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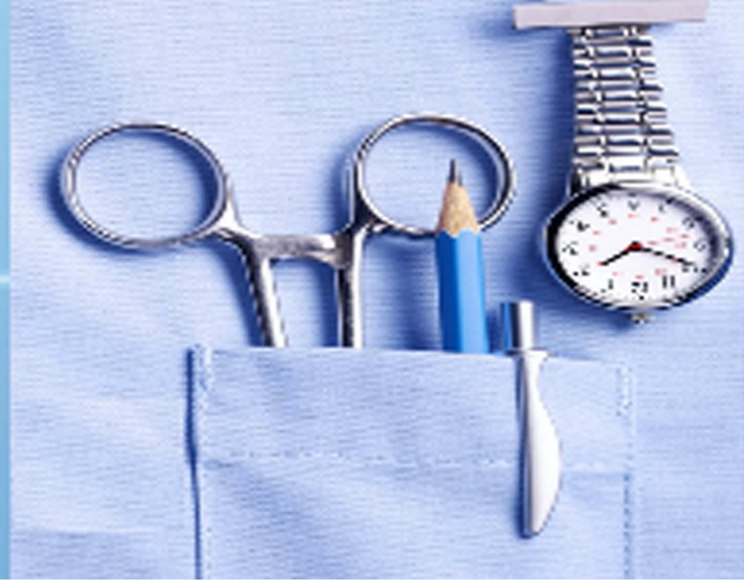
NURSING



Skills Laboratory Manual in
MENTAL HEALTH NURSING
(NRS 474)

Document Revision Control History

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APPLYING THE NURSING PROCESS IN THE PSYCHIATRIC MENTAL HEALTH SETTING

- The role of the nurse in psychiatry focuses on helping the client successfully adapt to stressors within the environment
- Goals are directed toward change in thoughts, feelings, and behaviors that are age appropriate and congruent with local and cultural norms
- Therapy within the psychiatric setting is very often team oriented (interdisciplinary)

Definition

- The nursing process consists of six steps
- It uses a problem-solving approach
- It is goal directed, with the objective being delivery of quality client care
- Nursing process is dynamic, not static
- It is an ongoing process that continues for as long as the nurse and client have interactions directed toward change in the client’s physical or behavioral responses

STANDARDS OF CARE

- They are standards that psychiatric nurses are expected to follow as they provide patient care using the nursing process
- They are relevant to professional nursing activities that are demonstrated by the nurse through the nursing process
- These involve assessment, diagnosis, outcome identification, planning, implementation, and evaluation
- The nursing process is the foundation of clinical decision making and include all significant action taken by nurses in providing psychiatric-mental health care to all clients

The ANA Standards of Care

Standard 1: Assessment

The psychiatric-mental health nurse collects patient health data

Definition

A systematic, dynamic process by which the nurse, through interaction with the client, significant others, and health care providers, collects and analyzes data about the client on physical, psychological, sociocultural, spiritual, cognitive, functional abilities, developmental, economic, and lifestyle dimensions (ANA, 2004).

Rationale

- The assessment interview enables the psychiatric-mental health nurse to make sound clinical judgments and plan appropriate interventions with the client
- It requires linguistically and culturally effective communication skills, interviewing, behavioral observation, record review, and comprehensive assessment of the patient and relevant systems
- Information is gathered to establish a database for determining the best possible care for the client
- Information for this database is gathered from a variety of sources including:
    1. Interviewing the client or family
    2. Observing the client and his or her environment
    3. Consulting other health team members
    4. Reviewing the client’s records
    5. Conducting a nursing physical examination
- The assessment is based on the Biopsychosocial Model

Standard 2: Diagnosis

The psychiatric-mental health nurse analyzes the assessment data in determining diagnoses.

Definition

Nursing diagnoses are clinical judgments about individual, family, or community responses to actual or potential health problems/life processes. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable to (NANDA, 2007).

Rationale

- The basis for providing psychiatric-mental health nursing care is the recognition and identification of patterns of response to actual or potential psychiatric illnesses, mental
- health problems, and potential co-morbid physical illnesses (ANA, 2000)
- Information gathered during the assessment are analyzed
- Diagnoses and potential problem statements are formulated and prioritized
- Diagnoses are according to accepted classification systems, such as the measurable, expected, patient-focused goals that translate into observable Behaviors (ANA, 2004)

Standard 3: Outcome Identification

The psychiatric-mental health nurse identifies expected outcomes individualized to the patient.

Definition

It is the identification of the expected outcomes by the psychiatric mental health nurse that are individualized and specific to the patient

Rationale

- The ultimate goal is to influence health outcomes and improve the patient's health status (ANA, 2000).
- Expected outcomes are derived from the diagnosis

- They must be measurable and estimate a time for attainment
- They must be realistic for the client's capabilities, and are most effective when formulated by the interdisciplinary members, the client, and significant others together.

Nursing Outcomes Classification

- The nursing outcomes classification (NOC) is a comprehensive, standardized classification of patient/client outcomes developed to evaluate the effects of nursing interventions
- The outcomes have been linked to NANDA diagnoses and to the Nursing Interventions Classification (NIC)
- NANDA, NIC, and NOC represent all domains of nursing and can be used together or separately
- There are 330 NOC outcomes include 311 individual, 10 family, and 9 community level outcomes

Standard 4: Planning

The psychiatric-mental health nurse develops a plan of care that is negotiated among the patient, nurse, family, and health care team and prescribes evidence-based interventions to attain expected outcomes

Definition

It is the development by the nurse of a plan of care that is negotiated among the patient, nurse, family, and health care team and prescribes evidence-based interventions to attain expected outcomes

Rationale

- A plan of care is used to guide therapeutic intervention systematically, document progress, and achieve the expected patient outcomes (ANA, 2000, p. 32).
- The care plan is individualized to the client's mental health problems, condition, or needs and is developed in collaboration with the client, significant others, and interdisciplinary team members, if possible
- For each diagnosis identified, the most appropriate interventions, based on current psychiatric/mental health nursing practice and research, are selected

- Client education and necessary referrals are included
- Priorities for delivery of nursing care are determined

Nursing Interventions Classification

- The nursing interventions classification (NIC) is a comprehensive, standardized language describing treatments that nurses perform in all settings and in all specialties
- NIC includes both physiological and psychosocial interventions, as well as those for illness treatment, illness prevention, and health promotion
- NIC interventions are comprehensive, based on research, and reflect current clinical practice
- They were developed inductively based on existing practice
- NIC contains 514 interventions each with a definition and a detailed set of activities that describe what a nurse does to implement the intervention
- The use of a standardized language is thought to enhance continuity of care and facilitate communication among nurses and between nurses and other providers

Standard 5: Implementation

The psychiatric-mental health nurse implements the interventions identified in the plan of care.

Definition

- The process of determining both the client's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

Rationale

- In implementing the plan of care, psychiatric/mental health nurses use a wide range of interventions designed to prevent mental and physical illness, and promote, maintain, and restore mental and physical health
- Psychiatric/mental health nurses select interventions according to their level of practice
- Basic level interventions:
    - Counseling
    - Milieu therapy
    - Promotion of self-care activities
    - Psychobiological interventions
    - Health teaching
    - Case management
    - Health promotion and health maintenance
    - Crisis intervention
    - Community-based care
    - Psychiatric home health care
    - Telehealth
- Advanced level interventions:
    - Consultation
    - Psychotherapy
    - Prescribe pharmacological agents
- Interventions selected during the planning stage are executed, taking into consideration the nurse’s level of practice, education, and certification
- The care plan serves as a blueprint for delivery of safe, ethical, and appropriate interventions
- Documentation of interventions also occurs at this step in the nursing process

LEVELS OF IMPLEMENTATION IN STANDARDS 5

5.1 Counseling

The nurse uses counseling interventions to assist clients in improving or regaining their previous coping abilities, fostering mental health, and preventing mental illness and disability.

5.2 Milieu Therapy

The nurse provides, structures, and maintains a therapeutic environment in collaboration with the client and other health care clinicians.

