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Review Article

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Intellectual Disability Nursing

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Abstract

Persons with mental retardation enter a group of persons with disabilities. We also use the term "persons with developmental disabilities" and "persons with special needs" but recently, for persons with mental retardation, we use the term "persons with intellectual disabilities". Sometimes negative opinions and negative attitudes, violence and discrimination were not directed against them, but such practices were advancing to the social pattern of behavior towards them. Even today we are witnessing that there is still a pattern of behavior toward them. Although society has been educating and expanding its vision and understanding of the world around it, it often happens that their abilities and their abilities create superficial conclusions. The presence of mental retardation does not justify any form of discrimination. Although more and more institutions dealing with improving the lives of persons with intellectual disabilities, they are in some ways deprived of their own choice and decision-making.

Keywords: Intellectual Disability, Patient, Nurse

Introduction

The practice setting for intellectual disability nursing is difficult to define because it is located in a complex landscape of service provision [1]. This includes, for example, residential care homes, independent living homes, supported living arrangements, as well as people with intellectual disabilities living in their own homes as well as family homes. There are also larger service configurations and very specialist settings, such as treatment and assessment services and challenging behaviour units, as well as specialist health or social care settings, such as hospices or homes for older people. Therefore much of the care planning and delivery of intellectual nurses now no longer takes place in traditional settings; rather it takes place in within the context of multi-disciplinary and multi-agency settings. However, because of professional requirements for intellectual disability nurses, regardless of where people with intellectual disabilities live, if they are in receipt of nursing care this should be guided by a care plan, whether the care comprises short intensive nursing interventions or long periods of care and support.

With its foundation in brain-behavior relationships and neuropathology, and its grounding in psychometrics, neuropsychology has a different perspective on intellectual disability [2]. To be sure, this perspective is not codified in a DSM (The Diagnostic and Statistical Manual of Mental Disorders) for neuropsychology, but it is seen in a rigorous research literature and in excellent reviews. Neurodevelopmental disorders are viewed in the context of abnormalities in or early insults to the developing nervous system. The neuropsychological perspective recognizes genetic, neurological, and other pathological etiologies that lead to developmental delays. Although neuropsychologists might use DSM-5, the AAIDD (American Association on Intellectual and Developmental Disabilities) rules, or the WHO (World Health Organization) International Classification of Disease (ICD) guidelines for diagnosis, and respect the Social Security disability listing requirements for intellectual disability, there is recognition of underlying pathology and functional outcomes. Furthermore, the psychometric aspects of neuropsychological training recognize that different ways of obtaining the same full-scale IQ score might lead to different diagnoses, no matter that the IQ level might satisfy other guidelines for ID.

Healing

Systems of art and science are modified over time, creating and organizing new knowledge in terms of, and in response to, a specific set of issues or problems [3]. The overarching evolutionary progress of humanity has always been towards higher order. In the past 300 years we have made vast strides in the worlds of art and science, learning to harness and distribute energy while creating new forms of machines, materials, and beauty. What has been slower in development is the subjective psycho/social/spiritual side of humanity. Our power to manipulate and control the outside world has advanced greatly, but we have not made similar advances in understanding our own behavior and our inner experience.

Current challenges facing society in general, and health care in particular, are pressing for a new way to comprehend and enhance the inner world of humankind. The lack of advances in understanding human behavior and inner experience have prevented us from solving

pressing issues such as war, the world population explosion, and the poisoning of our planet. On a personal scale, we are experiencing the growth of lifestyle-related chronic illness at all ages and stages of the life continuum. Depression, mental illness, addiction, and obesity point to a culture deeply in search of meaning as old forms and processes fall away.

Conventional healing efforts have been focused into the past, trying to unearth the origins of patterns that do not serve us well. Health care professionals have traditionally helped people who are suffering to focus on contextual issues within their lives: family, career, social, and economic issues. However, the quantum perspective in healing offers us a new and transformative approach to illness and crisis. Stepping out of our life situation—becoming witness—opens up the present moment, the place where resolution resides.

Plan

Where to hospitalize a young adult with developmental disabilities for inpatient care is another complicated issue [4]. Young adults want to be on adult patient floors. They would like to be with peers. Nurses on the pediatric wards are generally not accustomed to adult-sized patients. The pediatric nurses also choose to take care of children and have a child-focused system of caring. From the adult nursing standpoint, they are not used to pediatric disorders such as cerebral palsy, Down syndrome, or autism. They are not used to having the parent being so involved in the patient's care. In the setting of a teaching institution medicine residents may not be adequately experienced in the care of young adults with developmental disabilities.

In the transition plan, the hospital of choice should be decided ahead of time. The care coordinator can help facilitate a visit to the hospital. Education for the nursing staff could be started by asking the nursing staff what their needs are and providing them with information and training. Care plans can be sent to the adult emergency department. During the first hospitalization and perhaps the second, the pediatrician could round with the adult medical team and answer questions about the pediatric condition or how the patient responds to being ill.

