Mental Health Nursing

Nursing Process in Psychiatric Nursing

4

Dr. Afrah M. AL-Dubhani

Assistant Professor of community health

Therapeutic Communication

Outline:

- Introduction
- Assessment
- Nursing Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation
- Components of Assessment
- Sample of Nursing Care Plan

Introduction:-

- The **nursing process is an interactive**تفاعلي **, problem-solving process. It is systematic and individualized way to achieve outcome of nursing care.**
- The nursing process **respects** the individual's autonomy استقلالية الفرد وحريته **and freedom** to make decisions and be involved in nursing care.
- The nursing process is **accepted** by the nursing profession as a **standard**
  for providing ongoing nursing care that **is adapted to individual client needs.**
- The nurse and the patient emerge as partner in a relationship **built on trust** and directed toward **maximising the patient's strengths**, **maintaining integrity**, and **promoting adaptive response to stress**.

Introduction:-

- In **dealing with psychiatric patients**, the nursing process **can present unique challenges**.
- Emotional problems may be **vague مبهم , not visible** like many physiological disruptions.
- Emotional problems can also show **different symptoms and arise from a number of causes**. Similarly, **past events may lead to very different form of present behaviours.** Many psychiatric patients are unable to describe their problems.
- They may be highly withdrawn, highly anxious, ,or out of touch with reality.
- Their ability to participate in the **problem solving process** may also be limited if they see themselves **as powerless**.

Nursing process aims at individualized care to the patient and the care is adapted to patient's unique needs. Nursing process the following steps;

1. Assessment
2. Nursing Diagnosis
3. Outcome Identification
4. Planning
5. Implementation and
6. Evaluation

Assessment:-

Individualized care begins with a detailed assessment as soon as the patient is admitted. In the Assessment phase, information is obtained the patient in a direct and structured manner through observation, interviews and examination. Initial interview includes an evaluation of mental status. In such cases, where the patient is too ill to participate in or complete the **interview,** the behaviour the patient exhibits to be **recorded** and **reports** from family members if possible, can obtained. Even when the initial assessment is complete, each encounter نصادف، نواجه with the patient involves a continuing assessment .The ongoing assessment involves what **patient is saying or doing** at that moment.

HEALTH HISTORY AND PHYSICAL ASSESSMENT

- Client's complaintشكوى , present symptom and focus of concernبؤرة القلقِ
- Perceptions and expectations
- Previous hospitalizations and mental health treatment
- Family history
- Health beliefs and practices
- Substance use
- Sexual history
- Abuse
- Spiritual
- Basic needs (diet, exercise, sleep, elimination)
- Sociocultural

HEALTH HISTORY AND PHYSICAL ASSESSMENT

- Coping patterns
- Self-esteem
- Medical Examination
- Diagnostic Investigations
- Mental Status Examination

Subjective Data	Objective Data
• Name and general information about the client • Client's perception of current stressor or problem • Current occupational or work situation • Any recent difficulty in relationships • Any somatic complaints • Current or past substance use • Interests or activities previously enjoyed • Sexual activity or difficulties	• Physical exam • Behavior • Mood and affect • Awareness • Thought processes • Appearance • Activity • Judgment • Response to environment • Perceptual ability

- When the nurse investigates a patient's specific behaviour, it is valuable to explore the following,

1. Situation that precipitated مُعَجَّلthat behaviour
2. What the patient was thinking at that moment?
3. Whether that behaviour makes any sense in that context?
4. Whether the behaviour was adaptive or dysfunctional?
5. Whether a change is needed?

- If the nurse has to interview the patient she **should select a private place**, **free from noise** and **distraction** and **interview should be goal directed**. Although the patient is a regarded as a source of validation , the nurse should also be **prepared to consult with family members** or other people knowledgeable about the patient. This is particularly important when the patient is unable to provide reliable information because the symptoms of the psychiatric illness.

- She should gather Information from other information sources, including health care **records**, **nursing rounds**, change- of shifts, nursing care plans and evaluation of **other health care professionals**.

