Anxiety Nursing Care Plan

Patient Name:

Date:

Assessment

- **Symptoms:** [Describe the patient's anxiety symptoms, including severity, duration, and impact on daily life.]

- **History:** [Gather information about the patient's past history of anxiety, including any previous diagnoses, treatments, and response to treatment.]

- **Risk Factors:** [Identify any potential risk factors for anxiety, such as family history, genetic predisposition, stressful life events, or substance abuse.]

Diagnosis

- **Diagnosis:** [Determine if the patient meets the diagnostic criteria for an anxiety disorder based on established classification systems like the DSM-5 .]

- **Type of Anxiety Disorder:** [Specify the type of anxiety disorder, such as generalized anxiety disorder, panic disorder, or social anxiety disorder.]

Planning

- **Goals:** [Establish clear, measurable, achievable, relevant, and time-bound (SMART) goals for treatment.]

- **Interventions:** [Outline a range of interventions, considering both non-pharmacological and pharmacological approaches.]

- **Non-Pharmacological Interventions:**

  - [ ] Psychoeducation: Provide education about anxiety disorders, their causes, and evidence-based treatment options.
  - [ ] Relaxation Techniques: Teach relaxation techniques, such as deep breathing,progressive muscle relaxation, and mindfulness meditation.
  - [ ] Coping Skills: Help patients develop coping skills to manage stress, anxiety triggers,and negative thoughts.
  - [ ] Support Groups: Facilitate participation in support groups or therapy groups for individuals with anxiety disorders.

  Other interventions:

- **Pharmacological Interventions: same as above**

  - [ ] Medication: Administer prescribed medication as directed, monitoring for side effects and effectiveness.
  - [ ] Collaborate with the prescribing physician to ensure appropriate medication management.

  Other interventions:

Evaluation

- [ ] **Regular Monitoring:** Regularly monitor the patient's progress and symptoms, tracking changes over time using standardized assessment tools.
- [ ] **Intervention Effectiveness:** Evaluate the effectiveness of interventions and make adjustments to the care plan as needed to optimize treatment outcomes.
- [ ] **Functional Status:** Assess the patient's functional status and ability to perform daily activities, evaluating their overall quality of life.
- [ ] **Medication Compliance:** Monitor medication compliance and side effects to ensure appropriate medication management.

Additional notes:

Communication

- [ ] Maintain open communication with the patient and their family to address concerns, provide updates, and ensure everyone is informed about the treatment plan.
- [ ] Collaborate with other healthcare providers, such as psychiatrists, therapists, and social workers, to coordinate care and ensure a comprehensive approach.
- [ ] Document all assessments, interventions, and outcomes in the patient's medical record to provide continuity of care and facilitate communication among healthcare providers.

Additional notes:

Discharge Planning - leave space at the bottom of this for nurse/patient etc to write any other important discharge pointers. tickbox

- [ ] As the patient approaches discharge, provide education on self-management strategies, relapse prevention, and resource availability.
- [ ] Coordinate with community resources, such as support groups, therapy providers, and mental health services, to ensure ongoing care and support after discharge.
- [ ] Document discharge instructions and follow-up plans in the patient's medical record.

Additional notes: