



Nursing Process in psychiatric Nursing care

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Learning Objectives

At the end of this session the students will be able to:

- 1- Define the most important terms in the nursing process.
- 2- List and demonstrates the steps of the nursing process.
- 3- Illustrate each step of nursing process.
- 4- Explain nursing care plan with examples.






Introduction

The nursing process continues to guide nurses in clinical practice and

The **nurse-patient relationship** is the vehicle for applying the nursing process

- ✿ **Nursing process in theory:** is a multistep problem solving method in which client problems and needs are assessed ,diagnosed ,treated and resolved.
 - ✿ **Nursing process in practice:** is a more cyclic approach due to the client's changing responses to health and illness.
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KEY TERMS (TERMINOLOGY)



Nursing care plan :

It is a **set of actions** the **nurse** will **implemented** to resolve nursing problem identified by assessment . The creation of the plan is an intermediate stage of the nursing process.

nursing process in psychiatric care:

- **The nursing process** is a process by which nurses deliver care to the psychiatric patients to improve or solve their mental problems.

NANDA:NANDA diagnosis were first developed in 1973

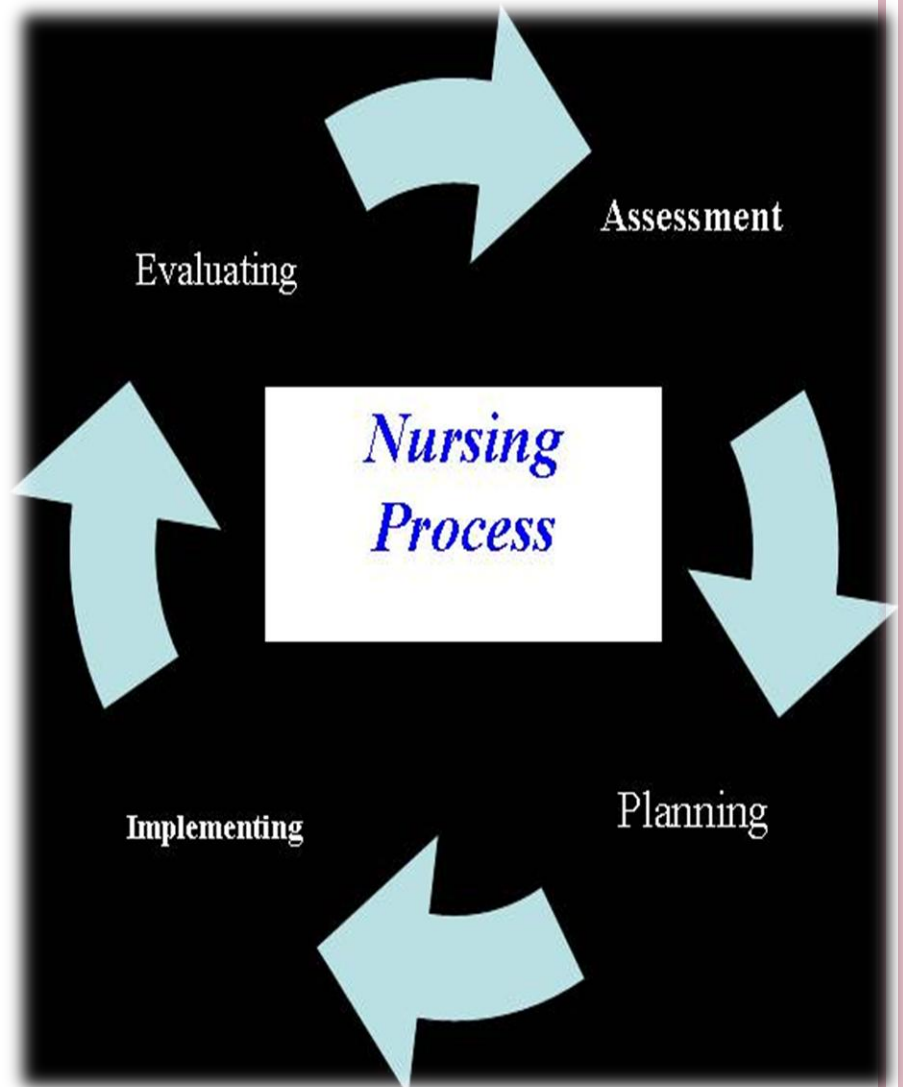
NANDA : North American Nursing Diagnosis Association ,

NANDA is the main organization for defining standard diagnosis in north America , now known as **NANDA**- international.

