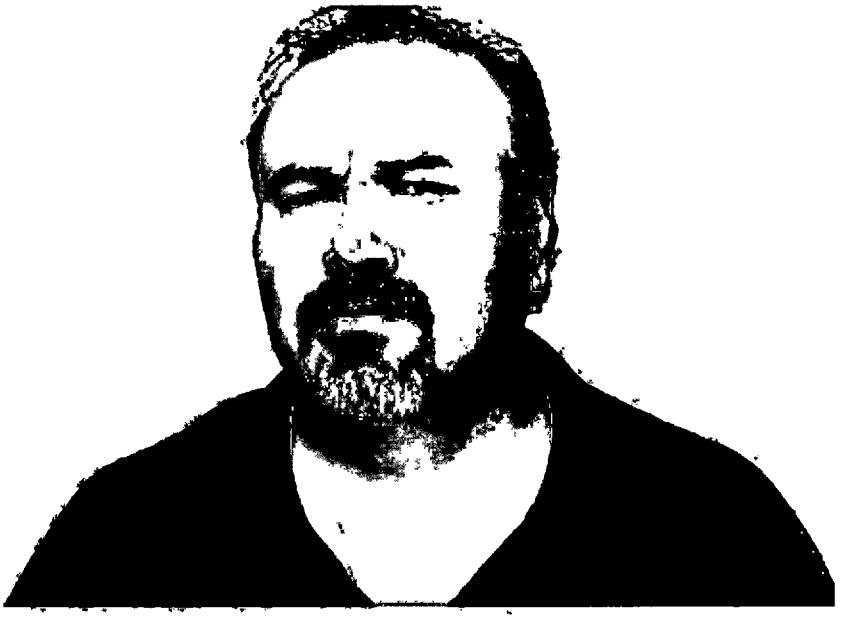
Apr 5th

Bipolar Depression/Mania
SKINNY Reasoning



Brenden Manahan, 35 years old

Primary Concept	
Mood and Affect	
Interrelated Concepts (In order of emphasis)	
	• Psychosis • Clinical Judgment • Patient Education

NCLEX Client Need Categories	Percentage of Items from Each Category/Subcategory	Covered in Case Study
Safe and Effective Care Environment		
✓ Management of Care	17-23%	✓
✓ Safety and Infection Control	9-15%	✓
Health Promotion and Maintenance	6-12%	✓
Psychosocial Integrity	6-12%	✓
Physiological Integrity		
✓ Basic Care and Comfort	6-12%	✓
✓ Pharmacological and Parenteral Therapies	12-18%	✓
✓ Reduction of Risk Potential	9-15%	✓
✓ Physiological Adaptation	11-17%	✓

SKINNY Reasoning

Part I: Recognizing RELEVANT Clinical Data

History of Present Problem:

Brenden Manahan is a 35-year-old male, who has been admitted to the crisis intervention unit for exacerbation of his bipolar disorder. He was admitted on a 501 (involuntary inpatient admission, patient has been deemed either dangerous to self or others) and brought to the hospital by police because his mother feared for his safety. In the past few weeks he stopped taking his medication because he feared that his mother was poisoning him.

Brenden has not slept in the past four days due to racing thoughts. He believes that he is the head of the CIA and told his mother that he needed her car to go to CIA headquarters in McLean, Virginia, and fire everyone. When the police arrived they noted that Brenden was speaking at a very rapid rate and pace and was becoming increasingly agitated. He began yelling that the police where there to poison him and prevent him from returning to his job.

He has been admitted to the locked mental health unit for evaluation of his mental capacity and stabilization. Brenden will participate in the following education groups: medication education, and bipolar illness education. The goal is to resume lithium carbonate and divalproex sodium.

Personal/Social History:

Brenden was diagnosed at 19 with bipolar I, and subsequently has been admitted six times due to non-adherence to the medication regimen. Brenden is divorced and has a 3-year-old son who lives with his mother. He was recently in court to have his visitations reduced to one supervised visit a week. He lives with his mother, who is supportive.

What data from the histories is important and RELEVANT and has clinical significance for the nurse?

RELEVANT Data from Present Problem:	**Clinical Significance:**
-Pt. is a danger to himself and others - Pt. has not been taking his meds - Pt has not slept and has racing thoughts - Pt. has delusions - Pt has rapid HR - Pt is becoming more agitated	- safety is the most priority - S/S of illness will reoccur - Pt will experience dangerous effect of sleep deprivation - Delusion is a symptom of Bipolar Disorder - a manifestation of anxiety & stress - if agitation continues, agression is a concern
RELEVANT Data from Social History:	**Clinical Significance:**
Dx of Bipolar I admitted six times Divorced, lives with mother	- there is a need to monitor and review med dosage and effectiveness - multiple admission times indicate non-adherence to med - unable to provide for self, and dependent to mother

Current VS:	**WILDA Pain Assessment** (5th VS):	
T: 99.1 F/37.3 C (oral)	**W**ords:	Patient denies
P: 110 (regular)	**I**ntensity:	n/a
R: 28 (regular)	**L**ocation:	n/a
BP: 142/84	**D**uration:	n/a
O2 sat: 99% room air	**A**ggravate: **A**lleviate:	WNL

