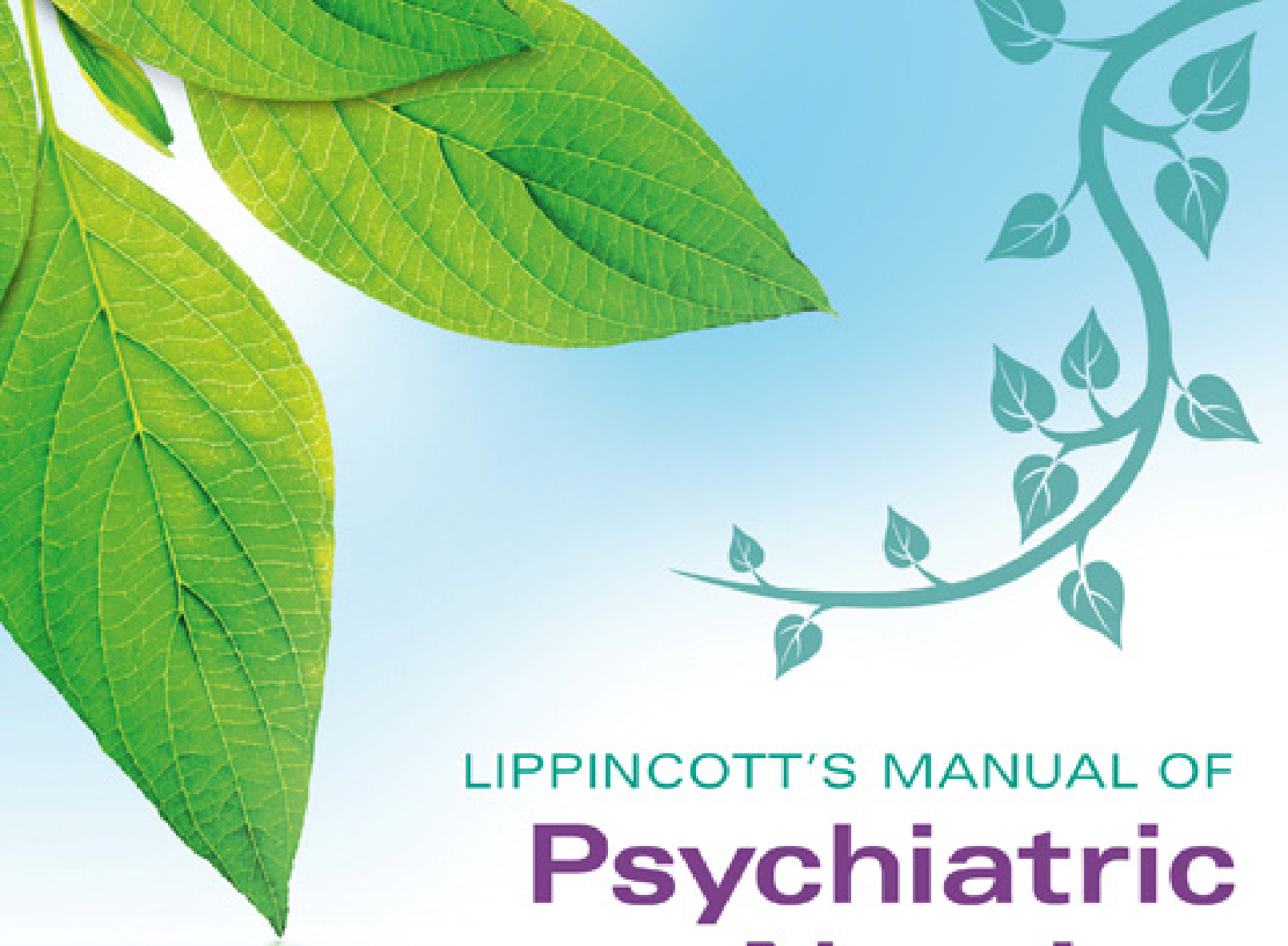

LIPPINCOTT'S MANUAL OF

Psychiatric Nursing Care Plans

EDITION 9

Sheila L. Videbeck
Judith M. Schultz

Wolters Kluwer Health | Lippincott Williams & Wilkins

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PREFACE

The ninth edition of *Lippincott's Manual of Psychiatric Nursing Care Plans* continues to be an outstanding resource for nursing students and practicing psychiatric–mental health nurses. The *Manual* is a learning tool and a reference presenting information, concepts, and principles in a simple and clear format that can be used in a variety of settings. The *Manual* complements theory-based general psychiatric nursing textbooks and provides a solid clinical orientation for students learning to use the nursing process in the clinical psychiatric setting. Its straightforward presentation and effective use of the nursing process provide students with easily used tools to enhance understanding and support practice.