Nursing Diagnosis

- After collecting all data, the nurse compares the information and then analyses the data and derives يَشتقُّ a nursing diagnosis.
- A **nursing diagnosis is a statement** of the patient's nursing problem that includes both the adaptive and maladaptive health هل نتج عن المشكله responses and contributing stressors.
- These nursing problems concern patient's health aspects that may need to be promoted or with which the patient needs help.

Nursing Diagnosis

- A nursing diagnosis may be an actualفعلي or potential health problem, depending on the situation.
- The most commonly **used standard** is that of the **North American Nursing Diagnosis Association (NANDA).**

A nursing diagnostic statement consists of three parts:

1. Health ***problem***
2. Contributing ***factors***
3. Defining ***characteristics***

Nursing Diagnosis

- The defining characteristics are **helpful** because they **reflect the behaviour** that are the target of nursing intervention. They also **provide specific indicators** for **evaluating the outcome** of psychiatric nursing interventions and for determining whether the **expected goals of the nursing care were met.**

Example:

- If a patient is making statements about dying, he is isolative, anorexic فقدان الشهيه, cannot sleep and wants to die. Then the nursing diagnosis can be-

1. **Helplessness** العجز , related to physical complaints, as evidenced by decreased appetite and verbal cues indicating despondency كآبة .
2. **Fatigue** تعب /اجهاد related to insomnia الأرق , as evidenced by an increases in physical complaints and disinterest لا مبالاة in surroundings.
3. **Social isolation** , related to anxiety, as evidenced by withdrawal and uncommunicative behaviour.

Outcome Identification

- The psychiatric mental health nurse identifies expected outcomes individualised to the patient. Within the context of providing nursing care, the ultimate أقصى goal is to influence health outcomes and improve the patient's health status. **Outcomes** should be mutually identified with the patient, and should be identified as **clearly** as clearly and **determine the effectiveness** and efficiency of their interventions.

- **Outcome Identification**

  Before defining expected outcomes, the nurse must realize that patient often seek treatment with goals of their own. **These goals may be expressed as relieving symptoms or improving functional ability.** The nurse must understand the **patient's coping response and the factors that influence them.** Some of these difficulties in defining goals are as follows:-

1. The patient may view a **personal problem** as **someone else's behaviour**.
2. The patient **may express a problem as feeling, such as "I am lonely" or "I am so unhappy".**

Clarifying goals is an essential step in the therapeutic process. Therefore the patient nurse relationship should be based upon mutually agreed goals. Once the goals are a greed on they must be stated in writing .**Goals should be written** in behavioural terms, and should be **realistically** described what the **nurse wishes to accomplish** within a **specific time span**.

- **Expected outcomes** and short term goals should be developed with short term objectives contributing to the long term expected outcomes.

Example of short term goals:

- At the end of the two weeks patients will stay out of bed and participate in activities
- At the end of the one week patient will sleep well at night.
- At the end of the one week patient will eat properly and maintain weight.

- **Planning**

1. As soon as the patient‘s problems are identified, nursing diagnosis made, planning nursing care begins.
2. The planning consists of:
3. Determining priorities
4. Setting goals
5. Selecting nursing actions
6. Developing /writing nursing care plan

- In planning the care the nurse can **involve** the patient, family, members of the health team. Once the goals are chosen the next task is to outline the plan achieving them. On the basis of an analysis, the nurse decides which problem requires priority attention or immediate attention. Goals stated indicates as to what is to be achieved if the identified problem is taken care of. These can be immediate short-term and long- term goals.

- The nursing action technique chosen will enable the nurse to meet the goals or desired objectives. **For example,** the short-terms for a depressed patient is **"to pursue him or her take bath"**. The nursing action may be **"The nurse firmly حزم direct the patient to get up and finish her/his bath before 8 O' clock.** On persuasionالإقناع the patient takes bath. This is an example of selection of the nursing action. **Writing or recording of the problems, goals, and nursing actions is a nursing care plan.**

- **Implementation**

  The implementation phase of the **nursing process is the actual initiation of the nursing care plan.** Patient outcome/goals are achieved by he performance of the nursing interventions. During the phase the nurse continues to assess the patient to determine whether interventions are effective. **An important part of this phase is documentation. Documentation** is necessary for legal reasons because in **legal dispute** “if it wasn’t charted, it wasn’t done".

