-injury (cutting with scissors and popsicle sticks), fire-setting, property destruction, aggression (yelling, screaming, hitting doors, climbing nursing stations), and elopement behaviors (jumping from vehicles, wandering in community).

Aggravating Factors: Suspension from school, poor peer relationships, lack of maternal support, strained relationship with father, impulsivity.

Relieving Factors: Enjoys drawing and group activities when engaged; distraction helps temporarily.

Treatments Tried: Outpatient therapy and medications (guanfacine, risperidone).

Severity/Impact: Severe. Patient is unsafe at home, high risk for suicide and self-harm, and unable to function appropriately at school or in community.

Primary Diagnosis on Admission (2 points):

Disruptive mood dysregulation disorder

Psychosocial Assessment (30 points)

History of Trauma	
Screening Questions:	**Client Answer**
Do you have a history of physical, sexual, emotional, or verbal abuse?	"Yes, I experienced verbal abuse from classmates at school. I have not experienced physical or sexual 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?	**No**
Have you experienced any other scary or stressful event in the past that continues to bother you today?	**No**
(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting	**(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.)		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**	**Yes (age 9)**	**Classmates**
Verbal Abuse	**No**	**Yes (age 11)**	**Classmates**
Military	**No**	**No**	**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 feel sad and hopeless**	The client reports feeling sad and hopeless most days for the past several weeks**,** with moderate intensity that affects her motivation and energy. She appears tearful at times and **s**louched during the interview, consistent with her report.	
Do you feel tired or have little energy?	**Yes, I feel tired most of the time.**	The client reports feeling tired daily, with moderate intensity, making it difficult to complete tasks at home and school. She was observed yawning and appearing fatigued during the session.	
Do you avoid social situations?	**No**		
Do you have	**Yes,** I have	The client states she struggles with schoolwork	

difficulties with home, school, work, relationships, or responsibilities	trouble managing school and home responsibilities	and home tasks frequently, describing ongoing challenges over the past several months. She demonstrates poor organization in her description of tasks.
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?	**NO**	**N/A**
Do you have difficulty falling asleep?	**No**	**N/A**
Do you frequently awaken during the night?	**No**	**N/A**
Do you have nightmares?	**No**	**N/A**
Are you satisfied with your sleep?	**YES**	
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**	
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	**No**	
Do you have not eat enough or have a loss of appetite?	**No**	
Have you recently experienced unexplained weight loss?	**NO**	

Amount of weight change:		
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 pace and feel tremors when anxious	The client reports intermittent pacing and tremors occurring several times per week, typically triggered by stress at school. She was observed fidgeting with her hands during the interview.
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?	**yes**	The client reports having wished she were dead several times in the past week, with moderate intensity. She states these thoughts are distressing but not constant. During the interview, she appeared calm and able to discuss these thoughts openly.
Have you ever tried to kill yourself?	**yes**	The client reports a prior suicide attempt, describing it as a single occurrence in the past. She acknowledges the attempt and shows insight into the danger of self-harm.
If the client answered either of the previous questions "yes", you must ask the client: **Are you having thoughts of killing yourself right know?**	**Not right now**	The client denies current suicidal thoughts. Observations during the assessment indicate she is engaged, maintains eye contact, and demonstrates appropriate insight and judgment regarding safety.

(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?		**5/10**	
How would you rate your anxiety on a scale of 1-10?		**5/10**	
Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
Terence Alexzander	**62 years old**	**Dad**	**N/A**
If yes to any alcohol or drug use, explain: N/A			
Family Medical History: Mom has mental health condition			
Family Psychiatric History (including suicide): NO			
Family alcohol or drug use (not covered by those client lives with): No			
Do you have children? If yes, what are their ages? No **Who are your children with now?** N/A			
Have you experienced parental separation or divorce, or loss/death/ or incarceration of family or friends? No **If yes, please tell me more about that:** N/A			

Are you currently having relationship problems?		
What is your sexual orientation: female	**Are you sexually active? No**	**Do you practice safe sex? N/A**
Please describe your religious values, beliefs, spirituality and/or preference: Christianity		
Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? Patient denies.		
Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): patient denies legal issues		
Whom would you consider your support system? Patient state no one. **How can your family/support system participate in your treatment and care? "**I don't know**."**		
What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.) Playing basketball, drawing		
What are your triggers? (A trigger is something that you have identified that brings on or worsens your mental health symptoms.) patient states Stress at school, conflict with peers, lack of support.		
Client raised by natural parents(dad and mom) **Natural parents** yes **Grandparents** **Adoptive parents** **Foster parents** **Other (describe):**		
Self-Care: **Independent** **Assisted** **Total Care**		
Education History: **Grade school** Currently in 6th grade **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) No	**First Use: N/A** **Last Use: N/A**	**N/A**
Alcohol No	**First Use: N/A** **Last Use: N/A**	**N/A**
Prescription Medications (Recreational Use)	**First Use: started at age 9** **Last Use: currently using for** **albuterol 90/inh**	**Q4H**
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**
Other: Specify	**First Use:N/A**	**N/A**

	Last Use:N/A	

Current Psychiatric Medications (10 points)
Complete all of your client's psychiatric medications
All information listed in this section must be pertinent to your patient.

