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Obsessive-compulsive disorder Initial assessment

Mental Health Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

27-year-old woman distressed by contamination fears. Care stage: At the first supervised assessment.

Medical history: Contamination fears and repeated washing consume substantial time and interfere with study. The patient recognizes distress and is seeking treatment support. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The person wishes to participate in decisions and prefers permission before others are involved. Assess support, work/study function, substance use and practical access without stigma.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Repeated washing and intrusive thoughts interfere with study and daily life.

Objective findings and required checks: Time-consuming rituals with skin irritation; assess insight, function and mood.

Physical examination and investigations: Assess symptom impact, comorbidities, skin condition and safety using appropriate clinical tools.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Obsessive-compulsive disorder: Intrusive thoughts and rituals can form a cycle of distress and temporary relief.

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Medical / surgical management

Build trust and support specialist cognitive-behavioural treatment including exposure and response prevention when prescribed.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed SSRI	Treat OCD symptoms when indicated	Monitor adverse effects, adherence and response over the agreed review period
skin treatment when prescribed	Treat washing-related irritation	Assess skin integrity.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Repeated washing and intrusive thoughts interfere with study and daily life. Time-consuming rituals with skin irritation; assess insight, function and mood. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize emotional distress affecting participation in care; skin damage or vulnerability to pressure-related injury; coping resources strained by illness or social stress; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Build trust and support specialist cognitive-behavioural treatment including exposure and response prevention when prescribed. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance. 4. Build trust and support specialist cognitive-behavioural treatment including exposure and response prevention when prescribed. Rationale: Intrusive thoughts and rituals can form a cycle of distress and temporary relief. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about discomfort, usual mobility and ability to reposition. Assess: Inspect skin, pressure points, wound characteristics and moisture exposure.	Skin damage or vulnerability to pressure-related injury. Possible factors: pressure, moisture, impaired sensation or tissue injury. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Skin is protected and existing damage shows no avoidable deterioration. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates the individualized skin-protection plan.	1. Assess skin and pressure risk using the local tool and clinical judgment. Rationale: Risk identification guides targeted prevention. 2. Individualize repositioning, heel offloading and pressure redistribution. Rationale: Reducing sustained pressure and shear protects tissue perfusion. 3. Use appropriate wound care and moisture management; refer for nutrition or specialist advice when needed. Rationale: Healing requires local protection and support for underlying contributors.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about stressors, strengths, support people and previous coping. Assess: Assess function, engagement and immediate safety needs.	Coping resources strained by illness or social stress. Possible factors: demands exceeding currently available support. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Chooses one feasible coping action and identifies a support person or service. Longer-term: Before the clinically approved transition or agreed follow-up: Has a realistic follow-up and support plan agreed with the care team.	1. Assess strengths and barriers collaboratively. Rationale: An individualized plan builds on resources the person can actually use. 2. Practice a simple coping strategy and divide tasks into achievable steps. Rationale: Small successes support confidence and participation. 3. Coordinate social, psychological or community support as indicated. Rationale: Practical barriers can limit recovery even when clinical treatment is available.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: After the first indicated intervention, at the	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain the therapy plan and supportive family responses; avoid abrupt forced ritual prevention outside treatment. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain the therapy plan and supportive family responses; avoid abrupt forced ritual prevention outside treatment.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Severe self-neglect, inability to eat or drink, suicidal thoughts or major skin infection needs urgent review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Intrusive thoughts and rituals can form a cycle of distress and temporary relief.

- Priority concerns: Emotional distress affecting participation in care; Skin damage or vulnerability to pressure-related injury; Coping resources strained by illness or social stress; Learning needs about the condition and care plan.

- Severe self-neglect, inability to eat or drink, suicidal thoughts or major skin infection needs urgent review.

- Explain the therapy plan and supportive family responses; avoid abrupt forced ritual prevention outside treatment.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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