Student Name: Jeremy Lacinski
Medical Diagnosis/Disease: Bipolar

NCLEX IV *(8)*: Physiological Integrity/Physiological Adaptation **NCLEX IV *(7)*: Reduction of Risk**

Anatomy and Physiology

Normal Structures

The brain consists of four main structures: The Cerebrum, the Cerebellum, the Pons, and the Medulla.
The cerebrum is thought to control conscious mental processes. The outer layer of the cerebrum is called gray matter, the inner portion, white matter.
The cerebellum controls muscle coordination and maintains bodily equilibrium.
The Pons is in front of the cerebellum and coordinates the activities of the cerebrum and the cerebellum by receiving and sending impulses from them to the spinal cord.
The Medulla is part of the brainstem situated between the pons and the spinal cord and it controls breathing, heartbeat, and vomiting.
Cerebrospinal fluid flows in the space between two of the layers in a space called the subarachnoid space. CSF is essentially salt water, and it is in constant circulation and serves several important functions.
The brain floats in CSF.

Pathophysiology of Disease

Bipolar disorder, formerly called manic depression, is a mental health condition that causes extreme mood swings that include emotional highs (mania or hypomania) and lows (depression).
Bipolar I disorder= at least one manic episode that may be preceded or followed by hypomanic or major depressive episodes. In some cases, mania may trigger a break from reality (psychosis).
Bipolar II disorder=at least one major depressive episode and at least one hypomanic episode, but you've never had a manic episode.
Cyclothymic disorder=at least two years, or one year in children and teenagers, of many periods of hypomania symptoms and periods of depressive symptoms (though less severe than major depression).

Anticipated Diagnostics

Labs

N/A

Additional Diagnostics

Physical exam
Psychiatric assessment
Mood charting
Criteria for bipolar disorder (DSM-5)
- DSM5 Manic =During this period, three or more of the following symptoms must be present and represent a significant change from usual behavior:

1. Inflated self-esteem or grandiosity
2. Decreased need for sleep
3. Increased talkativeness
4. Racing thoughts
5. Distracted easily
6. Increase in goal-directed activity or psychomotor agitation
7. Engaging in activities that hold the potential for painful consequences, e.g., unrestrained buying sprees

DSM5 Despressive disorder= The DSM-5 states that a person must experience five or more of the following symptoms in two weeks to be diagnosed with a major depressive episode:

1. Depressed mood most of the day, nearly every day

		2. Loss of interest or pleasure in all, or almost all, activities 3. Significant weight loss or decrease or increase in appetite 4. Engaging in purposeless movements, such as pacing the room 5. Fatigue or loss of energy 6. Feelings of worthlessness or guilt 7. Diminished ability to think or concentrate, or indecisiveness 8. Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt

NCLEX II *(3)*: Health Promotion and Maintenance **NCLEX IV *(7)*: Reduction of Risk**

Contributing Risk Factors	Signs and Symptoms	Possible Therapeutic Procedures	Prevention of Complications (What are some potential complications associated with this disease process)
Having a first-degree relative, such as a parent or sibling, with bipolar disorder Periods of high stress, such as the death of a loved one or another traumatic event Drug or alcohol abuse	-Depressed mood -Marked loss of interest -Significant weight loss -Either insomnia or sleeping too much -restlessness -Fatigue -Feelings of worthlessness -excessive guilt -inappropriate guilt -Decreased ability to think or concentrate, or indecisiveness -Thinking about, planning, or attempting suicide	Non-surgical Interpersonal and social rhythm therapy (IPSRT). Cognitive behavioral therapy (CBT). Psychoeducation. Family-focused therapy. Surgical N/A	Problems related to drug and alcohol use (remove substance from household) Suicide or suicide attempts (hospitalization for safety) Legal or financial problems (keep close eye on patient during episodes) Damaged relationships (understand the disorder can make the patient say things they do not mean) Poor work or school

			performance (Manic episodes can make the person not be able to understand)

NCLEX IV *(6)*: Pharmacological and Parenteral Therapies

Anticipated Medication Management

Mood stabilizers.
lithium (Lithobid), valproic acid (Depakene), divalproex sodium (Depakote), carbamazepine (Tegretol, Equetro, others) and lamotrigine (Lamictal).
Antipsychotics. olanzapine (Zyprexa), risperidone (Risperdal), quetiapine (Seroquel), aripiprazole (Abilify), ziprasidone (Geodon), lurasidone (Latuda) or asenapine (Saphris)
Antidepressants.
Antidepressant-antipsychotic. (Symbyax)
Anti-anxiety medications. (Benzodiazepines)

NCLEX IV *(5)*: Basic Care and Comfort

Non-Pharmacologic Care Measures

Quit drinking or using recreational drugs
Form healthy relationships
Create a healthy routine
mood chart
Support group
Relaxation
Yoga
Mediation
High calorie meals
Exercise program
Symptom recognition

NCLEX III *(4)*: Psychosocial/Holistic Care Needs

What stressors might a patient with this diagnosis be experiencing?

