

# Depression Nursing Care Plan

**Patient Name:**

**Date:**

**Assessment:**

- **Symptoms:** [List of depression symptoms, including severity]
- **History:** [Personal and family history of depression or other mental health conditions]
- **Risk factors:** [Identify potential risk factors for depression]

**Diagnosis:**

- [Diagnosis of depression based on DSM-5 criteria]

**Planning:**

- **Goals:** [Set specific, measurable, achievable, relevant, and time-bound (SMART) goals for treatment]
- **Interventions:** [List of interventions to address symptoms, improve functioning, and prevent relapse]
- **Timeline:** [Establish a timeline for achieving goals and evaluating progress]

**Intervention:**

- **Education:** [Provide patient with information about depression, treatment options, and self-management strategies]

- **Coping skills training:** [Teach patient coping skills for managing stress, negative thoughts, and emotions]
- **Medication management:** [Monitor medication compliance, side effects, and effectiveness]
- **Psychosocial interventions:** [Provide or coordinate therapy, support groups, or other psychosocial interventions]

#### **Evaluation:**

- **Symptom tracking:** [Monitor symptoms over time to assess progress]
- **Functional assessment:** [Evaluate patient's ability to perform daily activities and maintain social interactions]
- **Medication evaluation:** [Determine effectiveness and tolerability of medication]
- **Psychosocial intervention evaluation:** [Assess effectiveness of therapy, support groups, or other psychosocial interventions]

#### **Notes:**

- [Additional observations or concerns related to the patient's care]

**Signatures:**

- Nurse Signature:
- Date:

**Review:**

- Plan review date:
- Nurse Signature:
- Date: