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PRIMENA PROCESA ZDRAVSTVENE NEGE KOD OSOBE SA PROBLEMIMA U MENTALNOM ZDRAVLJU: PRIKAZ SLUČAJA

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SAŽETAK

Uvod/Cilj: Proces zdravstvene nege (PZN) predstavlja osnovni, sistematičan i individualizovan metod rada u sestrinstvu koji omogućava holistički pristup pacijentu. Njegova primena je od posebnog značaja u psihijatrijskoj nezi, gde su potrebe korisnika kompleksne i zahtevaju kontinuirano praćenje subjektivnih i objektivnih pokazatelja mentalnog stanja. Cilj ovog rada je prikaz primene procesa zdravstvene nege kod osobe sa problemima u mentalnom zdravlju kroz studiju slučaja.

Prikaz slučaja: Istraživanje je sprovedeno u Domu za duševno obolela lica „1. oktobar", Stari Lec. Ispitanik je pacijent muškog pola, star 61 godinu, sa medicinskom dijagnozom F20.0 (schizophrenia paranoides). Pacijent je hospitalizovan od 2013. godine, a kliničku sliku karakterišu akustične halucinacije, ubrzan misaoni tok (tahipsihija), povišeno raspoloženje (hipertimija) i pojačana voljna aktivnost (hiperbulija) bez realizacije planova. Takođe je identifikovan poremećaj spavanja (insomnija) i narušeni porodični odnosi sa ocem. Primenom PZN-a identifikovano je sedam sestrinskih dijagnoza. Plan nege obuhvatio je 15 samostalnih i 6 međuzavisnih sestrinskih intervencija. Ključne mere nege uključivale su uspostavljanje terapijskog odnosa i poverenja, kontinuirano praćenje i kontrolu halucinacija, sprovođenje higijensko-dijetetskog režima radi regulacije sna, usmeravanje pacijenta tokom logoreičnog govora, kao i podršku u održavanju socijalnih kontakata sa sinovima. Evaluacijom je utvrđeno delimično postizanje ciljeva u smislu stabilizacije ponašanja i bolje saradnje u aktivnostima samozbrinjavanja.

Zaključak: Studija slučaja potvrđuje da PZN omogućava svestrano sagledavanje pacijentovih potreba i jasnu definiciju sestrinske uloge u multidisciplinarnom timu. Neophodna je implementacija PZN-a u obaveznu sestrinsku dokumentaciju na nacionalnom nivou, kako bi se osigurao kvalitet, kontinuitet i pravna sigurnost u lečenju i nezi lica sa mentalnim smetnjama.

Ključne reči: Proces zdravstvene nege, sestrinstvo, potrebe za negom, lice sa mentalnim smetnjama

Uvod

Proces zdravstvene nege (PZN) je osnovni metod u sestrinskom radu čiji je glavni cilj rešavanje zdravstvenih problema, odnosno potreba bolesnika za negom. PZN predstavlja sistem međusobno povezanih i zavisnih koraka u rešavanju zdravstvenih problema bolesnika, a baziran je na timskom radu i praćenju kvaliteta nege koje su svojstvene sestrinskoj profesiji. Kroz proces zdravstvene nege ostvaruje se pozitivna interakcija između dva subjekta procesa, odnosno između medicinske sestre i korisnika zdravstvene zaštite (1,2). Američko udruženje medicinskih sestara je 1982. godine uvelo proces zdravstvene nege u sestrinsku profesiju, dok je 1984. godine započelo obavezno dokumentovanje procedura nege po procesu zdravstvene nege u akreditovanim zdravstvenim ustanovama (2,3). PZN je uveden u Jugoslaviji 1983. godine, dok se od 1986. godine izučava u nastavi tokom obrazovanja medicinskih sestara na višem i visokom nivou studija (3).

Proces zdravstvene nege sastoji se iz više međusobno povezanih faza koje proizilaze jedna iz druge (1,4). Prva faza je utvrđivanje potreba bolesnika za negom, nakon čega sledi druga faza – postavljanje sestrinskih dijagnoza, odnosno problema koji proizilaze iz utvrđenih potreba za negom. Sledeća faza je planiranje zdravstvene nege, odnosno sestrinskih intervencija koje imaju za cilj rešavanje sestrinskih dijagnoza, zatim realizacija planiranih aktivnosti i, na kraju, evaluacija nege, kako bi se procenilo da li je došlo do realizacije postavljenih ciljeva (1,2,5).

Zahvaljujući procesu zdravstvene nege, sestrinstvo se sve više razvija kao posebno stručno i naučno polje rada, pa samim tim prati razvoj medicine

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CASE REPORT

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THE IMPLEMENTATION OF THE NURSING PROCESS IN A PERSON WITH MENTAL HEALTH PROBLEMS: A CASE REPORT

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SUMMARY

Introduction/Aim: The Nursing Process (NP) represents a fundamental, systematic, and individualized method of work in nursing that enables a holistic approach to the patient. Its application is of particular importance in psychiatric care, where the needs of users are complex and require continuous monitoring of subjective and objective indicators of mental state. The aim of this paper is to demonstrate the application of the NP in a person with a chronic mental disorder through a case report.

Case report: The research was conducted at the Home for Mentally Ill Persons "1. oktobar" in Stari Lec. The subject is a 61-year-old male patient with a medical diagnosis of F20.0 (paranoid schizophrenia). The patient has been institutionalized since 2013, and the clinical presentation is characterized by auditory hallucinations, rapid thought flow (tachypsychia), elevated mood (hyperthymia), and increased volitional activity (hyperbulia) without the realization of plans. Additionally, sleep disturbance (insomnia) and strained family relationships with the father were identified. By applying the NP, seven nursing diagnoses were identified. The care plan included 15 independent and 6 interdependent nursing interventions. Key nursing measures included: establishing a therapeutic relationship and trust; continuous monitoring and control of hallucinations; implementing a hygienic-dietary regimen to regulate sleep; guiding the patient during logorrheic speech; providing support in maintaining social contacts with his sons. The evaluation determined partial achievement of goals in terms of behavioral stabilization and better cooperation in self-care activities.

Conclusion: The case report confirms that the NP allows for a comprehensive assessment of the patient's needs and a clear definition of the nursing role within a multidisciplinary team. It is essential to implement the NP into mandatory nursing documentation at the national level to ensure the quality, continuity, and legal security in the treatment and care of persons with mental health disorders.

Keywords: The nursing process, nursing, care needs, person with mental disorders

Introduction

The nursing process (NP) represents a fundamental method of work in nursing, and its main goal includes solving health problems, that is, meeting patients' health care needs. The nursing process is a system of mutually connected and dependent steps in solving patients' health problems, and it is based on teamwork and the monitoring of the quality of care that are characteristic of the nursing profession. A positive interaction is achieved between the two subjects of the process, that is, between the nurse and the user of health care through the nursing process (1,2). The American Nurses Association introduced the nursing process to the nursing profession in 1982, while in 1984 it became mandatory for nurses to document the care procedures according to the nursing process for accredited healthcare institutions (2,3). The nursing process was introduced in Yugoslavia in 1983, while since 1986 it has been studied at the undergraduate and graduate level of nursing education (3).

The nursing process consists of several phases that are mutually interconnected (1,4). The first phase is the assessment of patient's health care needs, followed by the second phase – nursing diagnosis, that is, the identification of specific problems that are related to the assessed health care needs. The next phase includes planning of health care or nursing interventions aimed at solving the nursing diagnosis, followed by implementation of planned activities and finally, the evaluation of health care, in order to assess whether the set goals have been realized (1,2,5).

Thanks to the nursing process, nursing is in-

i drugih nauka čiji je cilj unapređenje zdravlja ljudi i lečenje obolelih. Primena procesa ima značajnu ulogu u profesionalnom razvoju medicinskih sestara upravo zato što omogućava jasno definisanje stručnih aktivnosti koje one realizuju kroz primenu samostalnih i međuzavisnih sestrinskih intervencija, kao ravnopravni članovi zdravstvenog tima i saradnici lekara (6).

Sestrinska aktivnost koja je realizovana kroz primenu samostalnih ili međuzavisnih sestrinskih intervencija, ili koja će se tek sprovesti, treba da bude propisno dokumentovana. Precizna dokumentacija igra ključnu ulogu u zdravstvenim uslugama (7). PZN je neophodan da bi se identifikovale sve sestrinske intervencije koje su pružene pacijentima i prikazao napredak zdravstvenog stanja pacijenta tokom hospitalizacije (8). Takođe, on je i pokazatelj kvaliteta, kvantiteta i uspešnosti primenjenih metoda zdravstvene nege. Dokumentacija PZN-a pruža uvid u stanje pacijenta, planirane i sprovedene samostalne i međuzavisne sestrinske intervencije, kao i reakciju pacijenta na intervenciju (9). PZN takođe služi kao efikasan alat interprofesionalne komunikacije, kako u timu za zdravstvenu negu, tako i između medicinskih sestara i drugih članova zdravstvenog tima (10).

Iako je proces zdravstvene nege teorijski i normativno prepoznat kao standardizovani metod rada u sestrinstvu, brojna istraživanja ukazuju na značajne poteškoće u njegovoj primeni u kliničkoj praksi. Studija preseka sprovedena u pet državnih bolnica u Iračkom Kurdistanu, na uzorku od 210 medicinskih sestara, identifikovala je organizacione, edukativne i sistemske prepreke u primeni procesa zdravstvene nege, pri čemu je korišćen strukturirani upitnik koji se sastojao iz tri dela (11). Slični nalazi potvrđeni su u sistematskom pregledu i meta-analizi sprovedenoj u Etiopiji, koja je obuhvatila 17 primarnih studija i ukupno 2.819 medicinskih sestara, pri čemu je utvrđeno da približno polovina ispitanika dosledno primenjuje proces zdravstvene nege u svakodnevnoj praksi (12). Integrativni pregled literature iz zemalja subsaharske Afrike dodatno ukazuje na nedovoljnu i neujednačenu primenu procesa zdravstvene nege, koja se dovodi u vezu sa nedostatkom kontinuirane edukacije, opterećenjem poslom i ograničenom institucionalnom podrškom (13).

Psihijatrija predstavlja medicinsku disciplinu čiji je cilj proučavanje uzroka mentalnih poremećaja (14). Kao i svaka medicinska disciplina, i psihijatrija je specifična i individualna. Psihijatrija se razlikuje od drugih medicinskih disciplina ne samo po dijagnostici, već i po simptomima i znacima svake bolesti (14). Prikaz i razumevanje duševnog i telesnog oboljenja značajno se razlikuju, zbog čega je uspostavljanje adekvatnog terapijskog odnosa medicinske sestre sa osobama sa mentalnim poremećajima od posebnog značaja. Prema podacima Svetske zdravstvene organizacije, mentalni poremećaji predstavljaju jedan od vodećih globalnih javnozdravstvenih problema, sa značajnim i rastućim opterećenjem za zdravstvene sisteme, zbog čega je uloga primarne zdravstvene zaštite od posebnog značaja (15). Zbog porasta broja obolelih, kao i napretka psihijatrije, zdravstvena nega osoba sa problemima mentalnog zdravlja dobila je veću ulogu i stručniji kadar. Medicinske sestre imaju ključnu ulogu u lečenju ovakvih bolesnika, pri čemu se nega sprovodi na svim nivoima zdravstvene zaštite (14). Proces zdravstvene nege predstavlja strukturirani i podržavajući model rada koji omogućava sistematsko i individualizovano sagledavanje potreba pacijenta u kliničkoj praksi, a njegova primena ima poseban značaj u psihijatrijskoj zdravstvenoj nezi, gde se sve faze procesa prilagođavaju složenim psihološkim i socijalnim potrebama pacijenata, što se u ovom radu prikazuje kroz studiju slučaja (16, 17).

Cilj ovog rada je prikaz primene procesa zdravstvene nege kod osobe sa problemima u mentalnom zdravlju kroz studiju slučaja.

Prikaz pacijenta

Istraživanje je realizovano u Domu za duševno obolela lica „1. oktobar“, Stari Lec, nakon dobijanja saglasnosti direktorke ovog Doma (odluka broj: 01-729/23-1, od 05.05.2023). Ispitanik je potpisao formular za pristanak za učešće u istraživanju, čime je potvrdio da je upoznat sa ciljem, vrstom, načinom i svrhom istraživanja, uz potpuno očuvanje integriteta njegove ličnosti i zaštitu ličnih podataka. Istraživanje je bilo dobrovoljno, što znači da je ispitanik mogao da odustane ukoliko je smatrao da ga pitanja na bilo koji način uznemiravaju. Za potrebe istraživanja korišćena je standardizovana dokumentacija procesa zdravstvene nege (1), koja je prilagođena potrebama istraživanja i primene u uslovima Doma za duševno obolela lica „1. oktobar“, Stari Lec.

Sestrinska opservacija

Pacijent N. N., muškog pola, star 61 godinu, iz Beograda, razveden pre trideset godina, otac dva sina. Živi sa roditeljima. Hospitalizovan je u Domu za duševno obolela lica „1. oktobar“ od 2013. godine. Upućen je u Dom iz Klinike za psihijatrijske bolesti

creasingly developing as a special professional and scientific field of work, and therefore, follows the development of medicine and other sciences whose goal is to improve people's health and treat the ill people. The implementation of the process has a significant role in the professional development of nurses precisely because it enables a clear definition of professional activities that they realize through the implementation of independent and interdependent nursing interventions, as equal members of the health team and doctors' associates (6).

The nursing activity that has been realized through the implementation of independent or interdependent nursing interventions, or that is going to be realized, should be properly documented. Accurate documentation plays a key role in health services (7). The nursing process is necessary to identify all nursing interventions provided to patients and to show the progress of of patient's health status during hospitalization (8). It is also an indicator of quality, quantity and success of applied health care. The documentation provides insight into the patient's condition, planned and implemented independent and interdependent nursing interventions, as well as the patient's reaction to the intervention (9). Also, the nursing process serves as an efficient tool of interprofessional communication in the nursing care team, as well as between nurses and other members of the health care team (10).

Although the nursing process is theoretically and normatively recognized as a standardized method of work in nursing, numerous studies indicate significant difficulties in its implementation in clinical practice. A cross-sectional study conducted in five state hospitals in Iraqi Kurdistan, on a sample of 210 nurses, identified organizational, educational and systemic barriers to the implementation of health care processes, using a structured questionnaire consisting of three parts (11). Similar findings were confirmed in a systematic review and meta-analysis conducted in Ethiopia, which included 17 primary studies and a total of 2,919 nurses, where it was found that approximately half of the respondents consistently applied the nursing process in their daily practice (12). An integrative literature review from sub-Saharan African countries further indicates the insufficient and uneven implementation of nursing process, which is associated with a lack of continuing education, workload and limited institutional support (13).

Psychiatry is a medical discipline whose goal is to study the causes of mental disorders (14). Like any medical discipline, psychiatry is individual and special. Psychiatry differs from other medical disciplines not only in diagnosis, but also in symptoms and signs of each disease (14). The presentation and understanding of mental and physical illness differ significantly, which is why establishing an adequate therapeutic relationship between nurses and people with mental disorders is of particular importance. According to data of the World Health Organization, mental disorders represent one of the leading global public health problems, with a significant and growing burden on health systems, which is why the role of primary health care is of particular importance (15). Due to the increase in the number of patients, and therefore the progress of psychiatry, the nursing care of persons with mental health problems received a greater role and more professional staff. Nurses have a key role in the treatment of such patients, where care is provided at all levels of health care (14). The nursing process represents a structured and supportive model of work that enables a systematic and individualized assessment of patient's needs in clinical practice, and its application is of particular importance in psychiatric health care, where all phases of the process are adapted to the complex psychological and social needs of patients, which is shown in this paper through a case report (16,17).

The aim of this paper is to demonstrate the application of the nursing process in a person with a chronic mental disorder through a case report.

Case report

The study was conducted at the Home for Mentally Ill Persons "1. oktobar", in Stari Lec, after the consent of the director of this Home was obtained (decision number: 01-729/23-1, date May 5th,2023). The subject signed the consent for the participation in the study, thus confirming that he was familiar with the aim, type, method and purpose of the study, while fully preserving the integrity of his personality and the protection of personal data. The study was voluntary, which means that the subject could withdraw if he felt that the questions disturbed him in any way. For the purposes of the study, standardized documentation of the nursing process (1) was used, which was adapted to the needs of the study and implementation in conditions of the Home for Mentally Ill Persons "1. oktobar" in Stari Lec.

„Dr Laza Lazarević“. Medicinska dijagnoza: F20.0 (*Schizophrenia paranoides*). Prve simptome bolesti primetio je u oktobru 1990. godine i tada se, kako navodi, osećao „euforično i ubrzano“. Tada ga je otac prisilno odveo na Kliniku „Dr Laza Lazarević“. U periodu od 1990. do 2011. godine redovno je odlazio na kontrolne preglede, ali je više puta hospitalizovan usled pogoršanja psihičkog stanja. Svest kod pacijenta je očuvana, pacijent je orijentisan u vremenu i prostoru. Vitalne funkcije su u fiziološkim granicama (krvni pritisak 130/80 mmHg, puls 65/min, respiracije 16/min, telesna temperatura 36,5°C). Govor je formalno uredan i pacijent negira bolove. Pokretljivost ekstremiteta je očuvana. Kontroliše sfinktere. Stanje kože i vidljivih sluzokoža je u fiziološkim granicama. Pacijent navodi poteškoće sa uspavljivanjem i često buđenje. Fizički je aktivan, puši 20 cigareta dnevno tokom poslednjih 25 godina i samostalan je u aktivnostima samozbrinjavanja. Takođe, samostalno koristi mobilni telefon i odlazi u kupovinu u krugu Doma, dok novcem raspolaže uz nadzor socijalnog radnika. Pacijent navodi da je detinjstvo proveo sa babom, te da sa roditeljima nikada nije ostvario blizak odnos. O ocu govori ogorčeno, navodeći „određenu dozu mržnje“. Takođe, navodi da je otac bio strog i zaštitnički nastrojen, zbog čega je od malih nogu osećao strah. Sa bivšom suprugom nije u kontaktu, dok se sa sinovima redovno čuje i oni ga posećuju.

Opis bolesnika na osnovu posmatranja

Pacijent je komunikativan i saradljiv. Na pitanja odgovara opširno, pokazujući tendenciju ka opširnosti i skretanju sa tema, naročito kada govori o porodici (ocu), što ga vidno uznemirava. Gestikulacija i hod su uredni, a spoljašnji izgled ukazuje na urednu i negovanu ličnost.