Too often, students feel ill-prepared for their clinical psychiatric experience, and their anxiety interferes with both their learning and appreciation of psychiatric nursing. The *Manual* can help to diminish this anxiety by its demonstration of the use of the nursing process in psychiatric nursing and its suggestions for specific interventions addressing particular behaviors, together with rationale, giving the student a sound basis on which to build clinical skills.

The continued, widespread, international use of this *Manual* supports our belief in the enduring need for a practical guide to nursing care planning for clients with emotional or psychiatric problems. However, the care plans in this *Manual* do not replace the nurse's skills in assessment, formulation of specific nursing diagnoses, expected outcomes, nursing interventions, and evaluation of nursing care. Because each client is an individual, he or she needs a plan of nursing care specifically tailored to his or her own needs, problems, and circumstances. The plans in the *Manual* cover a range of problems and a variety of approaches that may be employed in providing nursing care. This information is meant to be adapted and used appropriately in planning nursing care for each client.

TEXT ORGANIZATION

The *Manual* is organized into three parts.

Part One, Using the Manual, provides support for nursing students, instructors, and clinical nursing staff in developing psychiatric nursing skills; provides guidelines for developing interaction skills through the use of case studies, role play, and videotaped interaction; and provides strategies for developing written nursing care plans.

Part Two, Key Considerations in Mental Health Nursing, covers concepts that are considered important underpinnings of psychiatric nursing practice. These include the therapeutic milieu, sexuality, spirituality, culture, complementary and alternative medicine, aging, loneliness, homelessness, stress, crisis intervention, community violence, community grief and disaster response, the nursing process, evidence-based practice, best practices, the interdisciplinary treatment team, nurse–client interactions, and the roles of the psychiatric nurse and of the client.

Part Three, Care Plans, includes 52 care plans organized into 13 sections. The section titles are General Care Plans; Community-Based Care; Disorders Diagnosed in Childhood or Adolescence; Delirium, Dementia, and Head Injury; Substance-Related Disorders; Schizophrenia and Psychotic Disorders/Symptoms; Mood Disorders and Related Behaviors; Anxiety Disorders; Somatoform and Dissociative Disorders; Eating Disorders; Sleep Disorders and Adjustment Disorders; Personality Disorders; and Behavioral and Problem-Based Care Plans.

NURSING PROCESS FRAMEWORK

The *Manual* continues to use the nursing process as a framework for care, and each care plan is organized by nursing diagnoses. The care plans provide an outcomes-focused approach, and therapeutic goals content is included in the basic concepts section and the introductory paragraphs of the care plans.

NEW TO THIS EDITION

- New information on Complementary and Alternative Medicine information and Using the Internet
- All care plans revised and updated
- Expanded outcomes statements with specific timing examples
- Updated Recommended Readings in each section
- Updated Resources for Additional Information for each section; additional information is also available on thePoint
- Updated references throughout the *Manual*
- Rationale for correct responses of the section review questions
- Updated NANDA International 2012–2014 nursing diagnoses included*
- New appendix on Electroconvulsive Therapy
- Expanded, updated, and reformatted Psychopharmacology Appendix
- New appendix on Side Effects of Medications and Related Nursing Interventions
- New appendix on Schizoid, Histrionic, Narcissistic, Avoidant, and Obsessive-Compulsive Personality Disorders

USING THE MANUAL

The *Manual* is an ideal text and reference for mental health and general clinical settings, including community and home care nursing, in addition to its use as a text for students. The *Manual* offers sound guidance to those professionals who have less confidence in dealing with clients who are experiencing emotional difficulties and offers new staff members guidelines for clear and specific approaches to various problems. The *Manual* can be especially helpful in the general medical or continuing care facility, where staff members may encounter a variety of challenging patient behaviors.

We believe that effective care must begin with a holistic view of each client, whose life is composed of a particular complex of physical, emotional, spiritual, interpersonal, cultural, socioeconomic, and environmental factors. We sincerely hope that *Lippincott's Manual of Psychiatric Nursing Care Plans*, in its ninth edition, continues to contribute to the delivery of nonjudgmental, holistic care and to the development of sound psychiatric nursing knowledge and skills, solidly based in a sound nursing framework.

