NURSING SERVICE GUIDELINES
INPATIENT BEHAVIORAL HEALTH

Guideline: **Care of the psychotic patient**

Policy Number Superseded: n/a

Responsibility: Inpatient Behavioral Health Personnel

Purpose of Guideline: Assessment and care of the psychotic patient.

Effective Date:
April 2026

Initial Effective Date:
September 1993

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.

PROCEDURE	POINT OF EMPHASIS
(1) Assess for symptoms of psychosis on admission or during hospitalization: (a) Delusions. (b) Hallucinations. (c) Disorganized thinking or speech. (d) Flat emotional affect. (e) Lack of goal directed activity. (f) Limited productive thoughts.	
(2) 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.	(2) The nurse will: (a) Use medication as ordered. (b) Be specific. Ask pointed, factual questions. Try to identify the patient's major current fears and concerns. Use simple words. (c) Do not 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 but do not become involved in lengthy interpretations. (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 and revisit later. (g) Keep environment quiet.
(3) Avoid touching the patient unless necessary, especially a paranoid patient.	
(4) Keep the unit structured with concrete activities.	
(5) Teach coping skills: (a) Including assertiveness. (b) Participation with others. (c) Anxiety relief activities. (d) Deep breathing.	
(6) Document clearly any hallucinations, patient thoughts, and actions.	
(7) Observe for suicidal behavior.	
(8) If patient becomes aggressive, attempt least restrictive interventions.	(8) Use of restraints when needed: 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.

(A) References.

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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.

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