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**Kwartalnik międzynarodowy**

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**DIAGNOSING AND PLANNING OF NURSING  
CARE FOR A PATIENT WITH A DIAGNOSIS OF  
SCHIZOPHRENIA USING THE INTERNATIONAL  
NANDA, NIC AND NOC CLASSIFICATIONS**

**Diagnozowanie i planowanie opieki pielęgniarzkiej wobec pacjenta  
z rozpoznaniem schizofrenii przy wykorzystaniu międzynarodowych klasyfikacji  
NANDA, NIC i NOC**

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A - Koncepcja i projekt badania, B - Gromadzenie i/lub zestawianie danych, C - Analiza i interpretacja danych, D - Napisanie artykułu, E - Krytyczne zrecenzowanie artykułu, F - Zatwierdzenie ostatecznej wersji artykułu

**Abstract (in Polish):**

**Cel pracy**

Celem pracy jest prezentacja zastosowania klasyfikacji NANDA, NIC, NOC w procesie planowania opieki pielęgniarzkiej wobec pacjenta z rozpoznaniem schizofrenii

**Materiał i metody**

Praca opiera się na metodzie analizy studium indywidualnego przypadku i wykorzystuje techniki badawcze takie jak: wywiad, obserwacja, pomiar, analiza dokumentacji pielęgniarzkiej i lekarskiej. W pracy wykorzystano narzędzia badawcze: Kartę Indywidualnej Opieki Pielęgniarzkiej, Skalę do oceny

zmęczenia wg Richardson, Skalę Oceny Ryzyka Samobójstwa SAD PERSONS wg Pattersona oraz test do oceny stanu funkcji psychicznych – MMSE.

### **Wyniki**

Na podstawie zebranych danych empirycznych i w oparciu o klasyfikację NANDA postawiono następujące diagnozy pielęgniarские: (1) zaburzony wzorzec snu [00198], (2) zmęczenie [00093], (3) upośledzona regulacja nastroju [00241], (4) upośledzona pamięć [00131], (5) izolacja społeczna [00054], (6) brak nadziei [00124], (7) bezsilność [00125], (8) upośledzona pamięć [00131], (9) upośledzone interakcje społeczne [00052], (10) lęk [00146], (11) przewlekły smutek [00137], (12) ryzyko samobójstwa [00150].

Dla diagnozy pielęgniarskiej (12) ryzyko samobójstwa [00150] zredagowano plan opieki pielęgniarskiej z zastosowaniem klasyfikacji NIC oraz NOC, który opierał się na dowodach naukowych zawartych w wymienionych klasyfikacjach.

### **Wnioski**

Problemy pielęgnacyjne występujące u pacjenta hospitalizowanego z powodu schizofrenii wynikają z objawów choroby oraz działań niepożądanych związanych z przyjmowaniem leków. Zastosowanie klasyfikacji NANDA, NIC, NOC w procesie diagnozowania i planowania opieki pielęgniarskiej pozwala na stosowanie działań opartych na dowodach naukowych

### **Abstract (in English):**

#### **Aim**

The aim of this paper is to present how the NANDA, NIC, and NOC classifications can be applied in the process of planning nursing care for a patient with a diagnosis of schizophrenia.

#### **Material and methods**

The paper is based on the method of analysis of an individual case study and uses research techniques such as interview, observation, measurement, and analysis of medical records. The following research tools were used: Individual Nursing Care Card, Richardson's Fatigue Rating Scale, Patterson's SAD PERSONS Scale for Suicide Risk Assessment, and the Mini-Mental State Examination (MMSE).

#### **Results**

Based on the collected empirical data and the NANDA classification, the following nursing diagnoses were made: (1) disturbed sleep patterns [00198], (2) fatigue [00093], (3) impaired mood control [00241], (4) impaired memory [00131], (5) social isolation [00054], (6) lack of hope [00124], (7) helplessness [00125], (8) impaired memory [00131], (9) impaired social interactions [00052], (10) anxiety [00146], (11) chronic sadness [00137], (12) risk of suicide [00150]. For the diagnosis: risk of suicide [00150], a nursing care plan using the NIC and NOC classifications was drawn up, utilising the scientific evidence included in these classifications.

#### **Conclusions**

Nursing problems occurring in a patient hospitalised due to schizophrenia result from symptoms of the disease and side effects associated with taking medicines. When applied in the process of diagnosing and planning nursing care, NANDA, NIC, NOC classifications allow nurses of evidence-based activities

**Keywords (in Polish):** opieka pielęgniarstwa, schizofrenia, NANDA, NIC, NOC.

**Keywords (in English):** nursing care, schizophrenia, NANDA, NIC, NOC.

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### **Short title**

Nursing care for a patient with a diagnosis of schizophrenia

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## **Introduction**

In terms of aetiology, schizophrenia, characterised by complex pathomechanism, is one of the least known mental disorders. The literature does not provide a clear answer as to the cause of this disease. According to one of the theories advocating the organic origin of schizophrenia, the presence of general psychopathology symptoms is considered to be marked by the occurrence of anatomical changes in the brain, mainly in the hippocampus, temporal lobe of the cerebral cortex, the septum pellucidum, the ventricular system of the brain, and the cerebellum. In cerebral imaging, a reduction in the thickness of the cerebral cortex and a decrease in the value of fractional anisotropy (FA) in the white matter of the brain are also observed [1].

Another theory provides evidence that the disease is caused by abnormal neurotransmitter concentrations (dopamine, serotonin, adrenaline, norepinephrine) within the anatomical structures of the brain, resulting in specific productive (positive) and defective (negative) symptoms. Productive symptoms (delusions, hallucinations) usually occur alternately, at different time proportions with defective symptoms (alogia, abulia, apathy, anhedonia). The frequency of these symptoms varies depending on the type of treatment used, genetic conditions and patient's involvement in the therapeutic process. The clinical picture of the patient also depends on the form of schizophrenia which can be differentiated into paranoid, hebephrenic, simple and catatonic schizophrenia. Disease also follows a specific, projection-remission course, which means that acute symptoms occur periodically, alternating with asymptomatic periods [2].

The North American Nursing Diagnosis Association (NANDA) has recommended the use of three documents in order to standardise the terminology used worldwide in nursing: The Taxonomy of Nursing Diagnoses, Nursing Interventions Classification (NIC), and Nursing Outcomes Classification (NOC) [3].

NIC (*Nursing Interventions Classification*) is a classification that includes all nursing interventions that are appropriate for the needs and condition of the subject of care (individuals, groups, communities), defined as a therapy applied to a patient, which is based on the clinical assessment of the patient and current medical knowledge. It serves to improve the overall condition of the patient (client). NIC is a standardised, comprehensive taxonomy which comprises both direct and indirect, unassisted and collaborative nursing interventions pertaining to the patient's physiological condition, treatment of diseases, and psychosocial disorders, as well as prevention and health promotion. Each of them is supported by scientific evidence in the form of references to specific sources, with all the necessary bibliographic data and a note on amendments, if any. The 7th edition of the Classification of Nursing Interventions lists 565 interventions and around 13 thousand actions [4].

NOC, referred to in Poland as *Klasyfikacja Wyników Pielęgniarskich* (Nursing Outcomes Classification), contains standardised terminology which describes changes (outcomes) in the patient's condition following the application of specific nursing interventions. The underlying concept of NIC makes it possible to evaluate the subject of care (patient, carer, family, community) in the period before and after the adoption of nursing measures. Every outcome listed in the Nursing Outcomes Classification is described on a four-aspect level according to definition, a five-degree assessment scale, a list of indicators, and references to auxiliary literature. The 6th edition of NOC lists 510 possible outcomes of care [5].

### **Aim**

The aim of this paper is to present the application of the international NANDA, NIC and NOC classifications of nursing diagnoses in the process of diagnosing and planning care for a patient diagnosed with schizophrenia.

### **Materials and methods**

The study based on case study method and the following research techniques: interview, observation, measurement, and analysis of nursing and medical records. The diagnostic process used research tools such as: Individual Nursing Care Card (Zarzycka, 2018), Richardson's Fatigue Rating Scale, Patterson's SAD PERSONS Scale for Suicide Risk Assessment, Mini-Mental State Examination (MMSE). The research was conducted from January to mid February 2019 at the 1st Department of Psychiatry, Psychotherapy and Early Intervention of the Independent Public Clinical Hospital No. 1 in Lublin. The paper version of the international NANDA, NIC and NOC classifications, translated into Polish, was used [6].

Based on the collected medical history, the patient subjectively rated fatigue on Richardson's Fatigue Rating Scale using three subscales: verbal, visual-analogue (10 cm line), and numerical (0-10), in the range of "I do not feel fatigue at all" vs. "I feel very intense fatigue" [7].

Patterson's SAD PERSONS Scale for Suicide Risk Assessment allows one to assess the risk of committing suicide on the basis of factors provided for in the scale, such as gender, age, occurrence of depression, a history of suicide attempts and hospitalisation, alcohol or drug abuse, loss of rational reasoning, separation, lack of family, declared suicidal intentions. Each of the existing risk factors is verified on a scale of 0-1-2 [7].

