NC Department of Adult Correction
PROTECTION • INNOVATION
REHABILITATION

Division of Institutions
Policy and Procedure

Chapter: S
Section: .3400
Title: Nursing Care Plan for Mental Health
Issue Date: August 9, 2021
Supersedes: March 2002

I. PURPOSE

A. To provide guidelines for mental health nursing staff in the treatment of mental health patients in the inpatient, residential and Therapeutic Diversion Unit (TDU) treatment settings.

B. The goal is to assist the patient in achieving their optimal level of wellness through the delivery of nursing care that is consistent, continuous, individualized and outcome focused**.**

II. POLICY

A. Mental health patients shall have a nursing care plan that identifies their immediate needs within 24 hours of admission to an inpatient, residential, or TDU treatment unit.

B. The nurse, as a member of the patient's treatment team, shall incorporate the nursing care plan into the interdisciplinary treatment plan.

C. The Mental Health Nursing Care Plan shall be a component of the general treatment plan for the patient. As such, the patient's progress towards identified goals shall be reviewed and discussed at interdisciplinary treatment team meetings.

III. PROCEDURES

A. An individualized Mental Health Nursing Care Plan shall be initiated after the registered nurse (RN) has completed an assessment/evaluation.

B. The RN initiating the treatment plan shall review the patient health care record and identify applicable concerns/problems.

C. The RN initiating the treatment plan shall schedule a patient review in the patient health care record on the Scheduler for 30 days after the initial nursing assessment/evaluation.

D. Clinical encounters shall reflect the patient's progress toward the treatment plan goals.

E. Treatment plan goals that have been met or identified as being no longer appropriate shall be terminated and a new mental health nursing care plan shall be initiated to reflect the patient's current problems or needs, if applicable.

F. Treatment plan goals not completed/met by the 30-day review, shall have documentation in the patient health care record (care plan) with a new review date no later than 30 days scheduled in the patient health care record on the Scheduler.

G. Treatment plan goals that have not been met at termination of treatment shall have documentation in the patient health care record (care plan) providing a rationale or explanation for the non-completion of the goal.

IV. REFERENCES

5th Edition Standards for Adult Correctional Institutions

5-ACI-6A-04, 5-ACI-6A-07, 5-ACI-6A-37, 5-ACI-6A-38, 5-ACI-6A-39

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