4.8: Planning

The Planning Standard of Practice by the American Nurses Association states, "The registered nurse develops a collaborative plan encompassing strategies to achieve expected outcomes." [1]

Review the competencies for the Planning Standard of Practice for registered nurses in the following box.

**ANA’s Planning Competencies** [2]

The registered nurse:

- Develops an individualized, holistic, evidence-based plan in partnership with the health care consumer, family, significant others, and interprofessional team.
- Designs innovative nursing practices that can be incorporated into the plan.
- Prioritizes elements of the plan based on the assessment of the health care consumer’s level of safety needs to include risks, benefits, and alternatives.
- Establishes the plan priorities with the health care consumer, family, significant others, and interprofessional team.
- Advocates for compassionate, responsible, and appropriate use of interventions to minimize unwarranted or unwanted treatment, health care consumer suffering, or both.
- Includes strategies designed to address each of the identified diagnoses, health challenges, issues, or opportunities. These strategies may include, but are not limited to, maintaining health and wellness; promotion of comfort; promotion of wholeness, growth, and development; promotion and restoration of health and wellness; prevention of illness, injury, disease, complications, and trauma; facilitation of healing; alleviation of suffering; supportive care; and mitigation of environmental or occupational risks.
- Incorporates an implementation pathway that describes an overall timeline, steps, and milestones.
- Provides for the coordination and continuity of care.
- Identifies cost and economic implications of the plan.
• Develops a plan that reflects compliance with current statutes, rules, regulations, and standards.
• Modifies the plan according to the ongoing assessment of the health care consumer’s response and other outcome indicators.
• Documents the plan using standardized language or recognized terminology.
• Actively contributes at all levels in the development and continuous improvement of systems that support the planning process.

As always, consult a current, evidence-based nursing care planning resource when planning nursing interventions individualized to each client’s needs. You might be asking yourself, “How do I know what evidence-based nursing interventions to include in the nursing care plan regarding mental health care?” There are several sources that can be used to select nursing interventions. Many agencies have care planning tools and references included in the electronic health record that are easily documented in the patient chart. Additionally, the Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an evidence-based resource center. [3]

Access the Evidence-Based Resource Center maintained by the Substance Abuse and Mental Services Administration (SAMHSA).

See sample planned nursing interventions for a client who has been diagnosed with Risk for Suicide in Table 4.6.

Table 4.6 Sample Nursing Interventions for Risk for Suicide

<table>
<thead>
<tr>
<th>Nursing Intervention</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>The nurse will…</td>
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<tr>
<td>Use an evidence-based process to conduct a suicide risk assessment.</td>
<td>Patients with suicidal ideation vary widely in their risk for a suicide attempt depending on whether they have a plan, intent, and past history of attempts. In-depth assessment of patients who screen positive for suicide risk must be completed to determine how to appropriately treat them. [4]</td>
</tr>
<tr>
<td>Document and communicate the client’s overall level of risk for suicide with the treatment team and the plan for mitigating their risk for suicide.</td>
<td>All interprofessional health care team members who might come in contact with a client at risk for suicide must be aware of the level of risk and the mitigation plans to reduce that risk. This information should be explicitly documented in the patient’s record. [5]</td>
</tr>
</tbody>
</table>
Perform an environmental risk assessment and remove features that could be used to attempt suicide.

Administer prescribed treatment and collaboratively manage psychiatric symptoms that may be contributing to the client’s suicidal ideation or behavior.

Express desire to help the client and validate the client’s experience of psychological pain while maintaining a safe environment for the client.

Develop a positive therapeutic relationship with the client; do not make promises that may not be kept.

Determine the client’s need for supervision and assign a room near the nursing station as necessary.

Search the newly hospitalized client and the client’s personal belongings for weapons or potential weapons and hoarded medications during the admission process and remove dangerous items.