The Mini-Mental State Examination (MMSE) test analyses patient's mental functions in various aspects: orientation as to time and place, memorising, paying attention, recalling, repeating, following

three-step instructions, reading, copying, writing. The patient receives 1 point for each correct answer to a question or a correctly completed task [7].

Empirical data were collected from the patient in accordance with the principles of scientific research. Informed consent was obtained for the processing of data, and information was provided to the respondents on their participation being voluntary and anonymous as well as on the treatment team's and researcher's adherence to the principle of professional confidentiality. All activities forming part of the research process were carried out with respect to the provisions of the Patients' Rights and Patients' Rights Ombudsman Act of 6 November 2008 (Journal of Laws 2009 No. 52 item 417), the Code of Professional Ethics of Nurses and Midwives of the Republic of Poland and the principles of protection of particularly sensitive personal data.

### **Description of the case**

The human subject of the study was a 38-year-old man suffering from paranoid schizophrenia with catatonic elements (ICD-10: F20.2), first diagnosed at the age of 16-17. The patient was admitted to the 1st Department of Psychiatry, Psychotherapy and Early Intervention of the Independent Public Clinical Hospital No. 1 in Lublin due to sudden deterioration of his mental state, persistent sleep disorders, and inability to urinate physiologically. Patient on the day of admission to the hospital: sleepless, restless, monologuing, anxious, visibly agitated.

During the initial hospitalisation period, he was autistic, without contact, and exhibiting productive symptoms. He occasionally verbalised delusional content with anxiety undertones that resulted in the temporary limitation of his ability to function in society. As the neuroleptic dose was being adjusted and the treatment modified accordingly, the patient reported decreased appetite (especially in the morning), fatigability, impaired cognitive processes (mainly memory, concentration, and attention), and frequent headaches and constipations.

The patient's medical history shows that since 2017 he has been experiencing extrapyramidal symptoms (bradykinesia, muscle tremors), which hinder his daily functioning. The course of treatment so far shows that there have been no suicide attempts in the past, and the patient has not been treated with LD treatments.

The man, who is single, lives with his deceased mother's sister, in their family home, in the countryside, and is an only child. His mother died in 2008. As declared by the patient, there was no history of mental illnesses or other somatic diseases running in his family.

The patient takes medication as prescribed by the doctor, under the nurse's supervision, and participates in occupational therapy (art therapy, cooking training), as well therapeutic talks with a psychologist and psychotherapist; community meetings addressing the current organisational problems of the ward are also held.

The results achieved by the patient in the research tools used along with their interpretation are shown in Table 1.

**Table 1. Interpretation of patient's results from the applied testing tools**

Research tool	Result
Richardson's Fatigue Rating Scale	On the Richardson's Fatigue Rating Scale (self-assessed fatigue), the patient rated his level of fatigue as significant; on the numerical scale it is classified as 6/10.
SAD PERSONS Scale for Suicide Risk Assessment	According to the results of the SAD PERSON scale (10 points / 14 points), the patient falls under the high risk of suicide; hospitalisation is necessary.
Mini-Mental State Examination (MMSE)	The patient scored 25 points / 30 points on the MMSE scale, which suggests the presence of cognitive impairment (without dementia).

### **Methodology of development of the nursing process according to NANDA, NIC, and NOC classifications**

NANDA as a classification of nursing diagnoses places special focus on the clinical analysis of the patient's condition, his or her needs, deficits, and problems, based on a precise interpretation of each nursing diagnosis, with respect to specific characteristics and related risk factors. From a practical point of view, a properly made diagnosis following the NANDA system requires the nurse to define clinical data (on the patient's condition and risk factors, whether direct or indirect) collected while determining the patient's condition and during the nurse's evaluation of health issues, i.e. subjective and objective examination (laboratory tests and diagnostic tests used in the diagnosis of the disease). Performing a comprehensive and accurate assessment serves the purpose of diagnosing which is based on the scientific evidence described in the classification [8, 9].

The next step in the nursing process, according to the North American Nursing Diagnosis Association system, includes action planning based on the NIC classification. It contains a set of interventions and actions that cover the entire nursing field treated as a scientific discipline, including its practical aspects. To properly determine the outcome of the process, the NOC classification should be used [8, 9].