- **Implementation**

  The nursing interventions are designed to prevent mental and physical illness and promote, maintain, and restore mental and physical health. The nurse may select interventions according to their level of practice. She may select counselling, milieu وسط therapy, self-care activities, psychological interventions, health teaching, case management, health promotion and health maintenance and other approaches to meet the mental health care needs of the patient.

- To implement the actions, nurses need to have **intellectual, interpersonal** and **technical skills**.

Nursing actions are of two types-

- **Dependent nursing action**: Action derived from the advice from the psychiatrist. For example, giving medicines.
- **Independent nursing actions:** This is based on nursing diagnosis and plan of care, pursuing the patient to attend to personal hygiene.

- **Evaluation**

  The continuous or ongoing phase of nursing process is evaluation. Nursing care is a dynamic process involving change in the patient's health status over time, giving rise to the need of new data, different diagnosis, and modifications in the plan of care.

- When **evaluating care the nurse should review all previous phases of the nursing process and determine whether expected outcome** for the patient have been met.

- This can be done checking –have I done everything for my patient? Is my patient better after the planned care? .Evaluation is a feed back mechanism for judging the quality of care given. Evaluation of the patient's progress **indicates what problems** of the patient have been **solved** , which need to be **assessed again**, replanted, implemented and **re-evaluated.**

- **Components of Assessment**
- **Mental Status Examination**
- **Appearance**

  Dress, grooming التَهَيُّأ , hygiene, cosmetics مستحضرات التجميل, apparent age, posture, facial expression.

- **Behaviour/activity**

  Hyperactivity or hyperactivity, rigid, relaxed, restless, or agitated مُهَيَّج motor movements, gait and coordination, facial grimacing التَكشير , gestures, mannerisms التكلّف ,, passive , combative مقاتل , bizarre غريب .

Attitude

- Interactions with interviewer: - Cooperative, resistive مقاوم , friendly, hostileمعادي , ingratiating متملق
- Speech-Quantity: - poverty of speech, poverty of content, volume.
- Quality: - articulate،يتكلم بوضوح , congruentتتطابق , monotonousرتيب , talkativeكثير الكلام , repetitious التكرار, spontaneous،من تلقاء نفسها , circumstantial ظرفية, confabulation تسامر , tangentialتماسي and pressuredضغوط
- Rate:-slowed, rapid

Mood and affect

- Mood (Intensity الكثافةdepth duration):- sad, fearful, depressed, angry, anxious قلق, ambivalent متضاربة , happy, ecstatic شاطح , grandiose فخم .
- Affect (Intensity depth duration) :- appropriate, apathetic لا مبالي , constricted مقيدة , blunted صريح , flat, labile قابل للتغيير , euphoric البهيجة .

Perception

- Hallucination, illusions, depersonalization, derealisation الغربة عن الواقع , derealisation تبدد الواقع distortions التشوهات

Thoughts

- Form and content-logical vs. illogical, loose حرassociations فضفاضة , flight of ideas, autistic متوحد عقليا, blocking الاعتراضbroadcasting البث , neologisms، الكلمات الجديدة, word salad سلطة كلمةِ, obsessions الهواجس, ruminations، تأملات , delusions الأوهام, abstract ملخّص vs. Concrete محدد

Sensorium and Cognition الحس والإدراك العقلي

- Level of consciousness, orientation, attention spanامتداد , , recent and remote memory, concentration, , ability to comprehend and process information, intelligence

Judgment

- Ability to assess and evaluate situations makes rational decisions, understand consequence of behaviour, and take responsibly for actions

Insight البصيره

- Ability to perceive and understand the cause and nature of own and other's situation الوضع

Reliability

- Interviewer's impression that individual reported information accurately and completely

Psychosocial Criteria

- Internal:-Psychiatric or medical illness, perceived loss such as loss of self concept/self-esteem
- External:-Actual loss, e.g. death of loved ones, diverse متنوع , lack of support systems, job or financial loss, retirement ,dysfunctional family system التقاعد و نظام الأسرة المختلة

Coping skills مهارات التأقلم

- Adaptation to internal and external **stressors**, use of functional, adaptive coping mechanisms, and techniques, management of activities of daily living.

