Schizophrenia Nursing Care Plan

Patient Information

- Full Name: Sarah Smith
- Date of Birth: 09 / 09 / 1982
- Gender: F
- Patient ID: /
- Contact Number: +00 0000 000
- Email Address: sarahsmith@email.com
- Medication use: Quetiapine, Citalopram
- Facility Details: _____

Impaired Social Interaction Care Plan

- [x] Disturbed thought processes
- [x] Isolation
- [ ] lack of knowledge around social constructs
- [x] mistrust of others
- [x] inability to maintain relationships
- [x] Inability to perceive and interpret the intentions of others

Impaired Social Interaction Assessment

Assessment	Notes
Assess their perceptions and feelings toward social interaction.	Patient displays fear and defenciveness towards new people and staff. This fear has also been directed at family members.
Determine family and support patterns.	Suspisous of family mebers exept 1 brother. This Family member in involved in care plan and
Observe speech, nonverbal gestures, and body language.	Lack of eye contact, pushing items away and food, will sit away from all group situations.

Evidenced by:	*Suggested intervention:*	*Notes and referrals:*
• Difficulty focusing or paying attention • Fearful or anxious around others • Inappropriate emotional responses • Poor eye contact • Disorganized speech and thoughts	• Develop a trusting relationship. • Provide positive reinforcement. • Encourage group activities. • Refer to specialists for social skills training.	Patient is fearful around others and responds with defensive tones to others. no violence or anger detected or displayed. Poor eye contact and often sentances do not lead into one another clearly. Intrest in gardening and willingness to join one staff member at a time doing this activity is currenlty creating a positive enviroment. Group gardening and trusting others are goals of care with psych

Disturbed Sensory Perception (Auditory/Visual) Care Plan

- ☐ Severe stress
- ☐ Sleep deprivation
- ☐ Excessive stimulation
- ☐ Altered sensory perception
- ☐ Misuse of medications, alcohol, or illegal substances

Disturbed Sensory Perception Assessment

Assessment	Notes
Assess medication adherence.	
Assess contents of hallucinations.	
Monitor for increasing agitation or anxiety.	

Evidenced by:	*Suggested intervention:*	*Notes and referrals:*
• Anxiety • Panic • Talking or laughing to self • Rapid mood swings • Seeing or hearing things that aren't there (hallucinations) • Inappropriate responses • Disorientation • Tilting head as if to listen to something	• Remove the client from chaotic environments. • Provide safety. • Aid distraction. • Help the patient recognize triggers.	

Risk For Self/Other-Directed Violence

- [ ] Suspiciousness of others
- [ ] Anxiety
- [ ] Command hallucinations
- [ ] Delusional thinking
- [ ] History of threats or violence against self or others
- [ ] Suicidal ideation
- [ ] Perception of a threatening environment
- [ ] Paranoia

Risk For Self/Other-Directed Violence Assessment

Assessment	Notes
Assess for a plan for suicide or violence.	
Observe for early cues of distress.	

Suggested intervention:	***Notes and referrals:***
• Maintain and convey a calm attitude. • Maintain distance from the patient. • Keep the patient safe. • *Administer tranquilizers/ restraint*	

Physician's Notes and Recommendations

- Patient requires impared social interaction plan
- no audio/visual concerns that arent currently managed or violence to self or others
- Focusing on social interactions and trust, patient is low risk and has potential in-home care

Physician's Signature: _____ Date: ____ / ____ / _____

Patient Acknowledgment

- I have reviewed the nursing plan and understand the information provided.

Patient's Signature: _____ Date: ____ / ____ / _____