### **Results**

The collected data allowed the following nursing diagnoses to be formulated: (1) *disturbed sleep patterns* [00198], (2) *fatigue* [00093], (3) *impaired mood control* [00241], (4) *impaired memory* [00131], (5) *social isolation* [00054], (6) *lack of hope* [00124], (7) *helplessness* [00125], (8) *impaired memory* [00131], (9) *impaired social interactions* [00052], (10) *anxiety* [00146], (11) *chronic sadness* [00137], (12) *risk of suicide* [00150]. From the above list, to illustrate methodologies in the NANDA, NIC, and NOC classifications, the *risk of suicide* (12) [00150] diagnosis was selected and a nursing care plan was developed for it (Table 2)

**Table 2. Nursing care plan for the (12) risk of suicide [00150] diagnosis**

Diagnosis: risk of suicide [00150]	
Cause: psychological factors, mental disorders.	
Definition: the risk of inflicting life-threatening harm on oneself.	
Symptoms	Subjective
	Objective
	threats to commit suicide, feelings of guilt, lack of hope, changes in behaviour
	age, male gender, compulsivity, noticeable behavioural changes, sudden improvement in mood following a period of severe depression.
Purpose: to reduce anxiety, improve coping, improve mood, learn to cope when delusions arise, strengthen support system.	
Nursing interventions	Empirical justification
Patient evaluation for the occurrence of suicidal thoughts.	Suicidal thoughts appear in various, both somatic and psychological, diseases [10]. While in somatic diseases they result e.g. from the pain [11], in the case of mental diseases they are conditioned by psychopathological symptoms and usually occur independently of the patient's will. The assessment of the severity of suicidal thoughts in people diagnosed with schizophrenia is based on the observation of the patient's behaviour, his or her verbal utterances, assessment of biological rhythm, conversation with the patient, and diagnostic tests.
Assessing the patient's ability to cooperate in order to encourage the reporting of any suicidal thoughts	It is difficult to clearly determine which patient is capable of attempting suicide and which is not. A declared attempt to take an action does not always mean that such an action will actually be taken; sometimes patients do not voice such intentions. Adequate therapeutic contact must be established with the patient to retrieve information on the emerging suicidal thoughts; it is only through an empathetic attitude and a positive relationship with the patient that he or she will feel encouraged to disclose any undesirable intentions [12].
Observing, recording and reporting changes in mood and behaviour that may increase the risk of a suicide attempt.	Suicidal thoughts are varied in severity (suicidal thoughts, suicidal tendencies, making a suicide attempt). Their severity depends on the advancement of the disease, recurrence and other external factors. It is important to remember that the occurrence of suicidal thoughts in a patient sends an important message as regards care. Such a patient should be treated as a person who may attempt suicide at any time. Nursing staff should continuously keep the patient under indirect supervision, establish a good therapeutic relationship with him or her, and pay special attention to predictors in the patient's behaviour such as sadness, despondency, decreased activity, assessment of the severity of psychopathological symptoms, isolation, refusal to accept meals, sleep disturbances, reluctance to interact with others, and unwillingness to talk. Continuous observation of the patient and thorough assessment of his or her mental status will allow appropriate action to be taken to prevent a suicide attempt [13,14].
Keeping the patient under surveillance while he or she uses potentially hazardous items (scissors, file, razor)	Patients with suicidal tendencies can take advantage of any situation to attempt suicide. The patient should be observed on a continuous basis and the safety rules for patients staying at the ward should be specified in the ward's regulations, procedures and standards of conduct approved by hospital's authorities.
Using various strategies to mitigate isolation and reduce the likelihood of a suicide attempt.	Engaging patients in the therapeutic process, organising theme-based and relaxation activities. During periods of heightened suicidal thoughts, the patient can be offered relaxation training, a conversation or psychological support. When suicidal thoughts are on a decrease, we may suggest participation in classes aimed to stimulate overall activity, creative classes or walks. As the mental status and recovery progress, so does the patient's well-being ultimately resulting in improved self-esteem [15].

