Lecture Objectives

1. Apply the nursing process and the ANA Standards of Care to the practice of psychiatric-mental health nursing.
2. Describe the importance of the interview in the assessment process.
3. Explain the components of a psycho social assessment.
4. Discuss how to use psycho social assessment data in formulating nursing diagnosis.
5. Define the nursing care planning process from a psychiatric mental health perspective.
6. Identify the role of the psychiatric mental health nurse as it relates to implementation of the nursing care plan
7. Discuss evaluation of psychiatric mental health nursing care.
8. Formulate nursing care plans for patients in the psychiatric mental health settings.

Reading Assignment:
Townsend, Chapter 9
Townsend Pocket Guide, Chapter 1 and Appendix H & I

Lecture Outline:
Introduction:
Nursing process provides nurses a methodology for a systematic framework for delivery of nursing care.
I. Nursing Process and ANA Standards of Care
   A. Assessment - Standard I (ANA Coalition of Psychiatric Nursing Organization, 1994) The psychiatric mental health nurse collects data in order to make sound clinical judgements and plan interventions
      1. A deliberate systematic, logical collection of data
      2. Purpose - to identify patient problems amenable to nursing interventions
      3. Scope - assessment should be holistic
      4. 5 dimensions of functioning - look for changes. Also strengths, as well as problem areas.
         a. physical
         b. psychological/emotional
c. intellectual/cognitive
d. sociocultural
e. spiritual

5. Sources of data
   a. Primary: the patient
   b. Family, friends, peers
   c. medical records
   d. physician and members of health care team

First level assessment
   Purpose: to determine immediate needs
   Involves observing and interviewing the patient and gathering information
   from the family
   Goal: to identify appropriate facts that light/illuminate the patient’s
   presenting problem
   Early data is usually not complete
      Problem lists
      Care plan data
      Health status assessment

Ongoing assessment- Second level assessment
   Purpose: enhancement of understanding of patient needs, current
   information on patient’s condition
   Involves continuous assessment and also implies intervention/response to
   interventions
   Goal: provides expanded data base
   Comprehensive in the five dimensions as it relates to the patient’s
   presenting here and now problem

Verification of data - review for accuracy
   Should occur continuously throughout care
   Plans based on erroneous data will usually not achieve the expected
   outcome of improving patient’s health status
   Verify data by talking with and asking patient questions
   Should especially be done when there is conflicting data, when the source
   may not be reliable and whenever serious harm may come to the patient
   because of inaccuracy
   Verify data by getting additional data from significant others, nursing
   colleagues and other health care personal who have had contact with the
   patient
II. Psychiatric Interview - a process and a tool to accomplish psycho social assessment

A. Goal directed communication, a systematic attempt to gain a broad range of information, involves observation, listening, and questioning. Assessment is the deliberate, systematic and logical collection of data which begins with the initial contact with the patient and is ongoing. From the assessment nursing diagnoses will be formulated which attaches meaning to data and will help clarify, validate and categorize.

1. Goals of Psychiatric Interview
   a. Assess current level of functioning
   b. Establish trusting rapport
   c. Explore past history of coping
   d. Formulate care plan

2. General considerations when assessing and interviewing
   a. Safe, private, comfortable setting that will have minimal interference/interruptions
   b. Inform patient of purpose “I need to ask you some questions so I can know more about you, so we can work together”
   c. Set a time frame- let patient know how long you will be asking questions (10-15 minutes)
   d. Do not take notes during psycho social assessment
   e. Be sure to end interview with a sense of closure- tie up loose ends and do not finish abruptly - tell patient your appreciate their time and willingness to share

3. Physical Assessment
   a. Physical data
      General: Does patient have any history of physical illness? Does patient have a physical condition in addition to emotional problems? These along with vital signs are about all you do in a psychiatric setting unless otherwise ordered by doctor
      Specific physical assessments that are important to make
      eating patterns
      sleep patterns
      energy level
      sexual activity
      physical reactions to psycho tropic medications

III. Psycho social Assessment

Psycho social Assessment - assessment of psychological, sociological, developmental, spiritual, and cultural data. Provides basis for treatment decisions and a baseline to evaluate change in behavior or function.
**PSYCHO SOCIAL ASSESSMENT - GO OVER GUIDELINE**

A. Patient’s perception of current situation/presenting problem
   1. ask to describe in own words why in the hospital?
   2. pay attention to what you already know about their condition and also the manner in which they describe the problem. Note; many times the nurses’ impression of the presenting problem is quite different than what is described by the patient. Also, sometimes people are hesitant at first due to embarrassment to tell the ‘real’ problem
   3. Brief recent history. Questions should elicit an account of the development of the presenting problem over the past several days or weeks. Exp. “How long have you thought this?” “What helped you decide to get help?” “What difficulties led you to being admitted?” “Did it happen slowly or suddenly?”

B. Cultural, Social, familial and environmental variables
   1. Social - what has changed in relation to the patient’s social spheres?
      a. school, work, church, community, hobbies Exp.” Has anything change at work?” “In the way you spend leisure time?” “Who is your support system?” “How have you been meeting your spiritual needs?”
   2. Family
      a. What/who is family structure (parents, siblings, spouse, children) This will provide clues for issues that may need further assessment
      b. Are you close to your family?
      c. Note the patient’s reaction when disclosing family information Exp. how does patient describe significant events such as parent’s divorce, father’s suicide, sister’s graduation from high school? Is there a note of hostility? Unresolved grief? Is there any family history of someone else having same problem? Substance abuse? Alcoholism? Suicide? Previous psychiatric hospitalization?
   3. Environment
      a. Has there been any change in where you live? The family history will also give cues as to what the patient’s environment has been like
4. Habits, activities, lifestyle
   a. Assess medications, ETOH, cigarettes
   b. What is a typical day like for you?
   c. How have you coped in the past?
   d. How have you been coping with the things you have to do every day? How do you feel about life? EXP. Can the 34 yr. old housewife care for her three children? Has the 48 yr old executive been able to concentrate on his work and manage his responsibilities?

THOUGHTFUL CAREFUL EXPLORATION OF PATIENT’S PERSONAL HISTORY WILL HELP IDENTIFY NEEDS, FEELINGS, AND MOTIVATION MANIFESTED IN CURRENT SYMPTOMS

Summary = in reviewing the personal history of any patient, the nurse should pay attention to areas of strength as well as areas of difficulty. Adaptive coping strategies, talents, accomplishments, insights and support systems are noted. These are your patient’s resources.

IV. Utilizing psycho social assessment data to formulate Nursing Diagnosis - Standard II
   A. The mental health nurse analyzes assessment data to determine nursing diagnosis.
   B. Purpose - attaches meaning to the data to help clarify, validate, and categorize. so that connecting relationships can be recognized. Clearly describes the problem/need the patient has so that the nurse can proceed with goal planning.
   C. Holistic assessment- problem list should be comprehensive, assessing patient in all dimensions
   D. Related to = listings of risk factors, for example
      Risk for violence: self directed or directed toward others RT history of self directed violence, lack of coping skills and dysfunctional family AEB “I got mad at my mother and decided I would hurt her and myself. My family has been so screwed up. My dad is in prison, my sister ran away. She would not have ran away if.....”
      Ineffective Individual Coping RT multiple life stressors.............

PROBLEM LIST GUIDELINE

V. A. Goal Setting - Standard III
   1. The psychiatric mental health nurse identifies expected outcome individually for the patient. The outcome is the desired achievable outcomes to be obtained within a predicted time span, given the presenting situation and available resources.
2. Long term goals- spell out the final desired outcome. Gives the overall direction for care. They are determined when a need for change is established.

3. Short term goal - focus on immediate achievement. Concrete and tangible, deal with expectations for the here and now. Completion of short term goals indicate that one is on the way to accomplishing LTG.

B. Planning - Standard IV

The mental health nurse develops a plan of care that specifies interventions to attain the identified outcome. The patient entering a mental health care setting is trying to find order in a chaotic existence, his world is arye and change is needed. Through assessment and analysis you have examined the patient’s physical and mental health, social and economic stressors, and functioning in family, work setting and community. Planning is the ordering of that information and using it in collaboration with the patient and other health team members to help the patient deal effectively with mental health needs and problems.

A. Definition - orderly structuring of interventions to achieve a goal. Provides map and reference markers to allow us to observe and evaluate progress. The plans must reflect the patient’s choices. Ask “Whose choices are these?” “Whose plan is it?” “Whose value does this reflect?”

B. Purpose - 1. To develop guidelines for helping the patient obtain a state of optimal wellness. 2. To establish the process/direction of change 3. To measure progress.

C. Process of planning - the concreteness of words on paper clarifies one’s thinking and keeps the plan on track, and serves as a reminder of where the planner has been and is heading.

Planning Interventions - interventions are approaches listed to assist in attaining goal. Criteria for interventions:

- Simple, concise, and clearly stated
- Specific
- Should relate to the identified goal
- Written in nursing terms
- Individualized
- Realistic
VI. Implementation - Standard V
A. The mental health nurse implements the interventions identified in plan of care
B. Specific interventions of mental health nurse according to standards of care
   1. Counseling
   2. Milieu Therapy
   3. Self Care Activity
   4. Psycho biological Interventions
   5. Health Education
   6. Case Management
   7. Health Promotion and Maintenance
   8.

VII. Evaluation of nursing care- Standard VI
A. The mental health nurse evaluates patient progress in attaining expected outcome.
   Evaluation is a continuous, dynamic process of measuring patient progress.
   If problems and goals have been identified in precise terms, evaluation is relatively simple

NURSING CARE PLAN GUIDELINE

OPERATIONALIZE PSYCHIATRIC MENTAL HEALTH NURSING CARE PLANS THROUGH GROUP CASE STUDY WORK

Documentation
Behavioral Charting --See Charting Guideline and Charting Handout

Nursing Case Management
A. Managed Care
   1. Purpose - to balance cost and quality of care
B. Case Management
   1. A method utilized to achieve managed care
C. Critical Pathways of Care (CPC)
   1. A tool utilized for care in a case management system. An abbreviated plan of care that provides outcome based guideline for goal achievement within a designated length of stay. See Table 7.4 for example of CPC for alcohol withdrawal
Guideline: Mental Status Exam
This is provided to facilitate understanding of the Mental Status Exam within the Psycho social Assessment

Purpose: This exam assesses current intellectual and emotional functioning of your patient. It is a tool for assessment that can be used with both psychiatric and medical-surgical patients.

1. **General appearance and behavior** - assess through general observations
   a. Grooming and dress - should be a precise description of the patient’s apparel and hygiene; compare with social norms.
   b. Facial expression - can be angry, sad, anxious, puzzled, tearful, etc.
   c. Motor behavior - can be retarded (underactive, overactive), spontaneous speech, fluidity of movement, speed and reaction time to questions.
   d. Level of consciousness - can be alert, confused, somnolent.
   Note: Do not just label what you see, describe as if you are making a “word picture” of the patient.

2. **Flow of thought and speech** - note how well the patient fits thoughts together; does he make sense? Note quantity/quality of speech to include voice volume, presence of slurring, etc.
   Examples of problems:
   - Push (pressured) Speech
   - Flight of Ideas
   - Tangential Speech
   - Circumstantiality
   - Blocking

3. **Affect** - is the outward expression of the internal mood. It can be assessed by content or verbal communication, voice tone, facial expression, posture, gestures, etc. It is considered “appropriate” only if it is congruent with the subject matter being discussed. If there is an in-congruency, affect is said to be inappropriate.
   Examples of descriptive words for affect
   - Depressed affect
   - Euphoric affect
   - Grandiose affect
   - Flattened affect
   - Labile affect
   Remember that you must five term and then describe your observations of patient behavior. Affect can be suspicious, hostile, puzzled, etc.
4. **Thought content** - this is assessed as you talk to the patient and is a general description of actual topics of conversation. You listen for themes of conversation and also for symptoms of psycho pathology.

   - Examples
     - Delusions - prosecutory, ideas of reference, grandiose, alien control, somatic
     - Hallucinations - auditory, visual, touch, smell, taste
     - Self deprecatory ideas - worthless, sinfulness, guilt
     - Phobias
     - Obsessions
     - Compulsions
     - Preoccupation with death, suicidal ideation
     - Depersonalization

   Be sure to describe any of these along with the term you use.