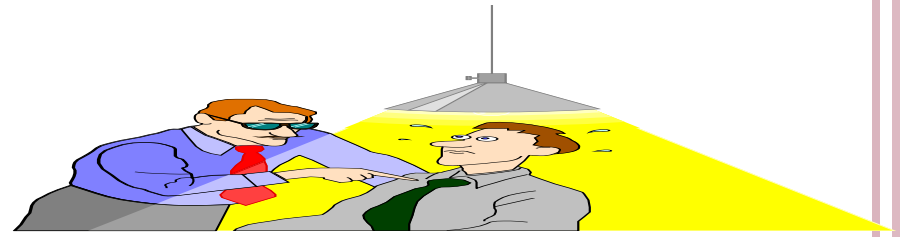


STEPS OR STANDARDS OF NURSING PROCESS

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



ASSESSMENT



- In this phase ,information is obtained from the patient in a **direct** and structured or **indirect** manner through observation of verbal and nonverbal behaviors based on the knowledge of normal and dysfunctional behaviors, interviews and examination,

- The Assessment may be: subjective or objective.

Subjective assessment: when psychiatric nurse collecting data by herself directly from the patient

Objective assessment: psychiatric nurse can use other information sources ,or from patient's family rather than patient.

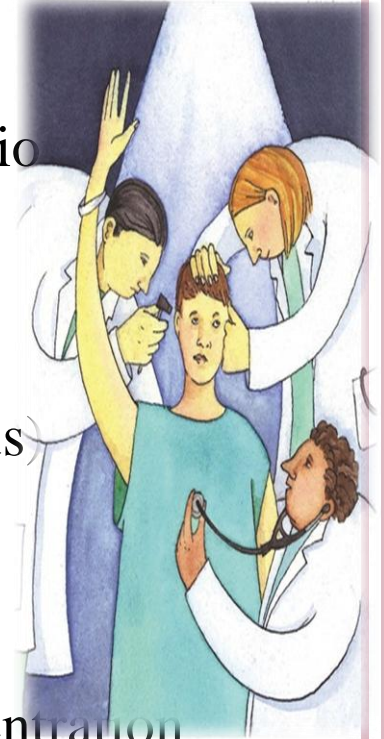
- The mental status examination: is the psychiatric-mental health component of client assessment, it is the basic for medical and nursing diagnosis and management of client care.



COMPONENTS OF PSYCHIATRIC NURSING ASSESSMENT

● Components of total client assessment= mental status examination criteria:-

- **Mental status examination :**
- Appearance ⇒ dress , hygiene , grooming, facial expression
- **Behavior \ activity** ⇒ hypo-activity or hyper-activity.
- **Attitude** ⇒ interactions with interviewer.
- **Speech** ⇒ quantity (poverty of speech)
⇒ quality (monotonous, talkative, repetitious)
- **Mood and affect** ⇒ sad, fearful, anxious.
- **Perceptions** ⇒ hallucinations, illusions.
- **Thoughts** ⇒ flight of ideas , blocking , word salad.
- **Sensorium \ cognition** ⇒ Levels of consciousness, concentration
- **Judgment** ⇒ take responsibility for action, make rational , decision making.
- **Insight** ⇒ ability to understand the cause and nature of own and others situations.



ASSESSMENT

Interview=Participant observation

Nursing role in participant observation:

- To maintain messages conveyed by the patient
- Be aware of her response to the patient
- She should be prepared to consult with members or other people knowledgeable about the patient
- The nurse also might using other information sources including : the patient's health care record reports ,nursing care plan, nursing rounds, change of shift reports



NURSING DIAGNOSIS



- **Nursing diagnosis:** is a process whereby nurses interpret data collected during the assessment phase of the nursing process and apply standardized labels to clients' health problems and responses to illness
- **Nursing diagnosis** are statements that describe an individual's health state or alteration in person's life processes.