RESOURCES FOR STUDENTS, INSTRUCTORS, AND PRACTICING NURSES

Visit thePoint at http://thePoint.lww.com/Schultz9e for materials to assist students and practicing nurses to write individualized care plans quickly and efficiently (see Part One, Using the Manual). Resources on thePoint include all 52 care plans, the Sample Psychosocial

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Assessment Tool, and lists of resources for additional information. Individual care plan files can be downloaded onto a personal computer to streamline the student's or nurse's efforts, enhance the care planning process, and facilitate the consistent use of care plans in any setting where mental health clients are encountered. Also included is a sample Watch & Learn video clip from *Lippincott's Video Guide to Psychiatric–Mental Health Nursing Assessment,* as well as Practice & Learn activities from *Lippincott's Interactive Case Studies in Psychiatric–Mental Health Nursing*.

ACKNOWLEDGMENTS

We wish to express our appreciation to all of those we have encountered, who have helped our learning and growth, and enabled us to write all the editions of this manual. We are truly grateful for the opportunity to know and work with them and to benefit from their experiences and their work. We also offer our heartfelt thanks to all those in our personal lives who have been supportive of us and of this work since the *Manual's* inception over 35 years ago!

Judith M. Schultz, MS, RN
Sheila L. Videbeck, PhD, RN

CONTENTS

PART ONE

Using the Manual

The *Manual of Psychiatric Nursing Care Plans* is designed for both educational and clinical nursing situations. Because the care plans are organized according to the nursing process within each nursing diagnosis addressed, the *Manual* can effectively complement any psychiatric nursing text and can be used within any theoretical framework. Because the plans are based on psychiatric disorders, client behaviors, and clinical problems, the *Manual* is appropriate for both undergraduate and graduate levels of nursing education.

In the clinical realm, the *Manual* is useful in any nursing setting. The *Manual* can be used to help formulate individual nursing care plans in inpatient, partial hospitalization, and outpatient situations; in psychiatric settings, including residential and acute care units, locked and open units, and with adolescent and adult client populations; in community-based programs, including individual and group situations; in general medical settings, for work with clients who have psychiatric diagnoses as well as those whose behavior or problems are addressed in the *Manual*; and in skilled nursing facilities and long-term residential, day treatment, and outpatient settings.

NURSING STUDENTS AND INSTRUCTORS

Development of Psychiatric Nursing Skills in Students

For a student, developing nursing skills and comfort with clients with psychiatric problems is a complex process of integrating knowledge of human development, psychiatric problems, human relationships, self-awareness, behavior and communication techniques, and the nursing process with clinical experiences in psychiatric nursing situations. This process can be fascinating, stimulating, and satisfying for both students and instructors, or it may be seen as arduous, frustrating, and frightening. We hope that the former is the common experience and that this *Manual* can be used to add to the students' knowledge base, guide their use of the nursing process, and suggest ways to interact with clients that result in positive, effective nursing care and increased confidence and comfort with psychiatric nursing.

Good interaction skills are essential in all types of nursing, and they enhance the student's nursing care in any setting. In addition, skillful communications enhance the enjoyment of working with clients and help avoid burnout later in a nurse's career. Efficient use of the nursing process and skills in writing and using care plans also help avoid burnout by decreasing frustration and repetition and increasing effective communication among the staff.

An important part of psychiatric nursing skill is conscious awareness of interactions, both verbal and nonverbal. In psychiatric nursing, interactions are primary tools of intervention. Awareness of these interactions is necessary to ensure *therapeutic*, not social, interactions and requires thinking on several levels while the nurse is planning for and engaged in the interaction:

- The nurse must be knowledgeable about the client's present behaviors and problems.
- The interaction should be goal directed: What is the purpose of the interaction in view of the client's nursing diagnosis and expected outcomes?
- The skills or techniques of communication must be identified and the structure of the interaction planned.
- During the interaction itself, the nurse must continually monitor the responses of the client, evaluate the effectiveness of the interaction, and make changes as indicated.

Techniques for Developing Interaction Skills

The *Manual* can be used to facilitate the development of interaction skills and awareness in classes, group clinical settings, and individual faculty–student interaction in conjunction with various teaching methods. Effective techniques include the following:

Case studies: presentation of a case (an actual client, hypothetical example, or paradigm case) by the instructor or student. The case may be written, presented by role-playing, or verbally described. Students (individually or in groups) can perform an assessment, write a care plan for the client, and discuss interventions and related skills, using the *Manual* as a resource.