5. **Sensorium (level of consciousness) and intellectual functions** - For each of these assessments, you must describe how you assessed, the patient’s response, and your impression/interpretation.

   A. Orientation - to person, place and time
   B. Memory - assess three areas of memory. First ask the patient how his memory has been.
      1. Immediate memory - name three items. Then ask the patient to repeat them immediately and again in three minutes and again in five minutes. You will continue with other assessments, but at three and five minutes ask the patient to recall the three items. Make a note of items missed at interval. Three or more errors are very suggestive of problems with storage of information and recall.
      2. Recent memory - ask specific questions about times and sequence of events of past few days (make sure it is something you know too!) Inability to give a coherent picture of the past few days suggests a recent memory problem
      3. Remote memory - ask specific questions about events and dates in distant past, i.e. birth date, birth place, date of marriage(s), or other life milestones (again choose something verifiable). Might have patient recall the past five presidents. Inability to give an answer at all is highly suggestive of memory dysfunction.
   C. Intellectual functioning - this includes areas of intellectual activity which are easily tested. You need to have a good idea of premorbid level of functioning and take into account such factors as education level, present ability to concentrate, and willingness to cooperate or make the effort to respond to testing.
D.

1. General fund of knowledge - notice how well patient is tuned in to the environment; can he relate recent news stories or talk about local politics? Can he recall the past five presidents? Name five major cities in the United States? Three or more errors in naming cities or states suggest impaired intellectual functioning. A person with a college degree or high IQ can have a poor fund of knowledge due to disordered thought processes.

2. Ability to calculate - this test area can give an idea as to how intact is a person’s ability to calculate and also concentrate. Ask the patient to:
   a. Perform “serial 7’s”, that is, subtract seven from 100 and continue to subtract from the answer (i.e., 100, 93, 87, etc.). This tests both ability to calculate and concentrate.
   b. Perform simple arithmetic problems such as making change or doing multiplication table.
   Seven or more errors with serial 7’s is considered poor and four to seven errors is considered fair. Errors can reflect poor education, low IQ as well as change due to organic impairment. Additionally, you must take into account the patient’s age and anxiety level. Your analysis/impression should include information as to concentration as well as calculation ability.

3. Ability to abstract - this test area helps the nurse assess the patient’s ability to generalize, to find meaning in symbols, and to conceptualize objects and events. It tests current reasoning ability, not prior performance. It is tested by asking the patient to interpret two or more proverbs. Start by explaining to the patient that a proverb is a saying and that you are going to say one and ask him what it means. Some examples are as follows: (Note - make sure you ask ones YOU understand!).
   “Don’t count your chickens before they are hatched”
   “A stitch in time saves nine”
   “Don’t cry over spilled milk”
   “Don’t put all your eggs in one basket”
   “People who live in glass houses should not throw stones”
   “A rolling stone gathers no moss”
   When a person is able to give the underlying meaning to a proverb correctly, we can say that he is able to think abstractly. For example, “Don’t count your chickens before they are hatched” means: Don’t anticipate or count on the outcome before it happens.
If a person cannot think abstractly, then this ability is impaired and you will observe concrete thinking. Using the same example above, the patient might say, “You can’t count chickens before they are hatched because they are still inside the shell”.

4. Insight - reflects patient’s awareness of psychiatric problems or behavior that is causing him/her problems. Can usually be determined at the onset of initial interviewing when the patient relates his presenting problem (chief complaint). You should be determining whether the patient recognizes the significance of the present situation, his recognition of need for treatment and whether or not any denial is going on. Frequently, psychiatric patients deny they have a problem and it is family members or friends who recommend treatment. There are degrees of insight. Example: A patient agrees he has a drinking problem, but blames it on his wife. Insight is described in terms of being good, fair, or poor.

5. Judgement - is defined as how a person makes decisions or comes to conclusions and also how he takes action. Judgement is closely related to insight, although a person can have good insight and still have poor judgement. Defects in judgement usually become apparent while the patient is relating current and past history. Example: How has he been handling interpersonal, occupational and economic activities? You might ask, “Why were you brought here?”, “What do you think should be done about this problem?” “What are your goals?”. Note also if patient is acting on delusions or hallucinations. Judgement is described in terms of being good, fair, or poor.