Prepoznavanje psihopatoloških fenomena

Svest: Očuvana. Pacijent je autopsihički i alopsihički orijentisan.

Opažanje: Prisutni poremećaji u vidu akustičnih halucinacija (čuje glasove sa kojima razgovara, ali navodi da nisu imperativnog karaktera). Halucinacije se javljaju uglavnom noću. Negira trenutne suicidalne ideje, mada navodi da ih je ranije imao.

Pažnja: Prisutan poremećaj u vidu popustljive pažnje (hipotenacitet) i pojačane usmerenosti na spoljne draži (hipervigilnost).

Pamćenje: Bez kvalitativnih i kvantitativnih poremećaja.

Mišljenje: Poremećaj forme mišljenja – ubrzan misaoni tok (tahipsihija) i logoreja (potreba za neprestanim pričanjem).

Emocije: Prisutna hipertimija (povišeno raspoloženje); pacijent je često neadekvatno veseo i uzbuđen.

Nagoni: Pojačan nagon za ishranom (polifagija), bez pratećeg povećanja telesne mase zbog pojačane fizičke aktivnosti.

Volja: Prisutna hiperbulija (pojačana voljna aktivnost); pacijent pravi brojne planove koje ne realizuje, već odmah prelazi na nove.

Određivanje dijagnoze nege, planiranje programa nege i ostvareni ciljevi

Na osnovu navedenog određena je sestrinska dijagnoza i napravljen je program nege (tabela 1). Primenom PZN-a identifikovano je 7 sestrinskih dijagnoza. Plan nege obuhvatio je 15 samostalnih i 6 međuzavisnih sestrinskih intervencija. Ključne mere nege uključivale su uspostavljanje terapijskog odnosa i poverenja, kontinuirano praćenje i kontrolu halucinacija, sprovođenje higijensko-dijetetskog režima radi regulacije sna, usmeravanje pacijenta tokom logoreičnog govora, kao i podršku u održavanju socijalnih kontakata sa sinovima. Evaluacijom je utvrđeno delimično postizanje ciljeva u smislu stabilizacije ponašanja i bolje saradnje u aktivnostima samozbrinjavanja.

Diskusija

Primena PZN kod pacijenta sa paranoidnom šizofrenijom omogućila je prelazak sa rutinske, simptomatske nege na holistički i personalizovani pristup. Identifikovanjem 7 sestrinskih dijagnoza i planiranjem 15 samostalnih, uz 6 međuzavisnih intervencija, rad sestre prestaje da bude isključivo izvršni (sprovođenje ordinirane terapije) i postaje analitički. Ovakav pristup direktno doprinosi vidljivosti sestrinskog udela u lečenju, jer se kroz sestrinske naloge jasno definišu kompetencije i odgovornost za ishod nege.

U kontekstu psihijatrijske nege, PZN ima specifičnu težinu zbog prirode same bolesti. Kako navode Zerihun i saradnici (18), dosledna primena procesa nege u mentalnom zdravlju značajno poboljšava kvalitet života pacijenata i smanjuje broj dana hospitalizacije, jer omogućava rano prepoznavanje relapsa kroz sistematsko praćenje psihopatoloških fenomena. U ovom istraživanju, to se ogledalo u preciznom definisanju intervencija za kontrolu akustičnih halucinacija i tahipsihije, što bi u tradicionalnom modelu

Nursing observations

The subject is a 61-year-old male patient from Belgrade, who divorced thirty years ago, father of two sons. He lives with his mother and father. He has been hospitalized at the Home for Mentally Ill Persons since 2013. He was referred to the Home from the Hospital for Psychiatric Diseases "Dr Laza Lazarević". Medical diagnosis is F20.0 (Schizophrenia paranoides). He noticed the first symptoms of disease in October 1990, and then he felt "euphoric and accelerated". Then his father forcibly took him to the Hospital "Dr Laza Lazarevic". He regularly went for check-ups from 1990 to 2011, and he was hospitalized several times due to the worsening of his mental condition. The patient's consciousness is preserved, and he is oriented to time and space. Vital functions are within physiological limits (blood pressure 130/80 mmHg, pulse 65/min, respirations 16/min, body temperature 36.5^{0}C). The speech is formally normal and the patient denies pain. Limb mobility is preserved. He controls sphincters. The condition of his skin and visible mucous membranes is within physiological limits. The patient reports difficulty falling asleep and frequent awakenings. He is physically active, has smoked 20 cigarettes a day for the past 25 years, and is independent in self-care activities. Also, he uses his mobile phone independently and goes shopping within the Home, while he handles his finances under the supervision of a social worker. The patient states that he spent his childhood with his grandmother, and that he never had a close relationship with his parents. He speaks about his father resentfully, stating "a certain amount of hatred". He also states that his father was strict and protective, which is why he felt fear from an early age. He is not in contact with his ex-wife, while he maintains regular communication with his sons and they visit him.