COMPONENTS OF THE NURSING DIAGNOSIS

PES

Three distinct components of an actual nursing diagnosis statement are:

- problem
- Etiology &
- Signs & symptoms

This format known as the **PES** format



COMPONENTS OF THE NURSING DIAGNOSIS

PES

○ P=Problem


Its come from the list of approved **NANDA** nursing diagnosis such as ineffective coping or, Disturbed thought processes

Some N.diagnosis require qualifying statements based on the nature of the problems.



Example of nanda diagnosis & qualifying assessment

NANDA Diagnosis	Qualifying statement
Imbalanced nutrition	Less than body requirements
Self care deficit	Bathing, dressing/grooming, feeding(total)
noncompliance	Medication, milieu activities
Deficient knowledge	Medications, treatment



COMPONENTS OF THE NURSING DIAGNOSIS PES

● E=etiology

- ◆ Known as related factors or contributing factors considered to be the cause of the problem nursing diagnoses
- ◆ often accompanied by several etiologic factors these factors may be psychological biologic relational environmental situational developmental or socio cultural ,For example:

altered thought process **related to** psychosocial stressors

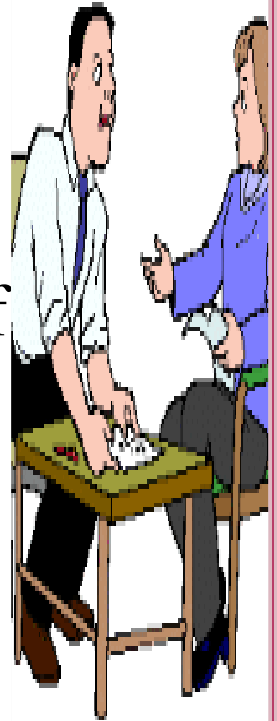
Altered thought process **as a result of** the schizophrenic process.



COMPONENTS OF THE NURSING DIAGNOSIS

PES

- **S=signs and symptoms**
 - Is the observable , measurable manifestations of client, Also known as defining characteristics
 - often require more specific descriptions to better represent the needs of the client being diagnosed . Ineffective coping has Ineffective problem solving
 - Example: Believes the others are planning to kill or harm her. (delusion of persecution)



EXAMPLE INCLUDE THE COMPONENTS OF NURSING DIAGNOSIS

○ **Problem**+ **Etiology**+ **Signs & symptoms**

○ For example:

Ineffective individual coping, related to response crisis “retirement”, as evidence by isolative behaviour, changes in mood.



RISK NURSING DIAGNOSIS



● Risk factors:

Are used in assessing potential health problems to describe existing health states that may contribute to the potential problem becoming an actual problem & **there is**