Role-play and feedback: used in conjunction with a case study or to develop specific communication skills. Interactions with actual clients can be reenacted or the instructor may portray a client with certain behaviors to identify, practice, and evaluate communication techniques; students and instructors can give feedback regarding the interactions.

Videotaped interactions: for case presentations and role-play situations to help the student develop awareness by seeing his or her own behavior and the interaction as a whole from a different, "outside observer" perspective.

Review of the video by both the instructor and the student (and in groups, as students' comfort levels increase) allows feedback, discussion, and identification of alternative techniques.

Written process recordings: used with brief interactions or portions of interactions with or without videotaping. Recalling the interaction in detail sufficient for a written process recording helps the student to develop awareness during the interaction itself and to develop memory skills that are useful in documentation. Process recordings can include identification of goals, evaluation of the effectiveness of skills and techniques or of the client's responses to a statement or behavior, and ways to change the interaction (i.e., as if it could be redone), in addition to the recording of actual words and behaviors of the client and the student.

Written care plans: developed for each client, based on the student's assessment of the client. Before an interaction with the client, the instructor can review the plan with the student, and the student can identify expected outcomes, nursing interventions, and interactions he or she plans to use, and so forth. After the interaction, both the care plan and the specific interaction can be evaluated and revised.

Using the *Manual* in Teaching Psychiatric Nursing

Instructors may find the *Manual* useful in organizing material for teaching classes and for discussion points. The "Key Considerations in Mental Health Nursing" section examines a number of issues germane to the general practice of psychiatric nursing and the delivery of nonjudgmental nursing care. Each group of care plans deals with a set of related problems that students may encounter in the psychiatric setting. These care plans represent the usual assessments and interventions the student or nurse will use in the planning and delivery of care to clients and families. The information in the "Key Considerations in Mental Health Nursing" section regarding sexuality, culture, aging, and so forth provides the context for the student to individualize the planning and delivery of care for each client. A small group of students could be responsible for the presentation of a client's care plan that illustrates one of these topics (e.g., loss or chemical dependence) to the entire class, with subsequent discussion of specific behaviors, problems, nursing diagnoses, interventions, and so forth.

CLINICAL NURSING STAFF

Written individual nursing care plans are necessary in any clinical setting because

- They provide a focus for using the nursing process in a deliberate manner with each client.
- They provide the basis for evaluating the effectiveness of nursing interventions, allowing revisions based on documented plans of care, not unspecified or haphazard nursing interventions.
- They are the only feasible means of effective communication about client care among different members of the nursing staff, who work at different times and who may not be familiar with the client (e.g., float, registry, or part-time nurses).
- They provide a central point of information for coordination of care, identification of goals, and use of consistent limits, interventions, and so forth in the nursing care of a given client.
- They maintain continuity over time when one nurse is working with a client (e.g., in a home health or other community-based setting).
- They are required to meet nursing standards of care and accreditation standards.
- They facilitate efficient care that saves time and avoids burnout among the staff.

However, written care plans often are perceived as troublesome, time consuming, or unrelated to the actual care of the client. This *Manual* was originally conceived to alleviate some of the challenges involved in writing care plans that deal with psychiatric problems. Many nurses felt that they had to "reinvent the wheel" each time they sat down to write a care plan for a client whose behavior was, in fact, similar to the behavior of other clients in their experience, although they recognized differences among individual clients and their needs. The *Manual* was first written to be a source for nurses, from which to choose parts of a comprehensive care plan appropriate to the needs of a unique person and to adapt and specify those parts according to that person's needs. The *Manual* can be seen as a catalog of possibilities for the care of clients with psychiatric problems that contains suggestions of nursing diagnoses, assessment data, expected outcomes, and interventions. (We do not mean to suggest, however, that all possibilities are contained in the *Manual.*) It is also meant to be a catalyst for thought about nursing care, a starting point in planning care for the client, and a structure for using the nursing process to efficiently address the client's needs.

Strategies for Promoting the Use of Written Care Plans

Even with the *Manual* as a resource, nursing staff still may be reluctant to write and use care plans. To encourage the use of written plans, we suggest that nurses identify the barriers to their use and plan and implement strategies to overcome these barriers. It may be helpful to present the use of written plans in a way that they can be easily integrated into the existing routine of the nursing staff and seen as beneficial to the staff itself (not only to clients but also for other purposes, such as accreditation requirements).