Description of the patient based on observation

The patient is communicative and cooperative. He answers the questions extensively, showing a tendency towards verbosity and digressing, especially when he talks about his family (father), which upsets him visibly. Gesticulation and gait are orderly, while the appearance indicates that the face is neat and well-groomed.

Recognizing psychopathological phenomena

Consciousness: preserved. The patient is autopsychically and allopsychically oriented.

Perception: disorders in the form of auditory hallucinations (he hears voices he talks to, but states that they are not command hallucinations). Hallucinations occur mainly at night. He denies having suicidal ideas at that moment, but states that he had them in the past.

Attention: deficit in the form of impaired attention (hypo-tenacity) and increased focus on external stimuli (hypervigilance).

Memory: no qualitative or quantitative disorders.

Thinking: an alteration in the form – rapid thought flow (tachypsychia) and logorrhea (need for constant talking).

Emotions: hyperthymia is present (elevated mood), the patient is inappropriately cheerful and excited.

Impulses: increased drive to eat (polyphagia), without the accompanying weight gain due to increased physical activity.

Will: hyperbulia present (increased volitional activity); the patient makes numerous plans, but he does not realize them, and immediately moves on to new ones.

Determining the diagnosis, planning the care program and realized goals

Based on all of the above mentioned, the nursing care diagnosis was determined, as well as the care program (Table 1). Seven nursing diagnoses were identified using the NP. The care plan included 15 independent and 6 interdependent nursing interventions. Key measures of care included the following: establishing the therapeutic relationship and trust, continuous monitoring and control of hallucinations, implementation of a hygienic-dietary regimen to regulate sleep, guiding the patient during excessive talking, as well as support to maintain social contacts with his sons. The evaluation showed the partial achievement of goals in terms of behavioral stabilization and better cooperation in self-care activities.

Discussion

The implementation of NP in the patient with paranoid schizophrenia enabled the transition from routine, symptomatic care to the holistic and personalized approach. By identifying seven nursing diagnoses and planning fifteen independent together with six interdependent interventions, the nurse's work ceases to be only executive (adminis-

Tabela 1. Određivanje dijagnoze nege i planiranje programa nege

OBRAZCI - problemi	**DIJAGNOZA NEGE**	**SESTRINSKE INTERVENCIJE**
PERCEPCIJA I ODRŽAVANjE ZDRAVLjA *Pušač 25 godina, u proseku puši kutiju cigareta dnevno*	Negativno zdravstveno ponašanje u vezi sa lošim navikama, što se manifestuje pušenjem.	- Edukacija pacijenta o posledicama konzumiranja duvana. - Motivacija pacijenta na smanjenje broja popušenih cigareta na dnevnom nivou. - Praćenje efekata postignutih dogovora.
NUTRITIVNO METABOLIČKI *Pojačan apetit, preobilni obroci* *Pored obroka, svakodnevno konzumira grickalice i slatkiše.*	Izmenjena ishrana - veća od telesnih potreba u vezi sa pojačanim apetitom i lošim navikama, što se manifestuje preobilnim obrocima i unošenjem grickalica i slatkiša između obroka.	- Konsultacija sa nutricionistom. - Kontrola telesne mase. - Kontrola unosa hrane van obroka. - Ograničenje unosa grickalica i slatkiša. - Kontrola neželjenih efekata terapije.
AKTIVNOSTI / ODMOR *Kasno i teško uspavljivanje.* *Buđenje tokom noći.* *Popodnvno spavanje oko 3 sata.*	Smetnje sa snom u vezi sa produženim popodnevnim spavanjem i konzumiranjem cigareta do kasno, što se manifestuje teškim uspavljivanjem i čestim buđenjem tokom noći.	- Negovanje rutine leganja i ustajanja u isto vreme. - Kontrola popodnevnog spavanja. - Ograničenje popodnevnog spavanje na 1 sat.
SAMOPERCEPCIJA *Osećanje tuge.* *Misli da je na teretu porodici.* *Nema prijatelje izvan Doma.* *Smatra da je za njega najbolje rešenje.* *institucionalni smeštaj*	Socijalna izolacija u vezi sa mišljenjem da je na teretu porodici i da je za njega samo institucionalni smeštaj, što se manifestuje odsustvom socijalnih kontakata izvan ustanove, izostankom partnerskog odnosa i povremenim osećajem tuge. Smanjena mogućnost staranja o sebi u vezi sa ispoljavanjem psihopatoloških fenomena, što se manifestuje potpunom zavisnošću od institucionalnog smeštaja.	- Opservacija korisnika. - Planiranje dnevnih aktivnosti. - Primena suportivne psihoterapijske tehnike. - Socioterapija – podsticanje aktivnog učešća.
ULOGE I ODNOSI *Loši odnosi sa roditeljima.* *Nema kontakt sa bivšom suprugom.*	Poremećeni porodični odnosi u vezi sa čestim konfliktnim situacijama i nedostatkom tolerancije, što se manifestuje odsustvom kontakta sa bivšom suprugom i lošim odnosom sa roditeljima.	- Razgovor sa psihijatrom o poremećenim porodičnim odnosima.
BEZBEDNOST/ ZAŠTITA *Pojava suicidalnih misli.*	Rizik od suicida u vezi sa povremenim suicidalnim mislima.	- Nadzor nad pacijentom 24h, naročito u periodima smanjene pažnje (rani jutarnji sati, promena smene). - Ozbiljno shvatanje svake verbalizacije suicidalnih namera ili samopovređivanja. - Identifikacija i uklanjanje potencijalno opasnih predmeta iz pacijentovog okruženja, uz praćenje verbalizacije suicidnih ideja i planova. - Uključivanje pacijenta u socioterapijske aktivnosti. - Kontrola terapije, radi postizanja terapijskog učinka i prevencije mogućeg pravljenja rezervi.