Brand/ Generic	guanFACINE	risperidone	risperiDONE	Albuterol HFA (PRN)	Hydroxyzine pamoate (PRN)
Dose	2mg	0.5 mg	0.25mg	90 mcg/inh	25mg
Frequency	HS	HS	QAM	Q4H	Q6H
Route	Oral	Oral	Oral	Inhalation	Oral
Classification	Alpha-2A adrenergic agonist (Jones & Bartlett, 2024)	Atypical antipsychotic (Jones & Bartlett, 2024)	Atypical antipsychotic (Jones & Bartlett, 2024)	Beta-2 adrenergic agonist (Jones & Bartlett, 2024)	Antihistamine / anxiolytic (Jones & Bartlett, 2024)
Mechanism of Action	Stimulates alpha-2A receptors in CNS to	Dopamine D2 and serotonin 5-HT2A receptor	Dopamine D2 and serotonin 5-HT2A receptor	Stimulates beta-2 receptors in bronchial	Histamine H1 receptor antagonist (Jones

	reduce sympathetic outflow (Jones & Bartlett, 2024)	antagonist (Jones & Bartlett, 2024)	antagonist (Jones & Bartlett, 2024)	smooth muscle to cause bronchodilation (Jones & Bartlett, 2024)	& Bartlett, 2024)
Therapeutic Uses	Reduce impulsivity, hyperactivity, emotional dysregulation (Jones & Bartlett, 2024)	Manage aggression, irritability, severe behavioral dysregulation (Jones & Bartlett, 2024)	Dopamine D2 and serotonin 5-HT2A receptor antagonist (Jones & Bartlett, 2024)	Treat bronchospasm, asthma exacerbations (Jones & Bartlett, 2024)	Anxiety, agitation, sleep (Jones & Bartlett, 2024)
Therapeutic Range (if applicable)	N/A	N/A	N/A	N/A	N/A
Reason Client Taking	DMDD/ ADHD	DMDD	DMDD	Asthma	Anxiety/ agitation
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	Behavioral de-escalation, structured activities before PRN use (Jones & Bartlett, 2024)	De-escalation techniques, quiet room before PRN (Jones & Bartlett, 2024)	De-escalation techniques, quiet room before PRN (Jones & Bartlett, 2024)	Encourage deep breathing and relaxation before use (Jones & Bartlett, 2024)	Relaxation techniques, deep breathing before PRN (Jones & Bartlett, 2024)
Contraindications (2)	Severe bradycardia, advanced heart block without pacemaker (Jones & Bartlett, 2024)	Hypersensitivity, severe CNS depression (Jones & Bartlett, 2024)	Hypersensitivity, severe CNS depression (Jones & Bartlett, 2024)	Hypersensitivity, tachyarrhythmia (Jones & Bartlett, 2024)	Hypersensitivity, prolonged QT (Jones & Bartlett, 2024)
Side Effects/Adver	hypotension (Jones	Sedation, weight gain	Sedation, weight gain	Tremor, palpitations	Drowsiness, dry mouth

se Reactions (2)	& Bartlett, 2024)	(Jones & Bartlett, 2024)	(Jones & Bartlett, 2024)	(Jones & Bartlett, 2024)	(Jones & Bartlett, 2024)
Medication/ Food Interactions	CNS depressants. (Jones & Bartlett, 2024)	CNS depressants, antihypertensives, (Jones & Bartlett, 2024)	CNS depressants, antihypertensives (Jones & Bartlett, 2024)	Beta-blockers (Jones & Bartlett, 2024)	CNS depressants (Jones & Bartlett, 2024)
Nursing Considerations (2)	Monitor BP & pulse; taper gradually if discontinuing. (Jones & Bartlett, 2024)	Monitor EPS, metabolic parameters; educate on side effects/adherence (Jones & Bartlett, 2024)	Monitor EPS, metabolic parameters; educate on side effects/adherence (Jones & Bartlett, 2024)	Monitor HR and respiratory status; educate on proper inhaler technique (Jones & Bartlett, 2024)	Monitor sedation, educate on fall risk. (Jones & Bartlett, 2024)

Medications Reference (1) (APA):

Jones & Bartlett. (2024). NDA Nurse's Drug Handbook. Jones & Bartlett Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** **Alertness:** **Orientation:** **Behavior:** **Speech:** **Eye Contact:** **Attentiveness:**	Appearance appropriate for age, grooming adequate. Alert and oriented ×3 (person/place/time). Behavior restless and agitated (climbing, hitting doors). Speech clear and coherent. Eye contacts intermittent. Attentiveness distractible, needs redirection.
MOOD: **How is your mood today?** **Affect:** **Consistency between mood and affect?**	The patient reports feeling "bad," expressing sadness and anger about being hospitalized; affect is dysphoric and irritable, congruent with the stated mood.

