Goals, Assessments, and Interventions for Specific Behaviors

Reference Tables from

Inpatient Psychiatric Nursing

Clinical Strategies & Practical Interventions

Linda Damon, MSN, MHA, RN
Joanne M. Matthew, MSN, PMHCNS-BC, RN
Judy L. Sheehan, MSN, RN
Lisa A. Uebelacker, PhD

Published in cooperation with
Butler Hospital
Providence, Rhode Island
www.butler.org

BUTLER HOSPITAL
a Care New England Hospital

TABLE 1.1
Goals, Areas of Assessment, and Interventions for a Patient with Anger

Goal	Assessment	Intervention
Safety		
Prevent or reduce risk for harm to others	Assess history of anger and aggression Consider whether anger is an acute or chronic problem Inquire about patient preferences for and ability to participate in de-escalation Observe the patients behavior, level of physical arousal, and responses to triggers on the unit Use standardized assessment instruments such as the Broset Violence Checklist	Have a plan for preventing aggression Manage environmental triggers Help the patient to de-escalate when needed
Stabilization		
Increase anger management skills	Assess readiness to learn and practice anger management skills Watch for denial that anger is a problem Identify specific triggers	Make expectations clear Share the nurse's assessment with a patient in real time Provide education about the emotion of anger Teach functional analysis Offer coping skills
Treatment Engagement		
Increase engagement in treatment	Assess barriers to treatment engagement: insight, cognitive capacity, and readiness for change	Show respect at all times Acknowledge and validate the patient's feelings

TABLE 2.1
Goals, Areas of Assessment, and Interventions for a Patient With Anxiety

Goal	Assessment	Intervention
	Safety	
Prevent or reduce risk of harm to self	Know whether there is a history of self-harm behaviors and ask about current self-harm ideation Understand what triggers severe anxiety in the patient; this may lead to self injurious behaviors Monitor for increased behavioral signs of agitation or anxiety See also Chapter 5, "The Patient With Nonsuicidal Self-Injury," and Chapter 9, "The Patient Who Is Suicidal"	Be proactive when an anxiety trigger is anticipated or has just occurred See also Chapter 5, "The Patient With Nonsuicidal Self-Injury," and Chapter 9, "The Patient Who Is Suicidal"
Maintain patient's physiological functioning within normal limits	Understand patient's baseline level of physiological functioning Assess vital signs Assess any concerns about cardiac issues or chest pain, gastrointestinal distress, other pain, or neurological symptoms Evaluate appetite, food intake, and elimination patterns	Treat elevated vital signs Provide for fluid and nutritional needs Provide support and assistance if a patient is hyperventilating

(*cont.*)

TABLE 2.1
Goals, Areas of Assessment, and Interventions for a Patient With Anxiety (*cont.*)

Goal	Assessment	Intervention
Stabilization		
Help to reduce symptoms of anxiety and agitation	Learn about level of anxiety and interventions that helped during previous shift Ask patient about her level of anxiety Identify triggers for anxiety Ask patient about his response to treatment Observe anxious behaviors and agitations on the unit	Provide a calm environment and structure to the patient's day Provide education about anxiety symptoms Identify times or triggers for high stress and anxiety, and be proactive Teach or encourage ways to relax Provide education on sleep medications and sleep hygiene Provide space to rest if needed Provide appropriate medication education and collaborate around medication provision Provide appropriate prn medication
Treatment Engagement		
Assist patients with engagement in treatment on the unit	Observe for indicators of increased ability to engage in treatment	Treat the patient calmly, professionally, and respectfully Match patients with the appropriate groups

TABLE 3.1
Goals, Areas of Assessment, and Interventions for a Patient With Disorganization