Table 1. Determining the nursing diagnosis and planning the care program

PATTERNS - Problems	NURSING DIAGNOSIS	NURSING INTERVENTIONS
PERCEPTION AND MAINTENANCE OF HEALTH A smoker for 25 years, smokes a pack of cigarettes a day on average	Negative health behavior related to bad habits manifested by smoking	- Educate the patient about the consequences of tobacco smoking. - Motivate the patient to reduce the number of cigarettes smoked on a daily basis. - Monitor the effects of the reached agreement.
NUTRITION-METABOLISM Increased appetite, excessive meals – he consumes snacks and sweets in addition to meals	Changed diet – greater than the body's needs in connection with increased appetite and bad habits, which is manifested by eating too many meals and eating snacks and sweets between meals	-Consultation with a nutritionist. -Control body weight. -Control the ways he accesses food outside of planned meals. -Limit the intake of snacks and sweets. -Control unwanted effects of therapy.
ACTIVITIES/REST He goes to bed late and it is difficult to fall asleep. Awakenings throughout the night. He sleeps for about 3 hours in the afternoon.	Sleep disturbances related to prolonged afternoon sleep and late-night cigarette smoking which makes it hard to fall asleep and is manifested by frequent awakenings during night.	-Cultivate the routine of going to bed and getting up at the same time. -Control the afternoon sleep. - Limit the afternoon sleep to one hour.
SELF-PERCEPTIONS Feeling sad. He thinks he is a burden to the family. He has no friends outside the Home. He thinks that institutional accommodation is the best solution for him.	Social isolation connected with the opinion that he is a burden to the family and that institutional accommodation is for him, which is manifested by the absence of social contacts outside the institution, absence of partner relationship and occasional feeling of sadness. Reduced ability to take care of himself connected with the manifestation of psychopathological phenomena, which is manifested by complete dependence on institutional accommodation.	-Observe the user. -Plan activities on a daily basis. -Implement supportive psychotherapy techniques. -Sociotherapy – encourage active participation.
ROLES AND RELATIONSHIPS Bad relations with parents. He has no contact with his ex-wife.	Strained family relations connected with frequent conflict situations and lack of tolerance, which is manifested by the absence of contact with his ex-wife and bad relationship with parents.	-Conversation with a psychiatrist about strained family relations.
SECURITY/PROTECTION The appearance of suicidal thoughts.	Risk of suicide related to occasional suicidal thoughts.	-Supervision of the patient (24 hours), especially when attention is expected to weaken (early morning hours, change of shift). -Take any threat of suicide or self-harm seriously. -Pay special attention to items that may come into his possession, which he could use in the realization, as well as whether he talks about potential ways of suicide. -Involve the patient in sociotherapy. -Control medications, not only to achieve therapeutic effect, but also to eliminate the possibility of making reserves.

rada moglo ostati u senci isključivo medikamentozne terapije.

Jedan od ključnih izazova identifikovanih u ovom radu jeste nepostojanje jedinstvenog nacionalnog obrasca sestrinske dokumentacije. Nedostatak standardizovanih protokola često vodi ka subjektivizmu u proceni i neujednačenom kvalitetu nege. Prema studiji koju su sproveli Zamanzadeh i saradnici (19), barijere za implementaciju PZN-a najčešće su organizacione prirode, uključujući nedostatak vremena i nedovoljnu kontinuiranu edukaciju, ali se ističe da je upravo dokumentovanje nege „ogledalo" profesionalizma. Bez pisane potvrde o sprovedenim intervencijama, rad medicinske sestre ostaje nevidljiv za zdravstveni sistem i podložan pravnim rizicima.