Fear of death
Pain
Role conflict
Hospitalization
Forced dependence
Anxiety
Loss of control

Client/Family Education

List 3 potential teaching topics/areas

• Hospitalization is needed if safety of self/others is in question.
• Education on signs of bipolar disorder
•Take Medication as directed and keep follow up appointment with PCP

NCLEX I *(1)*: Safe and Effective Care Environment

Multidisciplinary Team Involvement

(Which other disciplines do you expect to share in the care of this patient)

Support group
PCP
RN
Clinical psychologist
Psychiatrist

N201: Nursing Diagnosis Form

List the two Nursing Diagnoses along with expected outcomes, assessments, and nursing interventions for each patient. The nursing diagnosis must be complete, be in priority order, use correct terminology, and include relevant related to factors and AEB statements for actual problems.

NDx # 1 Impaired Social Interaction r/t difficulty with communication, concentration, delusions, inadequate emotional responses AEB appears upset, agitated, or anxious when others come too close in contact or try to engage him/her in an activity, dysfunctional interaction with others/peers, observed use of unsuccessful social interactions behaviors, spends time alone by self, unable to make eye contact, or initiate or respond to social advances of others, verbalized or observed discomfort in social situations
EO: Patient will attend one structured group activity within 5-7 days of my time of care.
EO: Patient will engage in one activity with a nurse by the end of the day.
EO: Patient will maintain an interaction with another client while doing an activity during my time of care.

Ongoing Assessments: Assess signs of increased agitation and anxiety q prn, Assess for decreased motivation to leave room or have social interactions q 3 hours, Assess environment for hazards q shift, Assess for flight response when others come within range to interact, Assess for signs of depression q shift, Assess for signs of self-harm q 3 hours or prn.

NI: 1. Keep the environment as free of stimuli (loud noises, crowding) as possible during my time of care.

2. Educate on useful coping skills that will needed for conversational and assertiveness situations during my time of care.

3. Administer medication as ordered during my time of care.

4. Provide periods of relaxation, and mediation during my time of care.

5. Encourage positive steps taken in increasing social skills and appropriate interactions with others during my time of care.

6. Provide structure each day to include planned times for brief interactions and activities during my time of care

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NDx # 2 Risk for Injury R/T affective, cognitive, psychomotor factors, biochemical or neurologic imbalances, exhaustion, dehydration, Extreme hyperactivity, physical agitation.

EO: Patient will be free of dangerous levels of hyperactive motor behavior with the aid of medications and nursing interventions within the first 24 hours of my care.

EO: Patient will not have signs of injury (cuts, bruises, abrasions) made by patient or others throughout the time of my care.

Ongoing Assessments: Assess environment q 3 hours, assess for change in mood, LOC, confusion q 2 hours, assess for fatigue, weakness, dizziness q 4 hours, Assess willingness to participate in group therapy, care of plan, and effectiveness of Medication q 2 hours, Observe for signs of lithium toxicity (nausea, vomiting, diarrhea, drowsiness, muscle weakness, tremor, lack of coordination, blurred vision, or ringing in your ears) q 1 hour after administration.

NI: 1. Provide a safe and structured environment during my time of care.

2. Watch for signs of improvement with medication, increased energy to act out suicidal thoughts during my time of care.

3. Educate on useful coping skills that will be useful in hospital setting or beyond after discharge from hospital during my time of care.

4. Provide frequent high-calorie fluids and foods during manic episodes during my time of care.

5. Provide periods of relaxation, and mediation during my time of care.

6. Keep the environment as free of stimuli (loud noises, crowding) as possible during my time of care.

7. Educate on signs of lithium toxicity during my time of care.

****Complete a Mental Health DocuCare on your patient– Review "Clinical Guidelines- Mental Health Assessment Guidelines 2020****

Reflection Paper

Directions: Write a 1-page reflection paper using Times New Roman, 12 pt. font and double-spaced. Include the following:

1. Describe an “Aha” moment you experienced during this learning experience.
2. What were the most important aspects of this simulation and what did you learn?
3. How will this simulation experience impact your nursing practice?

The “aha” moment I experienced during this simulation was when I was able to put together the clang association with the rapid firing of thoughts to come up with the patient was experiencing a manic episode. She was unable to control anything she was doing, exercising at inappropriate times, having inappropriate thoughts and actions to nursing staff. All these things are expected finds in a patient experiencing a manic episode. The nursing staff in the simulation was able to also see the findings, and able to begin treatment for the manic episode immediately.

The most important aspects of this simulation were the ability that the provide quick treatment for the attempted suicide from the patient, after discharge. The lithium therapy given was done correctly by frequent blood draws to make sure the toxicity factor of the lithium was not present. The ability to help the patient with education of each medication given was also important. Olanzapine 10 mg IM, for acute mania was an appropriate medicine prescribed, and was able to teach the patient that the injection is going to hopefully make sure feel better.

This simulation was a great way to show me what to expect if I was to be working in a mental health setting. I got to see how the the staff would lock the door after the patient and family entered. This showed me that these people if not locked into that part in the building then they could be a harm to others if not properly watched and cared for. I will use the idea that these patients need structure and a firm attitude to accomplish the plan of care for them. This simulation was a great way reinforce things we learned this year with mental health and safely treat the patient with the ability to see how adverse choices can have on a patient before dealing with patients and actions you can’t take back in a real word application.