

Outline for Mental Health Case Study

HNUR 2532 Mental Illness – Clinical Rotation

I. Nursing Assessment Data - (Include age, gender, Medical Diagnosis, physical abilities and inabilities (Ex. Incontinence), Assistive Devices (Ex. Cane, walker))

II. Develop a 3 Problem Care Plan for Client – (Include (3) Nursing Diagnosis, short & long-term goals for each - expected outcomes, (5) nursing interventions, evaluation criteria)

III. Communication with client – (describe any abnormal communication patterns exhibited, client willingness to communicate, and any barriers to communication noted)

IV. Family and Significant Others – obtain with communication with client or use of chart. Include any interactions or teaching needs that may be pertinent.

V. Treatment Possibilities – describe in detail to the ordered treatments that are currently being utilized by client, include a complete list of current medications with drug class, dose, common side effects to be alert to and most importantly why the client is placed on these medications.

- A. Individual/ Group Therapy
- B. Somatic Therapies
- C. Medications
- D. New/ Adjunctive Therapies

VI. Community Resources Available to Client – investigate to resources available to clients in this area.

VII. Discharge Plans and Treatment Needs – may use chart to view on treatment plan.

VIII. Legal/Ethical Considerations and Situations

IX. List any possible threats for this client in achieving Mental Wellness