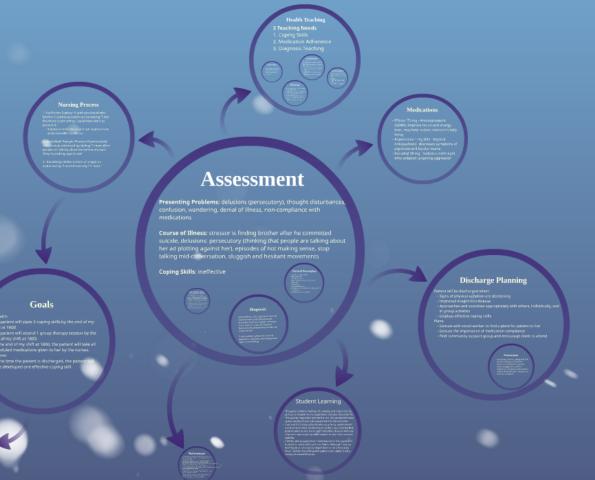
Comprehensive Nursing Care Plan

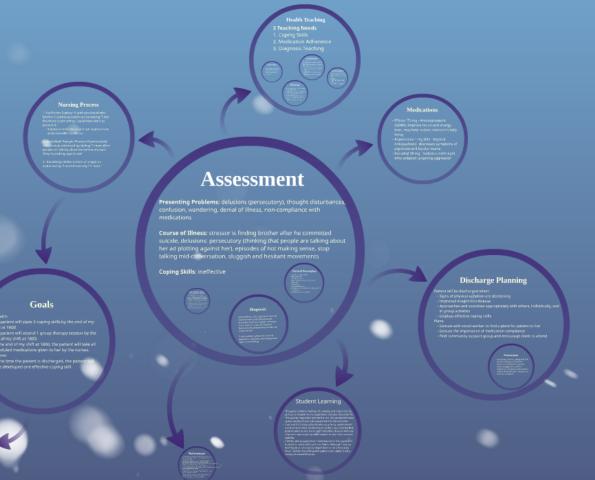
Interventions



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Comprehensive Nursing Care Plan

Interventions



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Diagnosis

Schizoaffective D/O: psychiatric disorder characterized by disturbed thought processes as well as irregular emotions. In this patient's case, the diagnosis features both schizophrenia and bipolar mood disorder

Patient exhibits symptoms of mania, depression, delusions, and disorganized speech and thinking

DSM-5 Diagnostic Criteria for Schizoaffective Disorder

- uninterrupted period of illness during which there is a major mood episode (depression or mania) concurrent with criteria of schizophrenia
- delusions or hallucinations for 2 or more weeks in the absence of a major mood episode during the lifetime duration of the illness
- symptoms that meet criteria for a major mood episode are present for the majority of the total duration of the active and residual portions of the illness
- disturbance is not attributable to the effects of a substance or other medical condition

Physical Description

- 20 yr old hispanic female
- · clean, groomed
- appropriate dress
- blunted affect, decreased emotional responses
- happy mood
- no suicidal ideations
- thought processes incoherent, disorganized and illogical
- oriented x3, not to situation

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Assessment

Presenting Problems: delusions (persecutory), thought disturbances, confusion, wandering, denial of illness, non-compliance with medications

Course of Illness: stressor is finding brother after he committed suicide, delusions: persecutory (thinking that people are talking about her ad plotting against her), episodes of not making sense, stop talking mid-conversation, sluggish and hesitant movements

Coping Skills: ineffective

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Nursing Process

- 1. Ineffective Coping r/t guilt associated with brother's suicide as evidenced by stating "I feel like there is something I could have done to prevent it."
 - highest priority because it can lead to more problems with her illness
- 2. Disturbed Thought Process r/t persecutory delusions as evidenced by stating "I know other people are talking about me behind my back. They're plotting against me"
- 3. Knowledge Deficit r/t lack of insight as evidenced by "I don't know why I'm here."

Goals

Short Term

- The patient will state 2 coping skills by the end of my shift at 1800.
- The patient will attend 1 group therapy session by the end of my shift at 1800.
- By the end of my shift at 1800, the patient will take all scheduled medications given to her by the nurses.

Long Term

 By the time the patient is discharged, the patient will have developed one effective coping skill.