<p>Observation of the patient during pharmacotherapy</p>	<p>Pharmacotherapy is a process the effects of which are not immediate. The period during which mental improvement occurs is 3-4 weeks.</p> <p>At the early stages of treatment, patients are reluctant to take medication, have no insight into the disease, and do not want to be hospitalised. They often hide medications, invoke vomiting after taking a medication orally, or hoard medicinal substances for suicidal purposes. It is essential that the nurse observes the patient during pharmacotherapy, both for therapeutic and safety reasons. When supervising the treatment process, the nurse should carefully assess patient's behaviour, speech, activity levels, and sleep patterns, and supervise medication intake in accordance with prescribed standards.</p>
<p>Engaging the patient in the care process, instructing the patient on how to self-manage disease-related symptoms</p>	<p>Self-management of disease symptoms results in improved self-esteem [16,17] and increased sense of one's worth. This is very important because of the patient's social functioning and the roles he or she plays in everyday life. Development of one's own resources is possible by engaging in practical skills training, adhering to medical recommendations, taking medications regularly, and being actively involved in social life. Return to everyday functioning forms an important aspect of the patient's life, preventing relapse and giving the patient a chance to live a normal life without social exclusion and stigma.</p>
<p>Provide the patient with information on coping techniques (assertiveness training, impulse control training, relaxation training)</p>	<p>The onset of suicidal thoughts can be triggered by stress, a period of exacerbation following medication withdrawal, distressing emotions, or traumatic events. The patient should be instructed on how to handle these difficult situations and how to respond to them (emotions journal). The patient should also have knowledge of pharmacotherapy, know why the treatment should not be discontinued and what might be the consequences, and should also be able to recognise the symptoms that precede relapse [18].</p>
<p>Assisting the patient in identifying a support network and identifying patient's own resources (members of clergy, family, caregivers).</p>	<p>The patient's own resources and the psychological support of those around are highly important throughout the treatment process. Depression that can occur in the course of schizophrenia includes in its spectrum the so-called negative depressive triad, which involves a negative image of oneself and negative thoughts about the present and the future. Lack of social support and no need to feel important in the eyes of those around intensifies negative attitudes in the patient and may ultimately lead to suicidal behaviours [19]</p>
<p>Educating the family on how to recognise the risk of suicide (behavioural changes, social withdrawal, sudden cessation of depression).</p>	<p>Both the patient and family should participate in psycho-educational sessions that provide knowledge about pharmacotherapy and early recognition of relapse. Those engaged in the treatment process should know how to recognise relapse (decreased activity levels, insomnia, patient's frustration, sudden changes in behaviour, aggression), when to notify the treating physician, and how to modify treatment. It is important to remember that sudden changes in a patient's mental status (deterioration vs. improvement) always result in relapse. Only the knowledge gained during psycho-educational sessions will allow adequate decision making and prevention of adverse patient reactions [20, 21].</p>
<p>Helping the patient benefit from family and religious support</p>	<p>Being religious and receiving support from loved ones may be a barrier to a suicide attempt [22].</p>
<p>Empathic understanding of the patient</p>	<p>Empathic understanding of the patient means making the patient feel safe, creating a good therapeutic relationship, showing support, not judging the patient and family, looking out for the patient's welfare and respecting the patient's rights [23].</p>
<p>Identifying patient rights and applicable standards.</p>	<p>Defining patient rights and applicable standards ensures that patients feel safe, provides them with legal protection, and enables them to make important life decisions [24].</p>



## Discussion

For many years now, debates have continued in Poland on the possibility of standardisation of nursing diagnoses and their terminology. Following in the model of medical classifications such as ICD-11, nurses are gradually introducing electronic means to manage the nursing process, using their own classification in individual patient records (*EHL – Electronic Health Record*). The introduction of such solutions will facilitate nurses' work and the development of nursing as a scientific field [25].

Using the NANDA, NIC, and NOC classifications in the care of a psychiatric patient being treated in an inpatient setting, it seems most appropriate to select nursing diagnoses from the following domains: "coping with stress", "safety/protection", "health promotion", "self-perception", and "activity/rest". They align with the reasons for hospitalisation as well as describe the most important problems of patients in psychiatric units [26].

In outpatient care, the use of NANDA, NIC, and NOC is also effective. Analyses of individual diagnoses made during nurses' visits at patients' homes suggest that the most frequent diagnosis is the one related to the process of socialisation and the need for social support. "Impaired thought process" is an equally common diagnosis which, however, was removed from the 2012-2014 NANDA-I taxonomy, making its application limited [27].

As regards diagnosing and planning care for patients in psychiatric units, the NANDA, NIC and NOC classifications fail to address many of the nursing problems faced by those who are mentally ill. This can make the process of care more complex and, when using interventions assigned to other nursing diagnoses, entail the need to take a broader perspective on the classification.

## Conclusions

Nursing problems occurring in patients hospitalised for schizophrenia result mainly from psychopathological symptoms of the disease (anxiety, lowered mood, sleep disorders, social isolation) and side effects of applied pharmacotherapy (resting tremor, constipations).

The scientific evidence applied in the planning of nursing care allows one to decide which nursing interventions will be appropriate in accordance with NANDA, NIC and NOC classifications.

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