Goal	Assessment	Intervention
Safety		
Prevent or reduce self-harm	Assess fall risk or risk for other accidental harm Observe whether patient uses needed assistive devices During the physical assessment, look for indicators of past or recent injury, or disease Assess whether the patient has adequate food and fluid intake Assess the patient's ability to take care of toileting needs	Ensure safety equipment is readily available and used Monitor the patient closely Provide assistance during bathing, dressing, and personal care Anticipate the patient's needs Ensure adequate nutrition
Prevent or reduce confrontations between patient and others	Know past history of aggression, including context for aggression Watch for increasing agitation, particularly when providing personal care Watch for socially objectionable or intrusive behavior that may trigger other patients to act aggressively	Provide personal care with care Respond sensitively to a patient who claims something has been stolen Manage heightened emotions with distraction Administer medications in a way that avoids conflict
Stabilization		
Decrease disorganized behavior and associated anxiety	Assess patient's ability to perform activities of daily living Observe communication and social behaviors Watch for repetitive and nonpurposeful activities	Avoid overstimulation or understimulation Orient the person frequently Anticipate potentially agitating periods of time

(*cont.*)

TABLE 3.1
Goals, Areas of Assessment, and Interventions for a Patient With Disorganization (*cont.*)

Goal	Assessment	Intervention
	Stabilization	
	Observe the patient for signs of agitation or anxiety	Encourage continuity of routines Keep interactions and activities simple Do not belittle the person
	Treatment Engagement	
Involve patient in unit-based activities to the extent possible	Look for day-to-day changes in level of organization	Encourage participation in the milieu Allow the patient to process any embarrassment

TABLE 4.1
Goals, Areas of Assessment, and Interventions for a Patient With Manic Behavior

Goal	Assessment	Intervention
Safety		
Prevent or reduce risk of accidental harm to self	Be aware of any risky behavior, such as running, standing on furniture, taking apart electronic equipment, or ambulating without a needed assistance device	Closely supervise the patient while engaging her in safe activities Manage the environment Provide firm limits and a consistent approach
Reduce risk of harm from others	Assess patient intrusiveness with other patients Monitor telephone use	Closely supervise the patient Manage the environment Provide firm limits and a consistent approach
Reduce risky sexual behaviors	Monitor patient's sexual comments with staff or patients Watch for sexualized behavior or manner of dress	Closely supervise the patient Provide firm limits and a consistent approach
Stabilization		
Stabilize daily biorhythms and routines	Assess nutritional and fluid intake, including amount and routines for intake Monitor acceptance of medication Assess activity and sleep patterns	Decrease or balance stimulation Establish and reinforce a daily routine Administer medication, encourage adherence, and provide medication education

(*cont.*)

TABLE 4.1
Goals, Areas of Assessment, and Interventions for a Patient With Manic Behavior (*cont.*)

Goal	Assessment	Intervention
Stabilization		
Help patients cope with repercussions of manic behaviors	Assess readiness to cope with repercussions of past behaviors, including decreased hypersexual, intrusive, or hyperactive behaviors, and more adherence to routines Listen for a patient expressing guilt or shame about past behaviors	Provide emotional support Provide education about the patient's illness using a chronic disease model Develop a relapse prevention plan
Treatment Engagement		
Assist patients with engaging in treatment on the unit	Assess patient's readiness to engage in treatment, that is, his ability to take medications, follow routines, follow rules, and accept limits Determine the degree to which the patient is frustrated with being on the psychiatric unit Determine whether the patient is able to accept that he has a psychiatric illness	Acknowledge the patient's frustration Use language that the patient is comfortable with Help the patient move toward acceptance of illness

TABLE 5.1
Goals, Areas of Assessment, and Interventions for a Patient With Nonsuicidal Self-Injury