Some possible barriers to the use of written plans and suggested strategies to overcome them are as follows:

Barrier: Not enough time allowed to write care plans.

Strategies: When making nursing assignments, consider writing the nursing care plan as a part of the admission process for a newly admitted client and allot time

accordingly. Enlist the support of the nursing administration in recognizing the necessity of allowing time to write nursing care plans when planning staffing needs. Include writing and using care plans in performance review criteria and give positive feedback for nurses' efforts in this area. Nursing supervisors and nursing education personnel also can assist staff nurses in writing plans on a daily basis.

Barrier: Having to "reinvent the wheel" each time a care plan is written.

Strategies: Use the *Manual* as a resource for each client's care plan to suggest assessment parameters, nursing diagnoses, and so forth, and as a way to stimulate thinking about the client's care. If your unit has standard protocols for certain situations (e.g., behavior modification, detoxification), have these printed in your care plan format with blank lines (___) to accommodate individual parameters or expected outcome criteria as appropriate. If your facility uses electronic medical records, you can construct templates using the *Manual*'s care plans and integrate facility-specific information (e.g., levels of suicide precautions, policies regarding restraints, and so forth), and then complete care plans for each client using the appropriate template.

Barrier: Care plans require too much writing, or the format is cumbersome.

Strategies: Streamline care plan formats and design them to be easily used for communication and revision purposes. Write and revise plans in collaboration with other nursing staff, in care planning conferences, or in informal, impromptu sessions. Design systems to address common problems that can be consistently used and adapted to individual needs (e.g., levels of suicide precautions). These can be specifically delineated in a unit reference book and briefly noted in the care plan itself (e.g., "Suicide precautions: Level 1") or integrated into electronic care plan templates.

Barrier: No one uses the care plans once they have been written.

Strategies: Integrate care plans as the basic structure for change of shift report, staffings and case conferences, and documentation. For example, review interventions and expected outcomes for current problems as you review clients in reports, and revise care plans as clients are reviewed. Base problem-oriented charting on nursing diagnoses in care plans; update care plans while charting on clients.

It may be helpful to hold a series of staff meetings and invite the input of all the nursing staff to identify the particular barriers in place on your nursing unit and to work together as a staff to overcome them.

Additional Benefits of Using Written Care Plans

In addition to overcoming resistance such as that noted, presenting the benefits of using care plans may be useful. Because the use of written care plans can enhance the consistency and effectiveness of nursing care, it also can increase the satisfaction of the staff and help avoid burnout. The following are among the benefits of using written care plans:

- Increased communication among nursing staff and other members of the health care team
- Clearly identified expected outcomes and strategies
- Decreased repetition (i.e., each nursing staff member does not need to independently assess, diagnose, and identify outcomes and interventions for each client)
- Routine evaluation and revision of interventions
- Decreased frustration with ineffective intervention strategies: If a nursing intervention is ineffective, it can be revised and a different intervention implemented in a timely manner
- Increased consistency in the delivery of nursing care
- Increased satisfaction in working with clients as a result of coordinated, consistent nursing care
- Efficient, useful structure for change of shift report, staffings or clinical case conferences, and documentation
- More complete documentation with decreased preparation time and effort related to quality assurance, utilization review, accreditation, and reimbursement issues

In addition to the above points, it may be helpful to integrate care plans and their use into other nursing education programs. For example, nursing grand rounds can include a case study presented using the written care plan as a framework. The care plan can also be used as a handout, a slide presentation, or as an exercise for the participants. Videotaped or role-playing sessions for nursing orientation programs or discussion of nursing assessment, planning, and intervention also can use written care plans. The *Manual* can be used as a resource in planning programs like these or used by the participants during the programs. Also, topics discussed in the "Key Considerations in Mental Health Nursing" section, groups of care plans, or specific care plans can be used to plan and implement topical in-service presentations, nursing development, or nursing orientation programs. Finally, the format used for the care plans in the *Manual* can be easily adapted using thePoint (http://thePoint.lww.com/Schultz9e) to construct nursing care plans for use in the clinical setting (e.g., replace "Rationale" column with "Outcome Criteria" column).

