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Psychiatric Nursing Process and Care Planning

Mental Health Nursing

Psychiatric nursing assessment, nursing diagnoses, planning, implementation, evaluation, individualised care plans and clinical documentation.

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CHAPTER 06 / MENTAL HEALTH NURSING 06. Psychiatric Nursing Process and Care Planning

1. Assessment and formulation

Collect psychiatric and physical history, MSE, functional capacity, sleep, medicines, substance history, nutrition, coping, support and safety concerns. Identify strengths as well as problems. Formulate factors predisposing, precipitating, perpetuating and protecting the individual (4 Ps); diagnoses guide but do not replace individualized assessment.

2. ADPIE and nursing diagnoses

Assessment -> nursing diagnosis -> planning -> implementation -> evaluation. Nursing diagnoses describe responses (e.g., anxiety, impaired sleep, risk for self-directed injury, social isolation where supported), not medical diagnoses. Terminology should follow current institutional nursing classification. Problem-focused diagnoses may use PES: problem, related factor, evidence. Risk diagnoses use risk factors, not signs of a problem that has not occurred.

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3. Sample care plan: depressive symptoms and self-harm risk

Nursing process	Example (illustrative)
Assessment	Patient reports hopelessness and recent suicidal thoughts; assess intent, plan, means, past attempts, support and physical status promptly.
Priority / goal	Safety; patient remains safe during admission, participates in agreed safety plan as able and identifies support contacts.
Implementation	Escalate risk to team; observation/environmental safety per individualized plan; nonjudgmental listening, address pain/sleep and prescribed treatment; collaborative safety planning.
Rationale	Timely assessment, reduced access to hazards and support can reduce immediate risk and facilitate help-seeking.
Evaluation	Reassess ideation, intent, distress and protective factors; document actual response and update plan.

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4. Additional care planning examples

For hallucinations: assess content, associated fear and safety, use reality-based communication and coping, monitor prescribed medication and distress. For mania: reduce stimulation, support sleep/nutrition, use clear consistent limits and monitor risk. For withdrawal: assess substance/timing and severity, vitals, prescribed protocol and escalation. Outcomes should be measurable and agreed where possible, not merely "patient will be cured."

5. Documentation and collaboration

Write date/time, specific findings, interventions, consent, medication and effects, safety level, communication and reassessment. Review within multidisciplinary team, at transfer and discharge. Include relapse warning signs, medication education, follow-up and crisis contacts; ensure accessible written plan. Never use a no-suicide contract as substitute for assessment or safety planning.

6. Important Examination Questions

Long Answer Questions

1. 1. Explain psychiatric nursing process and prepare a care plan for depression or psychosis.

Short Answer Questions

1. 1. Write PES format
2. 2. explain risk diagnosis
3. 3. describe evaluation and documentation.

Very Short Answer Questions (with answers)

1. 1. What is a nursing diagnosis? - Clinical judgment about human responses.
2. 2. What is a SMART goal? - Specific, measurable, achievable, relevant, time-bound.

7. Quick Revision

- Safety is a priority.
- Plans must be individualized and reviewed.
- Record outcomes rather than assumptions.

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8. Conclusion

Safety is a priority. Plans must be individualized and reviewed. Record outcomes rather than assumptions.

Practice questions

Choose one best answer. The answer key and explanations follow the questions.

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1. Which set identifies the four factors in a 4 Ps formulation?

A. Presenting, prescribing, predicting and preventing

B. Physical, personal, professional and procedural

C. Predisposing, precipitating, perpetuating and protecting

D. Planning, prioritizing, performing and prescribing

2. How should a risk nursing diagnosis be supported?

A. With signs proving the future problem has already occurred

B. With a medical diagnosis alone

C. With the same evidence format as every actual problem

D. With risk factors for a problem that has not yet occurred

3. Which goal best follows the described approach to psychiatric care-plan outcomes?

A. The patient will identify two support contacts before discharge.

B. The patient will be cured.

C. The nurse will provide general education whenever possible.

D. The patient will improve at some point.

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Answer key and explanations

1. C - Predisposing, precipitating, perpetuating and protecting

The 4 Ps organize factors influencing the individual's presentation.

2. D - With risk factors for a problem that has not yet occurred

Risk diagnoses use risk factors because the potential problem has not occurred.

3. A - The patient will identify two support contacts before discharge.

The goal is specific, measurable and time-bound rather than a vague promise of cure.

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