Goal	Assessment	Intervention
	Safety	
Prevent unintentional lethality from NSSI	Gather information about recent suicidal thoughts and behaviors and risky NSSI behavior Assess whether any serious and stressful life events have recently occurred Ask about ambivalence about living Understand history of suicidality Look for increases in medical severity of self-harm Assess environmental safety Watch for increases in patient's level of agitation or secretive or isolative behaviors	Increase level of observation Explore ambivalence and understand impulsivity Ensure environmental safety on the unit Use restraint as a last resort
Reduce frequency and severity of NSSI	Assess frequency and severity of urges to self-injure and actual NSSI Look for episodes of anxiety or agitation and assess which interventions are helpful for these episodes Assess whether the patient believes NSSI is a problem Watch for changes in patient behavior	Negotiate an agreement that the patient will inform staff if she feels at risk of self-harm Offer prn medication Utilize sensory interventions Have a plan for what will happen should the patient engage in self-harm Establish an appropriate level of supervision Employ room changes Note and acknowledge any decreased frequency or severity of NSSI

(*cont.*)

TABLE 5.1
Goals, Areas of Assessment, and Interventions for a Patient With Nonsuicidal Self-Injury (*cont.*)

Goal	Assessment	Intervention
	Stabilization	
Identify and decrease the distress that is an antecedent of NSSI	Note any episodes of distress and look for precipitating events or triggers Assess whether the patient has an increased capacity to name feelings	Help patients identify emotions that may trigger impulses for NSSI Validate the patient's feelings Remind the patient that feelings cannot be avoided but can be managed Help patients identify other triggers for urges to self-injure Offer medication to prevent the onset of distress
Assist patient in learning and using alternative coping skills	Assess patient's willingness to learn new coping skills Look for use of new coping skills	Review treatment plan goals and review expectation of collaborative engagement Help the patient to identify, learn, and use healthy coping skills Identify and praise the use of alternative coping skills Keep multiple copies of the coping skills and crisis prevention plan Encourage attendance at groups Adopt a harm-reduction stance

(*cont.*)

TABLE 5.1
Goals, Areas of Assessment, and Interventions for a Patient With Nonsuicidal Self-Injury (*cont.*)

Goal	Assessment	Intervention
Treatment Engagement		
Increase engagement in treatment and trust in treatment providers	Assess the patient's degree of trust in the nurse and other treatment providers Look for a willingness to engage in conversation and to respond to staff comments or concerns	Show nonjudgmental compassion Use good communication skills Give the patient an opportunity to grow and change Be consistent Understand that building trust is difficult for the patient and takes time
Subgoal: assist patient with the experience of a trusting relationship	Assess for a history of a positive trusting relationship in the past; positive use of staff interventions; episodes of staff or unit splitting	The nurse continues to respond with: consistency, empathy, neutrality (non judgmental), clear expectations, clearly stated consequences, honest feedback, and supportive validation

TABLE 6.1
Goals, Areas of Assessment, and Interventions for a Patient With Pain

Goal	Assessment	Intervention
Safety		
Prevent or reduce the risk for harm to self	Know that the presence of chronic pain increases risk for suicide ideation and behavior Identify and communicate suicide risk factors in report and team meetings Assess patient's suicide risk using direct inquiry Monitor medication to ensure it is not being "cheeked"	Create a safe environment for the patient Discourage isolation Express realistic hope about the future Treat the physical pain
Stabilization		
Reduce or alleviate pain symptoms	Assess pain intensity and severity regularly via self-report if possible; otherwise via observation Use a rating scale to track and document pain severity over time Monitor vital signs and related physical symptoms Watch for isolative behaviors on the unit	Assist physician with finding the source of pain and selecting effective interventions Administer medication to reduce or alleviate pain Teach about medications Teach the patient to accurately report her pain Teach relaxation and distraction techniques Provide nursing comfort measures
Decrease the patient's pain-related anxiety	Assess level of anxiety related to pain using direct inquiry and observation Assess pain-related catastrophizing	Explore and challenge patient's fears about pain Teach or encourage use of relaxation or distraction techniques Provide anxiety medications

(*cont.*)

TABLE 6.1
Goals, Areas of Assessment, and Interventions for a Patient With Pain (*cont.*)