Značaj ovog rada ogleda se i u afirmaciji sestre kao ravnopravnog člana multidisciplinarnog tima u ustanovama socijalne zaštite, kao što je Dom „1. oktobar". Da bi se PZN u potpunosti integrisao, neophodno je inicirati promene na zakonodavnom nivou i uvesti obavezne seminare koji bi osnažili sestre u sferama kliničkog prosuđivanja i kritičkog mišljenja. Samo kroz kontinuiranu edukaciju i zakonsko prepoznavanje PZN-a kao obaveznog standarda, sestrinstvo u Srbiji može dostići nivo autonomije i kvaliteta koji nalažu savremeni standardi Svetske zdravstvene organizacije.

Zaključak

Primena procesa zdravstvene nege kod pacijenta sa dijagnozom paranoidna šizofrenija omogućila je precizno identifikovanje specifičnih potreba koje prevazilaze puko zbrinjavanje simptoma. Kroz strukturirane faze procesa, nega je prilagođena kompleksnim psihopatološkim fenomenima poput akustičnih halucinacija, tahipsihije i poremećaja nagona. Izrada individualnog plana nege, koji obuhvata 15 samostalnih intervencija, potvrđuje sestrinsku profesiju kao autonomnu disciplinu unutar multidisciplinarnog tima. PZN omogućava sestrinskom radu da postane merljiv, vidljiv i naučno utemeljen, a ne samo pomoćna aktivnost u procesu lečenja. Dokumentovanje svih faza PZN-a služi kao ključni alat za kontinuirano praćenje stanja pacijenta i prevenciju propusta. Evaluacija postavljenih ciljeva pruža objektivan uvid u efikasnost primenjenih metoda, čime se direktno podiže standard zdravstvene usluge u ustanovama za zbrinjavanje duševno obolelih lica. Istraživanje ukazuje na kritičnu potrebu za uvođenjem jedinstvene sestrinske dokumentacije na nacionalnom nivou. Edukacija kadra i zakonska regulativa su preduslovi da PZN postane standard, a ne sporadična praksa, čime bi se osigurala ravnopravnost sestrinske profesije i bolji ishodi po mentalno zdravlje korisnika.

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tering prescribed therapy) and becomes analytical. This approach directly contributes to the visibility of the nursing role in the treatment, because nursing orders clearly define competences and responsibility for the outcome of care.

In the context of psychiatric care, the NP is particularly important due to the nature of disease itself. According to Zerihun et al. (18), the consistent implementation of the nursing process in mental health significantly improves the quality of life of patients and reduces the number of days of hospitalization, because it enables the early recognition of relapse through systematic monitoring of psychopathological phenomena. In our study, this is reflected in the precise definition of interventions for the control of auditory hallucinations and tachypsychia, which could stay in the shadow in the traditional model of work, in which the treatment included only the administration of medications.

One of the key challenges identified in this study is the absence of the uniform national form of nursing documentation. The lack of standardized protocols often leads to subjectivity in the assessment and uneven quality of healthcare. According to a study by Zamanzadeh et al. (19), the barriers to the implementation of the nursing process are most often organizational, including lack of time and insufficient continuous education. However, it is emphasized that documenting care is the "mirror" of professionalism. Without the written confirmation of realized interventions, the nurse's work remains invisible to the health system and subject to legal risks.

The importance of this study is also reflected in the affirmation of a nurse as an equal member of the multidisciplinary team in social welfare institutions, such as the Home "1. oktobar". In order for NP to be fully integrated, it is necessary to initiate changes at the legislative level and introduce mandatory conferences that would strengthen nurses in the spheres of clinical judgment and critical thinking. Only through continuous education and legal recognition of NP as a mandatory standard, nursing in Serbia can reach the level of autonomy and quality required by modern standards of the World Health Organization.

Conclusion

The implementation of the nursing process in a patient with paranoid schizophrenia made it possible to accurately identify specific needs that go beyond the mere treatment of symptoms. Through structured phases of the process, care is adapted to complex psychopathological phenomena such as auditory hallucinations, tachypsychia and impulse disorders. The creation of an individual care plan, which includes 15 independent interventions, confirms that the nursing profession is an autonomous discipline within a multidisciplinary team. The NP enables nursing work to become measurable, visible and scientifically based, and not just an additional activity in the treatment process. Documenting all phases of the NP serves as a key tool for continuous monitoring of the patient's condition and prevention of errors. The evaluation of set goals provides an objective insight into the effectiveness of applied methods, which directly raises the standard of healthcare services in institutions for mentally ill persons. The study points to the critical need for introducing the uniform nursing documentation at the national level. Staff education and legal regulations are prerequisites for the NP to become a standard, and not a sporadic practice, which would ensure the equality of the nursing profession and better outcomes for the mental health of users.

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