Nursing Service Guidelines
Inpatient Behavioral Health

Title: **PSYCHOTIC PATIENT**

Description: Psychosis describes a degree of severity not a specific disorder. A psychotic patient has a grossly impaired sense of reality often coupled with emotional and cognitive disabilities, which severely compromises his ability to function. He is likely to talk and act in a bizarre fashion, hallucinate or strongly hold ideas that are contrary to fact (delusions.) He may be confused and disoriented.

Population: Any psychotic patient

Procedure	Point of Emphasis
Assess for symptoms of psychosis on admission or during hospitalization • Delusions • Hallucinations • Disorganized thinking or speech • Flat emotional affect • Lack of goal directed activity • Limited productive thoughts	
Patient can expect care directed toward preventing complications or injury of the psychotic patient. Patient can expect to be helped to maintain contact with reality as much as possible.	The Nurse will: 1. Use medication as ordered. a. Low dose antipsychotic drug maintenance is the norm. b. Be specific. Ask pointed, factual questions. Try to identify the patient's major current fears and concerns, but don't be led into a lengthy discussion of complex delusions and hallucinations. Use simple words and state that patient may hear voices, but you don't. c. Don't rush the patient to respond to each question but do maintain some control over the direction of the conversation. d. Make some specific observations of the patient's behavior (e.g., "you look frightened, you look angry") but don't become involved in lengthy interpretations. Don't draw incorrect conclusions about the emotional state from inappropriate affect. e. Explain to the patient what is being done to him and why. f. If the conversation is going nowhere, e.g., the patient refuses to talk, break off the interview with a positive expectation, e.g., "I'll be back to see you in a little while when you are feeling better and able to talk." g. Keep environment quiet.
Avoid touching the patient especially a paranoid patient.	

Procedure	Point of Emphasis
Keep the unit structured with concrete activities. Teach coping skills • Including assertiveness • Participation with others • Anxiety relief activities • deep breathing	
Document Clearly any hallucinations, patient thoughts and actions.	
Observe for suicidal behavior.	
If patient becomes aggressive attempt least restrictive interventions.	2. Use of restraints when needed: a. Restraints are used only when less restrictive techniques have been exhausted and when patient continues to exhibit behavior injurious to himself or others. Refer to restraint/seclusion guideline.

Reviewed by: Tammy Cerrone, BSN, RN, Nursing Director Inpatient Behavioral Health

Approved: September 1993
Reviewed: 4/99, 3/02, 6/08, 7/17, 6/2023
Revised: 5/96, 4/05, 6/08, 8/11, 7/2020
Reviewed by Policy & Standard Committee, 8/11, 8/14, 7/17, 7/2020, 6/2023

References:

Van Schalkwyk, G. I., Davidson, L. & Srihari, V. (2015). Too late and too little: Narratives of treatment disconnect in Early psychosis. *Psychiatric Quarterly, 86*(4), 521-532.

Ajnakina, O., Trotta, A., Oakley-Hannibal, E., Di Forti, M., Stilo, S. A., Kolliakou, A., et al. (2016). Impact of childhood Adversities on specific symptom dimensions in first-episode psychosis. *Psychological Medicine, 46*(2), 317-326.

Stone, J. M., Fisher, H. L., Major, B., Chisholm, B., Wooley, J., Lawrence, J., et al. (2014). Cannabis use and first-Episode psychosis: Relationship with manic and psychotic symptoms, and with age at presentation. *Psychological Medicine, 44*(3), 499-506.

Mosby's Nursing Skills 2020