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Schizophrenia and distressing voices Comfort & daily function

Mental Health Nursing | Comfort & daily function

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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.

Clinical assessment

Subjective: Hears distressing voices and has withdrawn from friends.

Objective findings and required checks: Distractibility and reduced self-care; assess content, distress and immediate risk.

Physical examination and investigations: Assess mental state, risk, physical health, substances and medicine history.

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

Clinical focus and pathophysiology

Schizophrenia and distressing voices: Psychotic symptoms can alter perception, thought and functioning; causes require comprehensive assessment.

Medical / surgical management

Acknowledge distress without confirming false beliefs, use clear communication and coordinate prescribed psychosocial and medication care.

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Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed antipsychotic	Reduce assessed psychotic symptoms	Monitor movement effects, sedation, metabolic parameters and other drug-specific risks
medication review	Identify barriers and adverse effects	Use shared decisions with the treating team.

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

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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: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

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 about experiences, distress and thoughts of harming self or others directly and respectfully. Assess: Assess orientation, mental state, behaviour and possible medical contributors.	Disturbed interpretation of experiences affecting safety or function. Possible factors: changes in perception, cognition or mood. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Engages in a safe, calm interaction and accepts an agreed support step. Longer-term: Before the clinically approved transition or agreed follow-up: Patient and support team describe relapse signs and the follow-up plan.	1. Use calm, brief communication and acknowledge feelings without reinforcing false beliefs. Rationale: A consistent approach reduces confrontation and distress. 2. Assess immediate risk and possible delirium or substance-related causes; escalate concerns. Rationale: Medical and psychiatric emergencies may present with altered behaviour. 3. Maintain a low-stimulation setting and monitor prescribed treatment effects. Rationale: The environment and treatment response influence safety and recovery. 4. Acknowledge distress without confirming false beliefs, use clear communication and coordinate prescribed psychosocial and medication care. Rationale: Psychotic symptoms can alter perception, thought and functioning; causes require comprehensive assessment. The condition-specific plan addresses the underlying problem while response is	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
			monitored.	
Ask: Ask directly about safety, self-harm, aggression and access to harmful means. Assess: Assess risk, observation needs and environmental hazards collaboratively.	Immediate safety needs during altered mood, cognition or behaviour. Possible factors: reduced judgment, severe distress or loss of control. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Immediate risks are addressed using the least restrictive appropriate care plan. Longer-term: Before the clinically approved transition or agreed follow-up: A collaborative safety and follow-up plan is documented before transition.	1. Escalate imminent danger immediately and maintain observation according to risk and local policy. Rationale: Timely support protects life and prevents unobserved deterioration. 2. Use de-escalation, respectful communication and proportionate environmental safeguards. Rationale: Dignity and reduced stimulation can support safer engagement. 3. Review risk with the multidisciplinary team and document changes and handover. Rationale: Risk is dynamic and requires continuity across staff and settings.	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 which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	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 what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: 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.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves 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. Teach relapse monitoring, treatment follow-up, physical health care and family support with consent. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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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Health education and continuing care

Teach relapse monitoring, treatment follow-up, physical health care and family support with consent.

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

Commands to harm, inability to maintain safety, severe agitation or possible delirium requires urgent assessment.

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

- Psychotic symptoms can alter perception, thought and functioning; causes require comprehensive assessment.

- Priority concerns: Disturbed interpretation of experiences affecting safety or function; Immediate safety needs during altered mood, cognition or behaviour; Daily self-care needs exceed current ability; Learning needs about the condition and care plan.

- Commands to harm, inability to maintain safety, severe agitation or possible delirium requires urgent assessment.

- Teach relapse monitoring, treatment follow-up, physical health care and family support with consent.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

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B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council

https://www.indiannursingcouncil.org/gazette-notification

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