- **no** defining characteristics and
- there is **no** etiologic factors



RISK NURSING DIAGNOSIS

Also the risk N.diagnosis carries a *two-part* statement

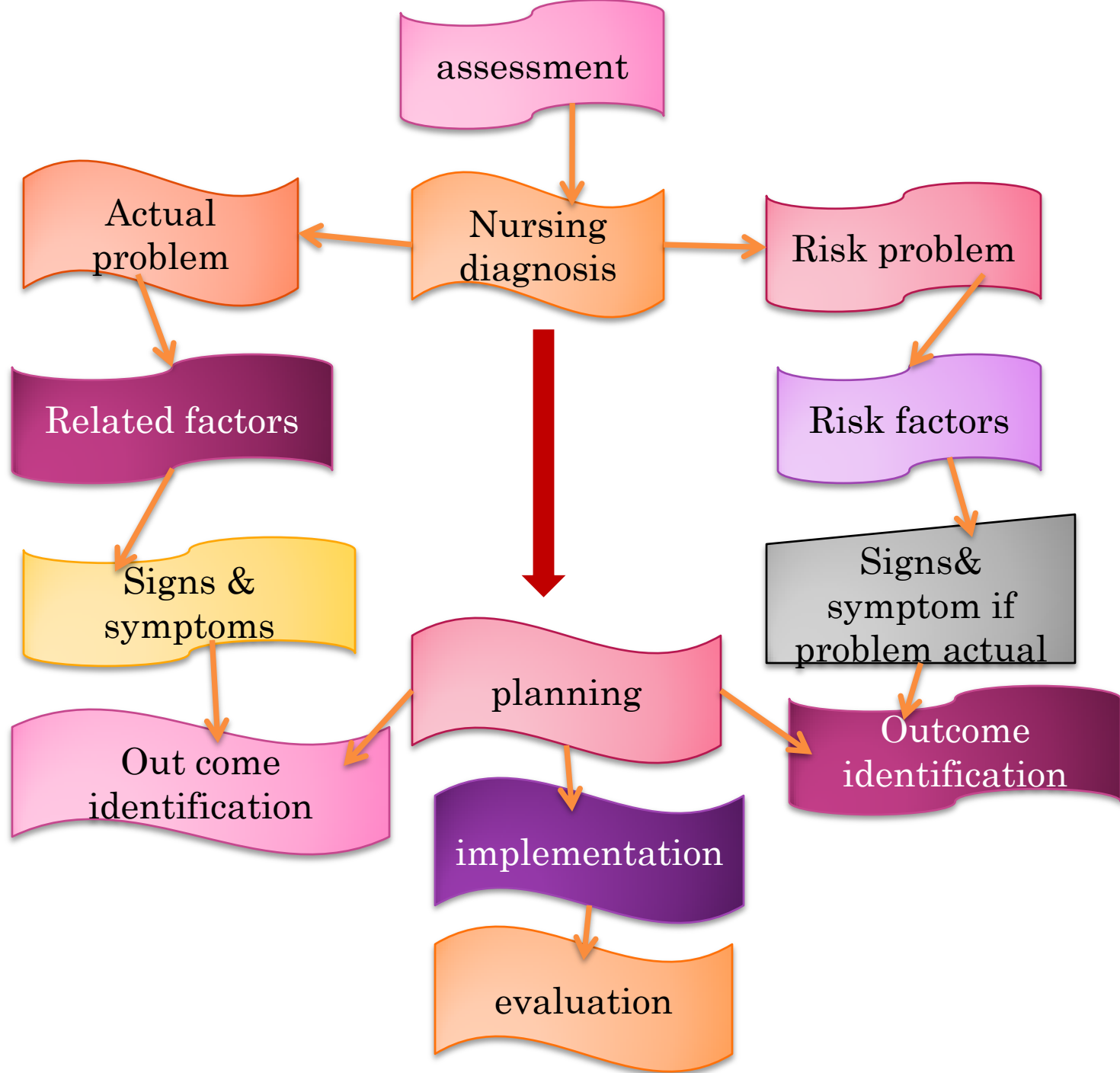
Part 1:nursing diagnosis

Risk for other directive violence

Part2 risk factors(predictors of risk problem)

- History of violence
- Panic state
- Hyperactivity, secondary to manic state
- Low impulse control





LONG AND SHORT TERM GOALS



- 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 expected out comes are derived from diagnosis ,guide later nursing actions and enhance the evaluation of care



IMPORTANCE POINT IN WRITING GOALS

- ❖ In writing goals psychiatric nurses should remember that they can be classified in to the (ABCs) or three domain of knowledge:
- ❖ Affective “feeling”
- ❖ Behavioral ”psychomotor”
- ❖ Cognitive ”thinking

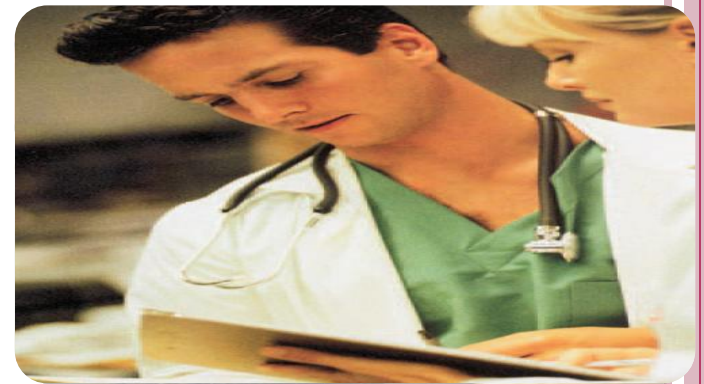


For example, it would be of limited help to teach a patient about medication if the patient did not value taking medications based on personal belief system or previous life experiences