Relationships

- Attainment إحراز and maintenance of satisfying, interpersonal relationships congruent تتطابق with developmental stages, including sexual relationship as appropriate for age and status

Cultural

- Ability to adapt and conform تتفق to present norms، أعراف , rules, ethics.

Spiritual (Value-belief)

- Presence of self-satisfying value-belief system that the individual regards as right, desirable, worthwhile, and comforting

Occupational

- Engagement is useful, rewarding activity, congruent تتطابق with developmental stages and societal standards (work, school and recreation)

Sample of Nursing Care Plan:-

Sample of Nursing Diagnoses (As per NANDA- North American Nursing Diagnosis Association)

	Nursing Diagnosis	Analysis
1.	Risk for injury related to accelerated motor activity	Accelerated مستعجل motor activity or impulsive مندفعactions
2.	Disturbed thought process related to impaired judgement associated with manic behaviour سلوك الهوس	Judgement impaired , mood of elation عجب (patient is using inappropriate dress and bizarre dressing)
3.	Self-care deficit (unkempt appearance) related to hyperactivity	Unable to take time for self-care is, dishevelled غير مرتبand unkempt
4.	Impaired verbal communication –flight of ideas related to accelerated معجلthinking	Accelerated speech with flight of ideas (thought speeded up causing rapid speech and flight of ideas, excessive planning for activities
5.	Ineffective coping related to related expressive mood	Euphoria, elation, cheerfulness مـــرح(an exaggerated مبالغ فيهsense of well being)
6.	Disturbedمختل thought process – grandiosity العظمةrelated to elevated مرتفعmood	Grandiosity-inflationالتضخم self-esteem
7.	Ineffective coping related to emotional liability مسؤولية associated with manic behaviour	Emotional labiality (unstable mood moves from cheerfulness to irritation easily with little irritation
8.	Disturbed thought process –related to delusion of grandeurعظمة	Grandiose delusions (Belief that well known political religious, or entertainment leader)

Sample of Nursing Care Plan:-

Sample of Nursing Diagnoses (As per NANDA- North American Nursing Diagnosis Association)		
	Nursing Diagnosis	**Analysis**
9.	Disturbed مختـــــلthought process decreased attention span مـدى and difficulty in concentration related to accelerated thinking	Short attention span, difficulty in concentrating , easily disturbed
10.	Risk for violence related to hostileمعادي and angry behaviour	Hostile comment التعليقand complaintsالشكاوى
11.	Impaired verbal communication related to pressure of speechضغط الكلام	Accelerated thinking, highly responsive to environmental stimuli, accompanying flight of ideas
12.	Nutrition: less than body requirements, imbalanced Nutrition: more than body requirements, imbalanced Nutrition: risk for more than body requirements, imbalanced	Weight loss (less food intake associated with depression which contributes to loss of appetite with weight loss/weight gain following pharmacological management/possible wieght gain
13.	Self-care deficit-neglect of personal hygiene related to depression	Neglect of personal hygiene (feeling of worthlessness associated with depression which contribute to lack of interest in personal hygiene

Sample of Nursing Care Plan:-

Sample of Nursing Diagnoses (As per NANDA- North American Nursing Diagnosis Association)		
	Nursing Diagnosis	**Analysis**
14.	Health Maintenance, ineffective – psychomotor retardation related to depression	Extreme slowness in performing activity
15.	Risk for violence- self-directed, related to depression	Bruises الكـدمات , cuts, scars, (possible destructive behaviour or abuse by others)
16.	Anxiety –neurological symptoms related to depression	Extreme nervousness (possible response to loss with symptoms to those of anxiety)
17.	Risk for violencerm	Suicidal feeling (Hopelessness contributes to total despair
18.	Sensory perceptual alteration – disorientation about time, place, and person related to increased anxiety	Confusion or disorientation
19.	Ineffective coping –obsessive thinking related to anxiety	Anxiety (Increased anxiety unapparent and discharge through obsessive thinking)
20.	Impaired Social interactions –inability to form warm, meaningful relationships, related to compulsive لا يقاوم behaviour	Lacks ability to develop warm relationship (has limited ability to express emotion)
21.	Ineffective coping –compulsion قهر related to need for excessive cleanliness)	Excessive cleanliness (Over emphasis for cleanliness and neatness)

