

HEALTH SERVICES POLICY & PROCEDURE MANUAL

North Carolina Department Of Correction
Division Of Prisons

SECTION: Planning Patient Care

POLICY # PL – 2

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SUBJECT: Initial Nursing Care Plan for Mental Health

EFFECTIVE DATE: March 2002

SUPERCEDES DATE: None

PURPOSE

To provide written guidelines for mental health nursing staff in treatment of psychiatric patients in the inpatient and residential treatment settings. The goal is to assist the patient in achieving their optimal level of wellness through the delivery of nursing care that is consistent, continuous, individualized, and outcome focused.

POLICY

Every psychiatric patient should have a nursing care plan which identifies at least the patient's immediate needs within 24 hours of admission. The nurse, as a member of the patient's treatment team, will incorporate the nursing care plan into the interdisciplinary treatment plan.

PROCEDURE

After an assessment by a registered nurse, a Psychiatric Nursing Care Plan will be initiated.

1. The RN identifying a problem or need will initiate the appropriate care plan, sign, initial and date the plan.
2. Other RN's contributing to the care plan will initial and sign in the **Contributing Staff** box.
3. The RN initiating the plan will check all areas in the **Assessment Data** box that apply to the assessment of the patient.

Additional information can be added in the "other" space.

- 4a. After reviewing the assessment data, the RN will check an identified or individualized short-term goal and sign, initial, and date the **Expected Outcome/Goals** box (page 1).
- b. The RN will also check an identified or individualized or individualized discharge/long term goal and sign, initial, and date the **Expected Outcome/Goals** box (page 2).
The RN will note a target date for the patient to attain the goal.
- c. The progress of the patient will be reviewed (page 2).

The RN will note a target date for the patient to attain the goal. The progress of the patient will be reviewed at least every 30 days. If the target date is still appropriate, the RN will date and initial in the "**Reviewed**" column.

At any point in the patient's treatment, the Psychiatric Nursing Care Plan can be "**Resolved**" – patient met the goal; or "**Revised**" – goal or target date are no longer appropriate. A new plan will be initiated.

5. The **Therapeutic Targets** box is a summary of the nursing objectives for this care plan.
6. The **Implementation** box identifies nursing interventions and their rationale. Nursing notes should reflect these interventions and the patients progress towards short and long term goals.
7. The RN can add more individualized interventions and rationales in the **Additional Interventions** Box.

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8. The Psychiatric Nursing Care Plan will be filed with the general treatment plan in the patient's record.
9. At time of discharge or transfer, the nurse's last note should include the patient's progress toward any unmet goal.

The Psychiatric Nursing Care Plan is a component of the general treatment plan for the patient. As such, the patient's progress towards identified goals should be reviewed and discussed at interdisciplinary treatment team meetings.



3/30/02

Paula Y. Smith, MD, Director of Health Services

Date

SOR: Psychiatric Nurse Managers