COGNITION: **Alertness:** **Orientation:** **Memory Impairment:** **Attention:**	The client is alert and oriented to person, place, and time (×3), demonstrates intact recent and remote memory, and is able to maintain attention during the interview despite occasional agitation.
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 client has a history of suicidal thoughts and self-harm but denies current suicidal or homicidal thoughts. She has no delusions, hallucinations, obsessions, or compulsions, and her thinking is clear without loose associations or flight of ideas.
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** **Insight into Illness:**	The client shows impaired judgment, demonstrated by risky behaviors like self-harm and fire-setting. Her insight is poor, as she does not fully understand her mental health condition or the dangers of her actions.
MOTOR ACTIVITY: **Assistive Devices:** **Gait:** **Abnormal Motor Activities:**	The client's motor activity is agitated and restless. She does not require assistive devices and demonstrates a normal gait when observed. Abnormal motor activities include climbing, hitting doors, and impulsive movements.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
8:5 AM	**58/min**	**123/85 left upper arm, sitting**	**16/min**	**97.6 F**	**88% room air**

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
8:15 AM	**0/10**	**N/A**	**N/A**	**N/A**	**N/A**

Nursing Care (6 points)

Overview of care provided today:

Patient was administered risperidone 0.25 mg at 7:20 AM. She participated in group activities, drawing, and engaged in a 1:1 therapeutic conversation.

Client complaints: Patient stated, “I don’t feel good. My hair is messy and oily,” and expressed a desire to take a shower.

Participation in therapy / groups: Patient participated in group activities and was engaged.

Medication compliance today: Patient was compliant with prescribed medication.

Behaviors exhibited today: Patient displayed anxiety and was observed yelling, screaming, throwing tantrums at staff, banging on doors, and climbing onto the nursing station.

Discharge Planning

Discharge location: Patient will be discharged to her home with her father at 1006 E Kerr Ave, Apt 201, Urbana, IL.

Follow up plan: The patient will remain inpatient for 7–10 days to continue group therapy and medication management. After discharge, she will follow up with outpatient therapy and psychiatry for continued treatment and support.

Education needs: The patient and her father will need education on prescribed medications (purpose and side effects), benefits of group therapy, healthy coping strategies, recognizing early warning signs of self-harm, and available crisis resources for safety planning.

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 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. Risk for Self-Directed Violence related to suicidal ideation and past attempt as evidenced by patient report.	High risk for self-harm due to history and current thoughts.	**1.** Patient will remain safe during stay.	• Safety checks q15 min. • Maintain safe environment. • Encourage expression of thoughts.	Suicide Prevention Lifeline (988) – 24/7 crisis support.
2. Anxiety related to hospitalization and poor coping as evidenced by yelling, screaming, and climbing on nursing station.	Patient shows high anxiety through behaviors.	**1.** Patient will verbalize feelings and use 1 coping skill.	Provide calm, supportive communication. Engage in groups/art activities. Teach relaxation techniques.	Community Mental Health Center – counseling and therapy support.
3. Ineffective	Lack of	**1.**	Reinforce	**1.**

Coping related to limited support system as evidenced by stating “I don’t know” when asked about support.	support and limited coping skills affect recovery.	Patient will identify 2 coping strategies and 1 support resource.	current positive coping (drawing, basketball). Involve social worker for resources. Educate on stress management.	NAMI – peer support and community programs.