Goal	Assessment	Intervention
Stabilization		
Help patient to improve functioning in the presence of pain	Assess level of functioning, including ability to complete activities of daily life, and home and work responsibilities, prior to hospitalization Observe level of functioning in the hospital	Assist patients with goal setting Reinforce functional activities; decrease focus on pain behaviors Support physical activity Teach sleep hygiene
Treatment Engagement		
Engage the patient in treatment despite the experience of pain	Assess patient's degree of engagement in unit activities and treatment Look for barriers to engagement, including mistrust of health care providers, and using "physical pain talk" as a way to avoid talking about other difficult topics	Respect and listen to patient; accept her physical pain as real Help patient recognize and accept relationship between his pain and psychiatric symptoms

TABLE 7.1
Goals, Areas of Assessment, and Interventions for a Patient With Paranoia

Goal	Assessment	Intervention
	Safety	
Prevent aggression toward others	Understand recent history of aggression Look for problems with impulse control Observe patient's response to interactions Watch for obvious and subtle indicators of agitation Assess content of hallucinations or delusions	Offer verbal reassurance Modify the environment and reduce demands Provide sensory interventions Provide space and privacy Offer prn medication Use containment as a last resort
Prevent active self-harm	Remember this can be difficult to predict for these patients Understand history of self-harm Assess content of hallucinations or delusions Watch for agitation or isolative behaviors on the unit	Administer medications Increase monitoring Modify the environment Use containment as a last resort
Prevent passive self-harm	Monitor eating, output, weight, hygiene, and acceptance of needed medications or medical interventions	Provide a clear rationale and offer reassurance Offer choices Modify environment while reducing demands
	Stabilization	
Decrease fear and anxiety	Assess agitation and look for environmental or internal triggers for anxiety Ask the patient directly about fear and anxiety Assess readiness for education about fear and anxiety	Be aware of one's own nonverbal behavior, expressed emotions, and tone of voice Provide verbal reassurance Treat the patient with respect Maintain consistency Offer prn medications

(*cont.*)

TABLE 7.1
Goals, Areas of Assessment, and Interventions for a Patient With Paranoia (*cont.*)

Goal	Assessment	Intervention
	Stabilization	
	Observe level of comfort in social situations	Help the patient to identify soothing activities Take care in choosing roommates
	Treatment Engagement	
Increase engagement in inpatient treatment	Assess ability to accept medications, participate in activities of daily living, socialize, and attend groups Look for small improvements	Help to increase willingness to take medications Promote engagement in groups Encourage engagement in unit activities

TABLE 8.1
Goals, Areas of Assessment, and Interventions for a Patient With Substance Use Disorders

Goal	Assessment	Intervention
Safety		
Provide a medically safe process of withdrawal from substances	Obtain information about patient's history of complications during detoxification, including seizures and DTs Use a standardized detoxification assessment scale every 1 to 4 hours to obtain and record vital signs and other withdrawal symptoms	Provide medications to stabilize vital signs
Prevent contraband from being brought to unit and prevent "sharing" of prescribed medications between patients (diversion)	Obtain information about patient's history of bringing contraband to unit Listen to other patients who may provide information about contraband Observe sudden changes in mental status or sudden increase in sedation	Search patients and their belongings Educate and observe visitors Lead discussion about contraband in community groups Provide stimulating activities for patients Intervene if contraband is found or suspected
Prevent suicide attempts and aggression	Please see Chapter 9, "The Patient Who Is Suicidal" and Chapter 1, "The Patient With Anger"	
Stabilization		
Increase patient comfort during withdrawal process	Observe how each patient is functioning and assess level of comfort Observe patient's use of comfort measures	Offer nonaddictive medications Offer comfort measures

(*cont.*)

TABLE 8.1
Goals, Areas of Assessment, and Interventions for a Patient With Substance Use Disorders (*cont.*)