Sample of Nursing Care Plan:-

Sample of Nursing Diagnoses (As per NANDA- North American Nursing Diagnosis Association)		
	Nursing Diagnosis	**Analysis**
22.	Potential for self harm related to poor impulse control associated with substance abuse)	Poor impulse دافعcontrol
23.	Potential for self-harm related to marked disorientation , disorganization, and confusion	Disorientation, disorganization and confusion (If marked , patient is at high suicidal risk)
24.	Distarbance of self-concept-insecurity related to suspiciousness	Insecurity, oversensitive, Failure to meet needs results in mistrust and insecurity
25.	Potential for violence directed towards others related t perceived threat or injustice to himself	Anger and hostilityالعداوة –may become physically violent (Overly concerned with protecting himself from environment : overly sensitive)
26.	Ineffective individual coping persecutory مستمر feeling related to mistrust.	Feeling of being misjudged , conspired تآمرagainst, spied upon تجسس على, followed , poisoned, draggedجر , obstructedعرقلت in achieving long term goals.

Nursing Diagnosis: Risk for violence, self directed.
Risk factors-Chronic illness, retirement, change in marital status

Patient Outcome	Nursing Intervention with Rationale	Evaluation
Patient will not harm himself	Observe patient's behaviour during routine patient care. Close observation is necessary to protect from self harm.	Patient remained safe, unharmed.
Patient will refrain امتنعfrom suicidalإنتحاري threats or behaviour gestures..إيماءات	Listen carefully suicidal statements and observe for non-verbal indications of suicidal intent. Such behaviours are critical clues regarding risk for self harm.	Absence of verbalized or behavioural indications of suicidal intent by the patient.
He will deny يحرمany plans for suicide	Ask direct questions to determine suicidal intentالنية , plans for suicide, and means to commitإرتكبْ suicide .Suicide risk increases when plans and means exists	Patient denies active suicide plans

Nursing Diagnosis: Ineffective individual coping, related to response crisis (retirement), as evidence by isolative behaviour, changes in mood, and decreased sense of well-being.

Patient Outcome	Nursing Intervention with Rationale	Evaluation
Patient will identify positive coping strategies, such as structuring leisure time.	Develop trusting relationship with patient to demonstrate caring and, encourage patient to practice new skills in a safe therapeutic setting.	Patient expresses trust in nurse-patient relationship.
Patient will combine past effective coping methods with newly acquired coping strategies	Praiseح مد patient for adaptive coping. Positive feedback encourages repetition of effective coping by patient	Patient discusses plans for use of past and newly learned coping methods.

Nursing Diagnosis: Self-care deficit (grooming, dressing, and feeding) related to manic hyperactivity, difficulty in concentrating and making decisions: as evidenced by inappropriate dress, and dysfunctional eating habits.

Patient Outcome	Nursing Intervention with Rationale	Evaluation
Patient will dress appropriately for age and status.	Offer assistance for selecting clothing and groomingالتَهَيُّأ to provide input and direction for appropriateness of dress and hygiene to preserve self-esteem and avoid embracement.	Patient dresses self appropriately and maintains hygiene.
	Encourage and remind patient to drink fluid and to eat food to focus the patient on necessary feeding activities , to prevent dehydration الجفافand starvationالمجاعة.	

Nursing Diagnosis: Self-care deficit (grooming, dressing, and feeding) related to manic hyperactivity, difficulty in concentrating and making decisions: as evidenced by inappropriate dress, and dysfunctional eating habits.

Patient Outcome	Nursing Intervention with Rationale	Evaluation
Patient will eat and drink adequately to sustain تحمّلْfluid balance and proper nutrition.	Provide recognition and positive reinforcement for feeding/dressing accomplishments to reinforceعزّزْ appropriate behaviours and enhance self-esteem.	Patient eats and drinks fluids necessarily to maintain physical health.

Thank you