QUALITIES OF WELL WRITTEN OUTCOME CRITERIA

- Specific rather than general
- Measurable rather than subjective
- Attainable rather than unrealistic
- Current rather than outdated
- Adequate in number rather than too few or too many
- Mutual rather than one sided



OUTCOMES IDENTIFICATION



- The psychiatric mental health nurse identifies expected outcomes individualised to the patient.
 - *Example of outcome identification*
 - for example: **Ineffective individual coping**, related to response crisis “retirement”, **as evidence by** isolative behaviour, changes in mood.
- ↓
- Client interacts socially with other clients and staff



Sample of exp .outcome, long & short term goals

Expected. outcome

- Patient will be socially engaged in the community

Long term goal

- The p.t will travel about the community independently within 2 months

Short term goal

- At the end of 1 week the p.t will walk to the corner and back home.

PLANNING

- The nurse develops a plan of care that prescribes interventions
- The planning consists of:
 - Prioritizing the nursing diagnoses
 - Identifying long & short term goals
 - Developing nursing interventions
 - Recording /writing nursing care plan



IMPLEMENTATION

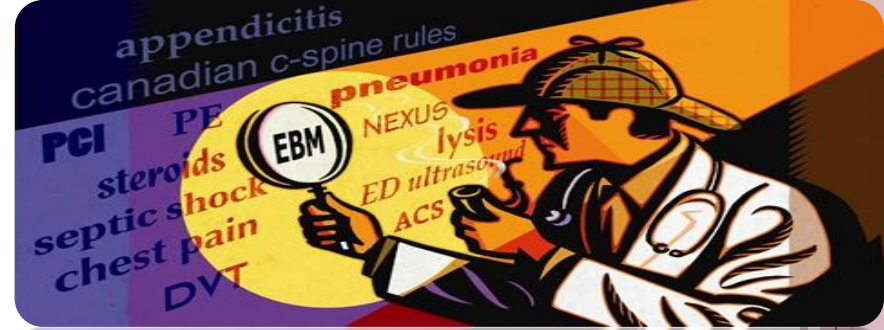
- The implementation phase of the nursing process : is the actual initiation of the nursing care plan.
- Involves putting the nursing care plan into

Action

Nursing activities (interventions) to meet the goals set with the client begin



EVALUATION



- ✦ Evaluation is an ongoing process
- ✦ The evaluation phase consist of two steps:
- ✦ First, the nurse compares the client's current mental health state with that described in the outcome criteria
- ✦ Second, the nurse considers all the possible reasons why client outcomes were not attained , it may be too soon to evaluate, and the plan of action needs further implementation



HOW TO WRITE AND APPLIED NURSING PROCESS IN PSYCHIATRIC CARE

Nursing Diagnosis	Etiologic \ related factors	Defining characteristics, As evidenced by
Anxiety	illness, loss of job, loss of parents	The client verbalizes: *difficulty falling asleep *increase muscle tension.

HOW TO WRITE AND APPLIED NURSING PROCESS IN PSYCHIATRIC CARE

○ Outcome identification and evaluation:

- 1- expresses feeling calm, relaxed with absence of muscle tension.
- 2- Demonstrates absence of avoidance behaviors (withdrawal , lack of contact with others and relief behaviors.
- 3- exhibits ability to make decisions and problem-solve.

○ Planning and implementation :

- 1- maintain client safety and the safety of the others.
- 2- show the client how to use slow deep breathing exercises .
- 3- reduce all environmental stimulation (noise , bright lights , people moving and talking.



EXAMPLE ILLUSTRATE HOW TO WRITE NURSING CARE PLAN

Nursing assessment	Nursing diagnosis	Nursing goal	Nursing intervention	Evaluation
<p>Patient believes that others in the Environment are Plotting evil against him (delusion of Persecution)</p>	<p>Altered thought process related to impaired ability to process and synthesize internal and external stimuli as evidenced by believes that his\her thought are responsible for world events or disasters.</p>	<p>Demonstrate Reality-based Thinking in Verbal and Non-verbal Behavior</p>	<p>1-Assess the delusion and need behind delusion 2- voicing doubt. 3- change the subject to reality talk. 4- not use rationale or argumentate 5- engage in productive activity.</p>	<p>Patient progress and response to treatment.</p>

THANK YOU

AND
GOODBYE