Goal	Assessment	Intervention
Stabilization		
Help patients begin to visualize a life without addicting substances.	Assess readiness to visualize such a life Look for clues about what such a life would like for this particular patient	Provide education and opportunities to visualize a different type of life Help patients learn to manage their emotions Help with goal setting Educate family members
Treatment Engagement		
Assist patients to engage in treatment on the unit	Assess patient's reason for coming in for treatment, readiness to engage in treatment, cognitive functioning, and past treatment experience	Use motivational enhancement techniques Tailor interventions for patients with impaired cognitive functioning Use past treatment experiences as important information Build trust Do not compel the use of labels, make assumptions, or force confrontations Facilitate participation in group therapy Encourage engagement in unit activities

TABLE 9.1
Goals, Areas of Assessment, and Interventions for a Patient With Suicide

Goal	Assessment	Intervention
Safety		
Prevent suicide or self-harm	Assess risk and protective factors and current suicidal ideation and behavior, using information from all sources including direct patient inquiry Assess environmental safety	Maintain a safe environment Increase direct patient contact Provide education to the patient and explore ambivalence Do not rely on no-harm contracts Ensure clear staff communication
Stabilization		
Decrease related psychiatric symptoms	Select and assess key target symptoms that are related to suicidality. Sample target symptoms include: hopelessness, insomnia, isolation, agitation, refusing medications, command hallucinations, and poor grooming and hygiene Track status of target symptoms	Provide access to peer support and other resources to decrease hopelessness Address depression and hopelessness directly Provide medications appropriate for target symptoms
Assist the patient in improving coping skills	Know coping skills that the patient is currently learning Ask patient about coping skills that have been helpful in the past Assess use of newly introduced coping skills	Help patients to identify and use useful coping methods

(*cont.*)

TABLE 9.1
Goals, Areas of Assessment, and Interventions for a Patient With Suicide (*cont.*)

Goal	Assessment	Intervention
Stabilization		
Help the patient develop a relapse prevention plan	Determine readiness to discuss relapse prevention Assess whether the patient is ready to learn more about their illness and its treatment	Help the patient to understand course and pattern of symptoms Help the patient to identify warning signs Help the patient to identify triggers of suicidality Assist the patient with making a relapse prevention plan Teach about expected course of illness
Treatment Engagement		
Assist patient with engaging in treatment on the unit	Watch for early signs of engagement such as talking with staff about symptoms, accepting medications, or asking for help Observe whether patient is participating in groups on the unit Assess interest in understanding illness and treatment Watch for barriers to engagement, such as return of symptoms	Assist patient with understanding the seriousness of her situation Increase the likelihood that the patient can confide his symptoms Attempt to increase willingness to take medications

TABLE 10.1
Goals, Areas of Assessment, and Interventions for a Patient Who is Withdrawn

Goal	Assessment	Intervention
	Safety	
Prevent passive self-harm	Review medical history Assess nutrition, hydration, self-care, acceptance of medications, and mobility Try to understand reasons why the patient is refusing care Assess for behavioral changes that may indicate medical complications As patient improves, assess for active self-harm ideation or behavior	Provide education and problem-solving Use prompting Make modifications to how food and fluids are typically offered Assist with using the bathroom and performing basic hygiene Encourage acceptance of medication and medical interventions
Prevent harm to others	Assess internal processes that can increase risk for aggression, such as fear related to believing that the environment is threatening in some way Note patient's previous pattern of aggressive behavior Watch for distinct changes in presentation	Identify triggers for aggression and make a proactive plan for managing them Offer assistance when a patient seems agitated Provide medications to decrease agitation

(*cont.*)

TABLE 10.1
Goals, Areas of Assessment, and Interventions for a Patient Who is Withdrawn (*cont.*)

Goal	Assessment	Intervention
Stabilization and Engagement		
Help patient to decrease withdrawal and increase treatment engagement	Review functioning prior to the episode precipitating hospitalization Assess effect of treatments on engagement Try to understand reasons for withdrawal Watch the patient's ability to engage in activities on the unit	Communicate in ways that increase engagement Be conscious of verbal and nonverbal communication with mute patients Choose appropriate groups and/or unit activities Provide interventions to decrease anxiety Treat underlying conditions Help increase motivation for treatment