The Veteran’s Health Administration showed that use of a Mental Health Environment of Care Checklist to facilitate a thorough, systematic environmental assessment reduced the rate of suicide from 4.2 per 100,000 admissions to 0.74 per 100,000 admissions. [6]

Symptoms of the disorder may require treatment with antidepressant, antipsychotic, or antianxiety medications. A systematic review has shown a significant effect for cognitive behavioral therapy in reducing suicidal behavior. [7]

The nurse must reconcile their goal of preventing suicide with recognition of the client’s goal to alleviate their psychological pain. [8]

Nurses connect suicidal clients with humanity by guiding the client, encouraging effective coping strategies, and helping them connect appropriately with others. [9]

Close assignment increases ease of observation and availability for a rapid response in the event of a suicide attempt. [10]

Clients with suicidal ideation may bring the means with them. This action is necessary to maintain a hazard-free environment and client safety. [11]
Limit access to windows and exits unless locked and shatterproof, as appropriate. Ensure exits are secure.

Suicidal behavior may include attempts to jump out of windows or escape to find other means of suicide. [12]

Place the client in the least restrictive, safe, and monitored environment that allows for the necessary level of observation. Assess suicidal risk at least daily and more frequently as warranted.

Close observation of the client is necessary for safety as long as the intent remains high. Suicide risk should be assessed at frequent intervals to adjust suicide precautions and ensure restrictions continue to be appropriate. [13]

Consider strategies to decrease isolation and opportunity to act on harmful thoughts (e.g., use of a sitter).

Clients have reported feeling safe and having their hope restored in response to close observation. [14]

Create a safety plan that includes a no-suicide contract. Contract verbally or in writing with the client for no self-harm and recontract at appropriate intervals.

Discussing thoughts of suicide and self-harm with a trusted person can provide relief for the client. A safety plan gets the subject out in the open and places some of the responsibility for safety with the client. However, research has suggested that self-harm is not prevented by contracts, and ongoing assessment of suicide risk is necessary. [15]

Explain suicide precautions and relevant safety issues to the client and family (purpose, duration, behavioral expectations, and behavioral consequences).

Suicide precautions may be viewed as restrictive. Clients have reported the loss of privacy as distressing. [16] Explaining the reasoning for safety precautions helps the client understand why they are being used even though they may feel restrictive and distressing. When clients and family members understand the reasoning for the precautions, they are more likely to comply.

Verify the client has taken medications as ordered (e.g., conduct mouth checks after medication administration).

The client may attempt to hoard medications for a later suicide attempt. [17]
Maintain increased surveillance of the client whenever the use of an antidepressant has been initiated or the dose increased. Antidepressant medications take anywhere from 2 to 6 weeks to achieve full efficacy. During that period, the client’s energy level may increase although the depression has not yet lifted, which increases the potential for suicide. 

Involve the client in treatment planning and self-care management of psychiatric disorders. Self-care management promotes feelings of self-efficacy. The more clients participate in their own care, the less powerless and hopeless they feel. 

Assist the client in identifying a network of supportive persons and resources (e.g., family, clergy, care providers). Social support and positive events were found to have a protective effect against suicidal ideation. 

Document client behavior in detail to support involuntary admission if actively suicidal. Read more about involuntary admissions in the “Patient Rights” section of the “Legal and Ethical Considerations” chapter. Involuntary inpatient admissions serve to keep the client safe from harm. Involuntary outpatient commitment is also available in many states and can improve treatment, reduce the likelihood of hospital readmission, and reduce episodes of violent behavior in persons with severe psychiatric illnesses. 

Involve the family in discharge planning (e.g., illness/medication teaching, recognition of increasing suicidal risk, client’s plan for dealing with recurring suicidal thoughts, and community resources). Family members must learn how to respond to cues early, support the treatment regimen, and encourage the client to initiate an emergency plan. When family members are aware of cues, treatments, and emergency plans, clients are less likely to act on thoughts of suicide or self-harm. 

Before discharge from the hospital, ensure the client has a safety plan to use after discharge, including a supply of prescribed medications and a plan for outpatient follow-up. Ensure they understand the plan or have a caregiver able and willing to follow the plan, as well as the ability to access outpatient treatment. Clients may have difficulty concentrating on the plan for follow-up. They may need assistance from others to ensure prescriptions are filled, appointments are attended, and transportation is available to appointments.
In the event of a client's suicide, refer the family to a support group for survivors of suicide. Psychoeducational support group participants found relief in sharing their bereavement with others.

**Establishing Safety**