USING THE ELECTRONIC CARE PLANS TO WRITE INDIVIDUALIZED PSYCHIATRIC NURSING CARE PLANS

The *Manual* includes electronic files located on thePoint that can be easily used to write individualized nursing care plans. ThePoint contains all of the care plans included in the *Manual*, plus the Sample Psychosocial Assessment Tool (Appendix A). The student or nurse can save the file(s) from thePoint onto the computer and use the information in the care plan as a guide to perform the client's assessment. Based on the assessment of the individual client, the student or nurse can then cut and paste content, delete information not relevant

to the client, include additional information related to the specific client, and add modifiers, time factors (deadlines), and so forth to complete the individualized plan. As the client's care progresses, the plan can be further modified and revised, based on the continuing evaluation of the plan and of the client's needs and progress.

USING WRITTEN PSYCHIATRIC CARE PLANS IN NONPSYCHIATRIC SETTINGS

Written care plans to address emotional or psychiatric needs in the nonpsychiatric setting are especially important. In such settings, certain psychiatric problems are rarely encountered, and the nursing staff may lack the confidence and knowledge to readily deal with these problems. Using the *Manual* in this situation can help in planning holistic care by providing concrete suggestions for care as well as background information related to the disorder or problem itself. In addition, the care plans can be used as the basis for a staff review or nursing in-service regarding the problem or behavior soon after it is assessed in the client.

USING THE INTERNET

The *Manual* includes Resources for Additional Information at the end of each section and the resources' Web addresses are located on thePoint to assist the student or nurse in locating further information related to that section on the Internet. Using search engines such as Google, Yahoo!, or others is quite common and can be an efficient means of locating current information, professional organizations, government agencies, and client- or caregiver-sponsored sites. However, the Internet can also be a source of incorrect and outdated information, as well as advertisements, computer viruses, and spyware that can be misleading or damaging. Therefore, it is important to use the Internet carefully and judiciously, particularly in obtaining information for client care or resources to which to refer clients.

In evaluating publications found on the Web, always evaluate at the source. If you find an article or book chapter or excerpt, check the publication date, authors and their credentials and conflict of interest statements, and the publication itself. Many articles are posted to look like professional articles but are in fact opinion or veiled advertisements. Also, check the references to an article, and determine if it is a research-based article or an opinion or editorial. In checking a publication, try to determine if it is peer-reviewed or published by a reputable professional association or government agency.

If you click on a link to a Web site previously unknown to you, be sure to have adequate virus protection on your computer and to enable your computer's pop-up blockers. When you reach a new site, look for information about the site to determine its source; for example, an "About" or "Contact Us" tab or link. An organization may also list a board of directors or advisors; looking at the background or credentials of such groups can be useful in determining credibility. Many sites are sponsored by pharmaceutical companies or other organizations that may have a vested interest in the information provided. Other sites are sponsored by individuals or client groups that also may have a specific point of view or bias toward or against specific types of information or care, or may be seeking donations or support as their primary purpose. Many such sites are valuable and useful, but others can influence clients to engage in nontherapeutic behavior, often under the guise of providing "support." If you are unable to determine the source or sponsor of a site, be especially cautious about using it or relying on information it provides.

In evaluating the quality of a site, check for currency of the site as well as the information provided. Look for a "date last updated" note or the resources posted. If there are links to other sites and many do not work, the site may be outdated. Looking at the site design and the types of links posted can also help determine its credibility. If there is a registration or log-in required, evaluate the type of information required and read the privacy notice or terms and conditions. Many sites rely on obtaining personal information in order to send newsletters or advertisements in the future; there may also be attempts at identity theft or hacking into computers or e-mail systems.

Clients can benefit from your guidance regarding using the Internet also. Teaching clients guidelines such as those noted above will help them find useful and credible information, but also recognize unfounded or dangerous information as well. Many sites promise dramatic results from using particular products or practices; these should be viewed with caution and evaluated according to the parameters above and checking other, nonaffiliated sources for corroboration. Clients need to be especially careful of advice provided by sites on the Internet; they should be cautioned to always check with their treatment team before changing current treatment or starting a new technique or substance (e.g., supplement) they find on the Internet.

There are a number of resources that specifically address using the Internet. Visit thePoint (http://thePoint.lww.com/Schultz9e) for a list of these and other helpful Internet resources. These include Medline Plus, the Medical Library Association, and the American Academy of Family Physicians. In addition, the US federal government has a number of resources that provide excellent information and initial Web searches, including the National Institutes of Health, Health Finder, and the Substance Abuse and Mental Health Services Administration.