5.3 Promotion of Self-Care Activities

The psychiatric-mental health nurse structures interventions around the client's activities of daily living to foster self-care and mental and physical well-being

5.4 Psychobiological Interventions

The psychiatric-mental health nurse uses knowledge of psychobiological interventions and applies clinical skills to restore the client's health and prevent further disability

5.5 Health Teaching

The psychiatric mental health nurse, through health teaching, assists clients in achieving satisfying, productive, and healthy patterns of living.

5.6 Case Management

The psychiatric mental health nurse provides case management to coordinate comprehensive health services and ensure continuity of care.

5.7 Health Promotion and Health Maintenance

The psychiatric-mental health nurse employs strategies and interventions to promote and maintain health and prevent mental illness. Standards specific to the advanced practice psychiatric/mental health nurse are included

5.8 Psychotherapy

The advanced practice psychiatric-mental health nurse uses individual, group, and family psychotherapy, and other therapeutic treatments to assist clients in preventing mental illness and disability, treating mental health disorders, and improving mental health status and functional abilities

5.9 Prescriptive Authority and Treatment

The advanced practice psychiatric-mental health nurse uses prescriptive authority, procedures, and treatments in accordance with state and federal laws and regulations, to treat symptoms of psychiatric illness and improve functional health status

5.10 Consultation

The advanced practice psychiatric-mental health nurse provides consultation to enhance the abilities of other clinicians to provide services for clients and effect change in the system.

Standard 6: Evaluation

The psychiatric-mental health nurse evaluates the client's progress in attaining expected outcomes.

Rationale

- Nursing care is a dynamic process involving change in the client's health status over time, giving rise to the need for data, different diagnoses, and modifications in the plan of care
- Evaluation is a continuous process of appraising the effect of nursing and the treatment regimen on the client's health status and expected health outcomes
- During the evaluation step, the nurse measures the success of the interventions in meeting the outcome criteria
- The client's response to treatment is documented, validating use of the nursing process in the delivery of care
- The diagnoses, outcomes, and plan of care are reviewed and revised as need is determined by the evaluation.

Example

A newly admitted client with the medical diagnosis of schizophrenia demonstrating the following behaviors:

1. Inability to trust others
2. Verbalizing hearing voices
3. Refusing to interact with staff and peers
4. Expressing a fear of failure
5. Poor personal hygiene

From these assessments, the treatment team may determine that the client has the following problems:

1. Paranoid delusions
2. Auditory hallucinations
3. Social withdrawal
4. Developmental regression

Team goals would be directed toward the following:

1. Reducing suspiciousness
2. Terminating auditory hallucinations
3. Increasing feelings of self-worth

From this team treatment plan, nursing may identify the following nursing diagnoses:

1. Disturbed sensory perception, auditory (evidenced by hearing voices)
2. Disturbed thought processes (evidenced by delusions)
3. Low self-esteem (evidenced by fear of failure and social withdrawal)
4. Self-care deficit (evidenced by poor personal hygiene)

- Nursing diagnoses are prioritized according to life -threatening potential
- Maslow's hierarchy of needs is a good model to follow in prioritizing nursing diagnoses
- Disturbed sensory perception (auditory) is identified as the priority nursing diagnosis, because the client may be hearing voices that command him or her to harm self or others
- Nursing in psychiatry, regardless of the setting (hospital, home, community) is goal-directed care
- The goals (or expected outcomes) are client oriented, are measurable, and focus ona resolution of the problem (if this is realistic) or on a more short-term outcome (if resolution is unrealistic)
- For example, in the previous situation, expected outcomes for the identified nursing diagnoses might be as follows:

  1. The client will demonstrate trust in one staff member within 5 days.
  2. The client will verbalize understanding that the voices are not real (not heard by others) within 10 days.
  3. The client will complete one simple craft project within 7 days.
  4. The client will take responsibility for own self-care and perform activities of daily living independently by time of discharge.

- Nursing interventions can be independent from or as part of a multidisciplinary team work and treatment regimen.
- Independent nursing actions such as focus on:

  1. Establishing trust on a one-to- one basis (thus reducing the level of anxiety that is promoting hallucinations)
  2. Giving positive feedback for small day-to-day accomplishments in an effort to build self-esteem
  3. Assisting with and encouraging independent self-care

- Nursing actions that are directed toward achievement of the team's treatment goals focuses on:

  1. Administering medications
  2. Taking part in case studies
  3. Participating in several therapies such as art therapy, OT, vocational training

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Psychiatric Mental Health Nursing Clinical Course

Mental Status Assessment

Gathering the correct information about the client's mental status is essential to the development of an appropriate plan of care. The mental status examination is a description of all the areas of the client's mental functioning. The following are the components that are considered critical in the assessment of a client's mental status.

IDENTIFYING DATA

1. **Name**
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2. **Gender**
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3. **Age and Date of Birth:**
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4. **Race/culture**

   a) **What country did you (your ancestors) come from?**

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5. **Occupational/financial status**

   a) **How do you make your living?**

   b) **How do you obtain money for your needs?**

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6. **Educational level**

   a) **What was the highest grade level you completed in school?**

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7. **Significant other**

   a) **Are you married?**

   b) **Do you have a significant relationship with another person?**

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8. **Living arrangements**

   a) **Do you live alone?**

   b) **With whom do you share your home?**

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9. **Religious preference**

   a) **Do you have a religious preference?**

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10. **Allergies**

   a) **Are you allergic to anything?**

   b) **Foods? Medications?**

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11. Special diet considerations

a) **Do you have any special diet requirements?**

b) **Diabetic? Low sodium?**

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12. Chief complaint:

a) **For what reason did you come for help today?**

b) **What seems to be the problem?**

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13. Medical diagnosis

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14. Psychiatric diagnosis

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GENERAL DESCRIPTION

Appearance

1. **Grooming and dress:**

   a) **Note unusual modes of dress.**

b) **Note evidence of soiled clothing.**

c) **Note use of makeup.**

d) **Is appearance neat or unkempt?**

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2. Hygiene:

a) **Note evidence of body or breathe odour.**

b) **Note condition of skin, fingernails**

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3. Posture:

a) **Note if standing upright, rigid, slumped over.**

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……………………………………………**Height and weight**

a) Perform accurate measurements.

- **BP:** ……….
- **Temperature:** ………………………………………………………………………………………….
- **Weight:** ……………………………………………………………………………………………………..
- **Height:** ………………………………………………………………………………………………………
- **Others:** ………………………………………………………………………………………………………

4. Level of eye contact

a) Intermittent

b) Occasional and fleeting

c) Sustained and intense

d) No eye contact

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……………………………………………………………………………………**Hair colour and texture**

a) Is hair clean and healthy looking?

b) Is hair greasy, matted, or tangled?

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………………………………………………………………………………………**Evidence of scars, tattoos, or other distinguishing skin marks**

a) Swelling or bruises

b) Birth marks

c) Rashes

5. Evaluation of client's appearance compared with chronological age

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<u>Motor Activity</u>

1. Tremors

a) Do hands or legs tremble? (Continuously, At specific times)

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2. Tics or other stereotypical movements

a) Evidence of facial tics

b) Jerking or spastic movements

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3. Mannerisms and gestures

a) Specific facial or body movements during conversation

b) Nail biting

c) Covering face with hands

d) Grimacing

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4. Hyperactivity

a) Gets up and down out of chair

b) Paces

c) Unable to sit still

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5. Restlessness or agitation

a) Lots of fidgeting

b) Clenching hands

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6. Aggressiveness

a) Overtly angry and hostile

b) Threatening

c) Uses sarcasm

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7. Rigidity

a) Sits or stands in a rigid position

b) Arms and legs appear stiff and unyielding

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8. Gait patterns

a) Evidence of limping

b) Limitation of range of motion

c) Ataxia

d) Shuffling

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9. Echopraxia

a) Any evidence of mimicking the actions of others?

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10. Psychomotor retardation

a) Movements are very slow.

b) Thinking and speech are very slow.

c) Posture is slumped.

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11. Freedom of movement (range of motion)

a) Note any limitation in ability to move.

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<u>Speech Patterns</u>

1. Slowness or rapidity of speech

a) Note whether speech seems very rapid or slower than normal.

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2. Pressure of speech

a) Note whether speech seems frenzied.

b) Is speech unable to be interrupted?

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3. **Intonation**

   a) **Are words spoken with appropriate emphasis?**

   b) **Are words spoken in monotone, without emphasis?**

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4. **Volume**

   a) **Is speech very loud? Soft?**

   b) **Is speech low-pitched? High-pitched?**

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5. **Stuttering or other speech impairments**

   a) **Hoarseness**

   b) **Slurred speech**

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6. **Aphasia**

   a) **Difficulty forming words**

   b) **Use of incorrect words**

   c) **Difficulty thinking of specific words**

d) **Making up words (neologisms)**

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General Attitude

1. **Cooperative/uncooperative**

   a) **Answers questions willingly**

   b) **Refuses to answer questions**

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2. **Friendly/hostile/defensive**

   a) **Is sociable and responsive**

   b) **Is sarcastic and irritable**

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3. **Uninterested/apathetic**

   a) **Refuses to participate in interview process**

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4. **Attentive/interested**

a) **Actively participates in interview process**

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5. **Guarded/suspicious**

   a) **Continuously scans the environment**

   b) **Questions motives of interviewer**

   c) **Refuses to answer questions**

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EMOTIONS

Mood

1. **Depressed; despairing**

   a) **An overwhelming feeling of sadness**

   b) **Loss of interest in regular activities**

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2. **Irritable**

a) **Easily annoyed and provoked to anger**

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3. **Anxious**

a) **Demonstrates or verbalizes feeling of apprehension**

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4. **Elated**

a) **Expresses feelings of joy and intense pleasure**

b) **Is intensely optimistic**

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5. **Euphoric**

a) **Demonstrates a heightened sense of elation**

b) **Expresses feelings of grandeur (“Everything is wonderful!”)**

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6. **Fearful**

a) **Demonstrates or verbalizes feeling of apprehension associated with real or perceived danger**

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7. **Guilty**

   a) **Expresses a feeling of discomfort associated with real or perceived wrongdoing**

   b) **May be associated with feelings of sadness and despair**

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8. **Labile**

   a) **Exhibits mood swings that range from euphoria to depression or anxiety**

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Affect

1. **Congruence with mood**

   a) **Outward emotional expression is consistent with mood (e.g., if depressed, emotional expression is sadness, eyes downcast, may be crying).**

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2. **Constricted or blunted**

   a) **Minimal outward emotional expression is observed.**

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3. **Flat**

   a) **There is an absence of outward emotional expression.**

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4. **Appropriate**

   a) **The outward emotional expression is what would be expected in a certain situation (e.g., crying upon hearing of a death).**

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5. **Inappropriate**

   a) **The outward emotional expression is incompatible with the situation (e.g., laughing upon hearing of a death).**

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THOUGHT PROCESSES

Form of Thought

1. Flight of ideas

a) Verbalizations are continuous and rapid and flow from one to another.

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2. Associative looseness

a) Verbalizations shift from one unrelated topic to another.

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3. Circumstantiality

a) Verbalizations are lengthy and tedious, and because of numerous details, are delayed reaching the intended point.

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4. Tangentiality

a) Verbalizations that are lengthy and tedious and never reach an intended point.

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5. Neologisms

a) The individual is making up nonsensical-sounding words, which have meaning only to him or her.

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6. Concrete thinking

a) Thinking literal; elemental

b) Absence of ability to think abstractly

c) Unable to translate simple proverbs

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7. Clang associations

a) Speaking in puns or rhymes; using words that sound alike but have different meanings

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8. Word salad

a) Using a mixture of words that have no meaning together; sounding incoherent.

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9. Perseveration

a) **Persistently repeating the last word of a sentence spoken to the client (e.g., Ns: "George, it's time to go to lunch." George: "lunch, lunch, lunch, lunch.")**

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10. Echolalia

a) **Persistently repeating what another person says**

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11. Mutism

a) **Does not speak (either cannot or will not)**

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12. Poverty of speech

a) **Speaks very little; may respond in monosyllables**

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13. Ability to concentrate and disturbance of attention

a) **Does the person hold attention to the topic at hand?**

b) **Is the person easily distractible?**

c) **Is there selective attention (e.g., blocks out topics that create anxiety)?**

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Content of Thought

1. **Delusions (Does the person have unrealistic ideas or beliefs?)**

a) **Persecutory: A belief that someone is out to get him or her in some way (e.g., "The FBI will be here at any time to take me away.")**

b) **Grandiose: An idea that he or she is all-powerful or of great importance (e.g., "I am the king and this is my kingdom! I can do anything!")**

c) **Reference: An idea that whatever is happening in the environment is about him or her (e.g., "Just watch the movie on TV tonight. It is about my life.")**

d) **Control or influence: A belief that his or her behaviour and thoughts are being controlled by external forces (e.g., "I get my orders from Channel 27. I do only what the forces dictate.")**

e) **Somatic: A belief that he or she has a dysfunctional body part (e.g., "My heart is at a standstill. (e.g., "It is no longer beating.")**

f) **Nihilistic: A belief that he or she, or a part of the body, or even the world does not exist or has been destroyed (e.g., "I am no longer alive.")**

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2. Suicidal or homicidal ideas

a) Is the individual expressing ideas of harming self or others?

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3. Obsessions

a) Is the person verbalizing about a persistent thought or feeling that is unable to be eliminated from his or her consciousness?

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4. Paranoia/suspiciousness

a) Continuously scans the environment

b) Questions motives of interviewer

c) Refuses to answer questions

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5. Magical thinking

a) Is the client speaking in a way that indicates his or her words or actions have power? (e.g. "If you step on a crack, you'll break your mother's back!")

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6. **Religiosity**

a) **Is the individual demonstrating obsession with religious ideas and behaviour?**

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7. **Phobias**

a) **Is there evidence of irrational fears (of a specific object, or a social situation)?**

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8. **Poverty of content**

a) **Is little information conveyed by the client because of vagueness or stereotypical statements or clichés?**

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PERCEPTUAL DISTURBANCES

1. **Hallucinations (Is the person experiencing unrealistic sensory perceptions?)**

a) **Auditory (Is the individual hearing voices or other sounds that do not exist?)**

b) **Visual (Is the individual seeing images that do not exist?)**

c) **Tactile (Does the individual feel unrealistic sensations on the skin?)**

d) **Olfactory (Does the individual smell odours that do not exist?)**

e) **Gustatory (Does the individual have a false perception of an unpleasant taste?)**

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2. Illusions

a) **Does the individual misperceive or misinterpret real stimuli within the environment? (Sees something and thinks it is something else.)**

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3. Depersonalization (altered perception of the self)

a) **The individual verbalizes feeling "outside the body;" visualizing himself or herself from afar.**

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4. Derealisation (altered perception of the environment)

a) **The individual verbalizes that the environment feels "strange or unreal" and has a feeling that the surroundings have changed.**

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SENSORIUM AND COGNITIVE ABILITY

1. **Level of alertness/consciousness a. Is the individual clear-minded and attentive to the environment?**

a) **Or is there disturbance in perception and awareness of the surroundings?**

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2. **Orientation: Is the person oriented to the following?**

a) **Time**

b) **Place**

c) **Person**

d) **Circumstances**

……

3. **Memory**

a) **Recent (Is the individual able to remember occurrences of the past few days?)**

b) **Remote (Is the individual able to remember occurrences of the distant past?)**

c) **Confabulation (Does the individual fill in memory gaps with experiences that have no basis in fact?)**

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4. **Capacity for abstract thought**

a) **Can the individual interpret proverbs correctly? ("What does 'no use crying over spilled milk' mean?"**

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IMPULSE CONTROL

1. **Ability to control impulses. (Does psychosocial history reveal problems with any of the following?)**

a) **Aggression**

b) **Hostility**

c) **Fear**

d) **Guilt**

e) **Affection**

f) **Sexual feelings**

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JUDGMENT AND INSIGHT

1. **Ability to solve problems and make decisions**

a) **What are your plans for the future?**

b) **What do you plan to do to reach your goals?**

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2. **Knowledge about self**

a) **Awareness of limitations**

b) Awareness of consequences of actions

c) Awareness of illness

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2. "Do you think you have a problem?"

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3. "Do you think you need treatment?"

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4. Adaptive/maladaptive use of coping strategies and ego defence mechanisms (e.g., rationalizing maladaptive behaviours, projection of blame, displacement of anger)

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