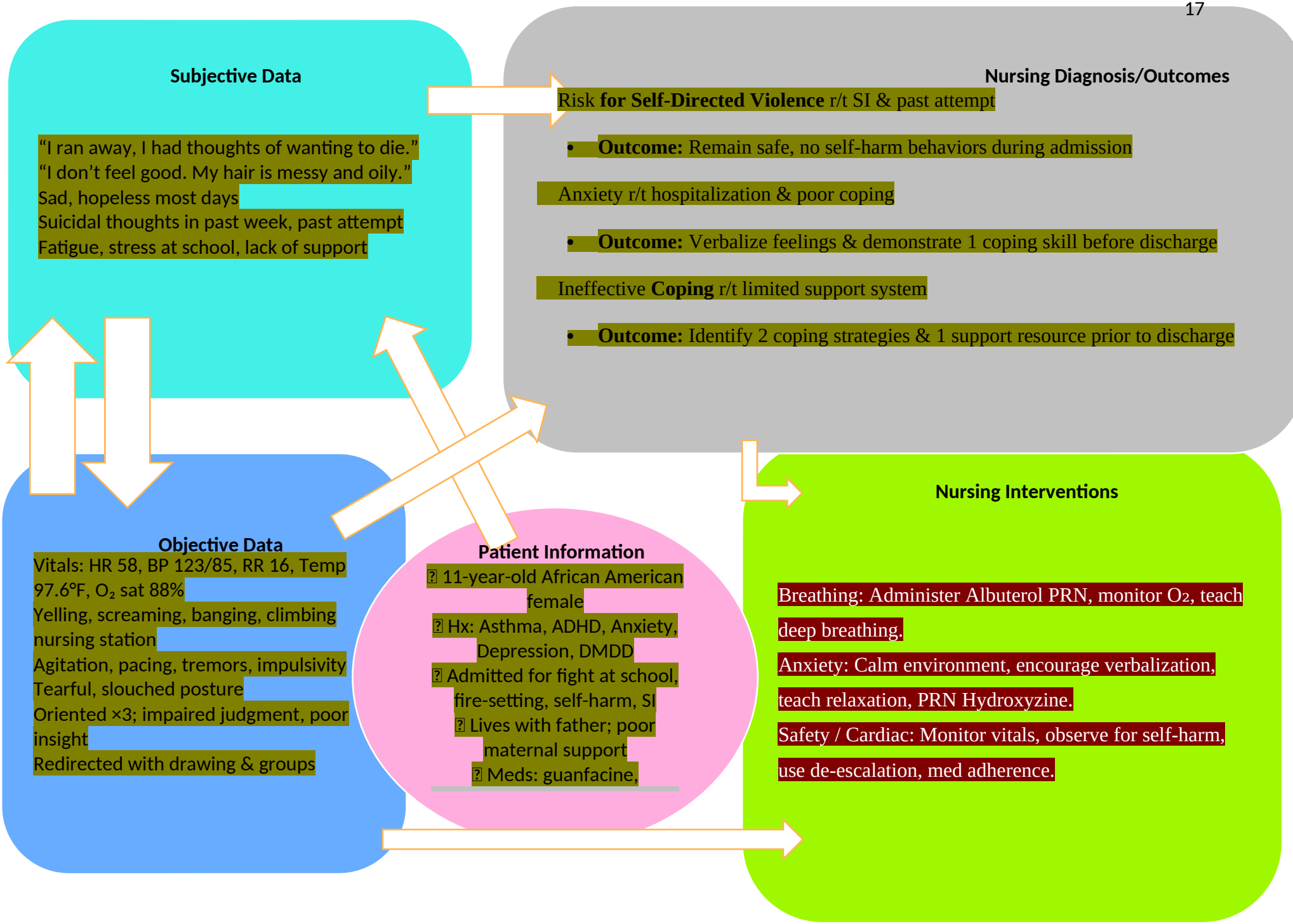
Other References (APA):

Phelps, L. (2020). Sparks & Taylor’s Nursing Diagnosis Reference Manual 11th edition. Wolters Kluwer.

Jones & Bartlett. (2024). NDA Nurse’s Drug Handbook. Jones & Bartlett Learning.

Stahl, S. M. (2021). *Stahl’s essential psychopharmacology: Neuroscientific basis and practical applications* (5th ed.). Cambridge University Press.

Concept Map (20 Points):


Subjective Data
"I ran away, I had thoughts of wanting to die."
"I don't feel good. My hair is messy and oily."
Sad, hopeless most days
Suicidal thoughts in past week, past attempt
Fatigue, stress at school, lack of support
Nursing Diagnosis/Outcomes
Risk for Self-Directed Violence r/t SI & past attempt
• Outcome: Remain safe, no self-harm behaviors during admission
Anxiety r/t hospitalization & poor coping
• Outcome: Verbalize feelings & demonstrate 1 coping skill before discharge
Ineffective Coping r/t limited support system
• Outcome: Identify 2 coping strategies & 1 support resource prior to discharge
Objective Data
Vitals: HR 58, BP 123/85, RR 16, Temp 97.6°F, O₂ sat 88%
Yelling, screaming, banging, climbing nursing station
Agitation, pacing, tremors, impulsivity
Tearful, slouched posture
Oriented ×3; impaired judgment, poor insight
Redirected with drawing & groups
Patient Information
 11-year-old African American female
 Hx: Asthma, ADHD, Anxiety, Depression, DMDD
 Admitted for fight at school, fire-setting, self-harm, SI
 Lives with father; poor maternal support
 Meds: guanfacine,
Nursing Interventions
Breathing: Administer Albuterol PRN, monitor O2, teach deep breathing.
Anxiety: Calm environment, encourage verbalization, teach relaxation, PRN Hydroxyzine.
Safety / Cardiac: Monitor vitals, observe for self-harm, use de-escalation, med adherence.