Essentially this is a written document that articulates a plan of care for an individual with intellectual disabilities [1]. This plan will typically identify what this person can and will do in their day-to-day living and what support they need to do so. This process of constructing a care plan is complex and can potentially involve a large number of people and sources of information. The use of a nursing model can help to make this process more manageable and thereby enhance care. Planning care and its delivery has different emphases depending on its purpose, function and who carries out the assessment. For example, a person with intellectual disabilities living in a community setting will require different information to be collected from health, generic and social care assessments as opposed to someone detained under the Mental Health Act in a treatment and assessment unit. It is the case that in the preceding example both of these assessments will look at different areas of need; however the overall process of care planning and its delivery should ideally take into consideration all the assessed needs/areas, and the construction of any care plan should reflect and include these. For example, an occupational therapist might assess the daily living skills of a person with intellectual disabilities living in the community, whereas a clinical psychologist might assess the behavioural needs of someone in a treatment and assessment unit; a social worker might assess someone with learning disabilities as to whether they meet eligibility criteria for services (and to identify which service is appropriate) and, finally, a nurse might assess the health needs of an individual. All of these contributions might well assist in the construction of an overall care plan for someone with intellectual disabilities.

Management

This is a system of assessing individual needs and, from this, constructing a 'package of care' to meet those needs [1]. Care managers play a pivotal role in helping people to achieve valued, fulfilling lifestyles; they can be instrumental in commissioning new initiatives built around the needs of the person, rather than expecting them to fit into existing provision, however inappropriate. It has been observed that care managers occupy a crucial point which straddles human services and the wider community. A really effective care manager is likely to practise in a person-centred way, and probably has some characteristics in common with a 'service broker'. Intellectual disability nurses are in a strong position to carry out this role, given their specialist training and understanding of the service user's perspective based on their partnership approach. Good care management practice involves working in a person-centred way. However, one could argue that care management is still often applied as an 'administrative tool for cost management'.

Nurses

Intellectual disability nurses, as an occupational group, are in a particularly strong position to implement and refine PCP (person-centred planning) [5]. Among nurses assets are the specialist nature of intellectual disability nurse training and the high proportion of time spent with people who have an intellectual disability; this compares with other professionals who may make a single visit for assessment purposes, but spend an insufficient time to develop a relationship. However, the greatest contribution of nursing is its emphasis on interpersonal skills and the therapeutic relationship. Although nurses generally must balance service users freedom with the professional, ethical 'duty of care', they have a philosophical history of supporting service user's autonomy.

Ethics

Ethical dilemmas may present in the care planning and care delivery process [6]. This is usually when it is not clear what the right thing to do is or when healthcare professionals, family carers and a person with an intellectual disability are not in agreement about a course of action. In some cases this may be more complex to resolve due to the severity of the intellectual disabilities and difficulties with communication.

Ethical dilemmas involving care planning for people with intellectual disabilities may demand that the nurse negotiates many differing points of view. It is important that the intellectual disability nurse constantly reflects on their own set of values, beliefs and attitudes. This will better enable them to support the care planning process. If ethical problems arise the intellectual disability nurse must ensure that they strive to understand the other person's point of view. This will help in effectively supporting the person when different opinions emerge.

Mental Health

The neglect of the mental health needs of people with intellectual disabilities over the last century can clearly be observed in the

corresponding lack of developments in the provision of eclectic interventions and services [7]. Historically, the only treatment that was afforded to people with a dual diagnosis was containment within locked wards in the institutions/intellectual disability hospitals, or chemical restraint by medication. However, from undertaking a comprehensive holistic assessment a multi-modal plan of care that may include behavioural approaches, other psychological interventions, changes in the person's environment, improving communication, social skills training and medications (if required), can be implemented. In addition, the humanistic ways of relating to people already alluded to, have potential value to counter the reductionist medical and deficit psychiatric models that may disenfranchise the humanity of this population, thereby providing a more holistic and pro-active approach to care planning and delivery for this client group.

Conclusion

Psychiatric care includes providing services to individuals related to mental, physical and developmental health. Psychiatric nurses operate in various roles that provide health services to individuals, families, groups, and communities. The practice of psychiatric nursing takes place within the field of direct practice, education, management and research. Prior to all principles, one should emphasize one that precedes the other principles, which is holistic approach to the patient. The holistic approach see the man extensively beyond boundaries, medicine, biology, sociology and psychology in a classical sense, unites those disciplines and sees a man in a wider context, with all its dimensions, including the community in which he lives. Man is viewed as an individual with all his personalities. The basis of holistic approach to the patient is that the patient is an active and equal participant in the treatment process and as such bears part of the responsibility for the outcome of the treatment.

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