Patient Care Begins:

What VS data are RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT VS Data:	**Clinical Significance:**
~~Temperature~~ Pulse Respiration BP	- WNL - shows tachycardia d/t anxiety & agitation - shows tachypnea d/t anxiety & agitation - show hypertension d/t anxiety & agitation

Current Assessment:	
GENERAL APPEARANCE:	Is disheveled, and according to his mother, he has not showered in several days.
NEURO:	Oriented to person and place but not to time, impaired ability to concentrate, labile emotions, has not slept for four days
RESP:	Breath sounds clear however, patient is breathing rapidly and deeply
CARDIAC:	Pink, warm and dry, no edema, heart sounds regular with no abnormal beats, pulses strong, equal with palpation at radial/pedal/post-tibial landmarks
GI:	Abdomen soft/nontender, bowel sounds audible per auscultation in all four quadrants, has adequate appetite.
GU:	Voiding without difficulty, urine clear/yellow
SKIN:	Skin integrity intact
CHEMICAL USE:	Denies both use/abuse of ETOH or other street drugs

What assessment data is RELEVANT and must be recognized as clinically significant by the nurse?

RELEVANT Assessment Data:	Clinical Significance:
1. General appearance 2. Neuro assessment 3. Respiratory assessment	- The client is unable to provide care for self - Impaired cognition can be a threat to self & others - Hyperventilation can occur if rapid respiration continues.

Mental Status Examination:	
APPEARANCE:	Is disheveled, and according to his mother he has not showered in several days. He is unshaven, and has a significant odor coming from his body and or clothes. His clothes are not consistent with the weather, it is 95 degrees and is wearing multiple layers of clothing and has winter boots on.
MOTOR BEHAVIOR:	Psychomotor agitation present, appears restless; he is unable to sit still
SPEECH:	Talking fast with pressured speech.
MOOD/AFFECT:	Appears ecstatic, bright affect
THOUGHT PROCESS:	Delusional, flight of ideas/ jumping from one idea to another
THOUGHT CONTENT:	Believes that the CIA is controlling the nurses' actions and following him and that he must get to the CIA headquarters immediately.
PERCEPTION:	Denies hallucinations
INSIGHT/JUDGMENT:	Has lack of insight into current condition and reason for inpatient hospitalization
COGNITION:	Oriented to person and place but not to time, his immediate and recall were intact but remote memory is not.
INTERACTION:	Approaches others, but does not engage in lasting conversation
SUICIDAL/HOMICIDAL:	Denies homicidal/suicidal ideation

What MSE assessment data is RELEVANT that must be recognized as clinically significant to the nurse?

RELEVANT Assessment Data:	Clinical Significance:
Disheveled appearance Motor Behavior Speech Thought process Thought content Insight and judgement Cognition & interaction	- appearance indicates impaired function of self care - a symptom of manic - a symptom of mania - a symptom of mania - Delusion can be a potential safety risk - Even though homicidal and suicidal ideation was denied, monitor client closely.

Diagnostic Results:

Basic Metabolic Panel (BMP)					
	Na	K	Gluc.	Creat.	
Current:	142	4.0	102	1.0	
Complete Blood Count (CBC)					
	WBC	% Neuts	HGB	PLTs	
Current:	8.9	70	12.9	325	
MISC.					
	Lithium				
Current:	0.2 ↓				

What data must be interpreted as clinically significant by the nurse? *(Reduction of Risk Potential/Physiologic Adaptation)*

RELEVANT Diagnostic Data:	**Clinical Significance:**
Glucose 102↑ Lithium 0.2↓	- Glucose is slighly elevated. S/S of hyperglycemia may accur with increasing glucose level such as frequent urination, increased thirst, blurred vision and confusion. - Because of ~~the~~ non-adherence to medication, Lithium level is below normal limits that causes bipolar symptoms to reoccur, S/S such as depression, violent behavior, impulse control disorder can occur.

Part II: Put it All Together to THINK Like a Nurse!

1. ***After interpreting relevant clinical data, what is the primary problem?***
(Management of Care/Physiologic Adaptation)

Problem:	Pathophysiology in OWN Words:
The patient is experiencing mania. does not take medication. agitated, and have delusional thoughts.	White matter Hyperintensities and reduction of graymatter is shown in MRI. Increased ventricular size is present. There is a deficient of norepinephrine, dopamine, seratonin and an excess of catecholamine. Levels of noradrenaline are too high.

Collaborative Care: Medical Management

2. State the rationale and expected outcomes for the medical plan of care. *(Pharm. and Parenteral Therapies)*

Medical Management:	Rationale:	Expected Outcome:
Admit to unit and engage patient in milieu	- To plan care for patient's well-being and improvement.	Pt will become calmer VS will return to normal
Urine drug screen	- to assess drug level and infections	- UTI will not show
Lithium 600 mg PO BID	- a tx for Bipolar Disorder	- mood will be stable
Depakote 375 mg PO BID	- Works with balance of neurotransmitter in brain	- Will show improvement in mood & delusion
Trazodone 100 mg PO PRN sleep	Promote sleep & relaxation	will have - ~~promote~~ sleep and less agitated
Lorazepam 1 mg PO BID	Help Pt with anxiety and have a calming effect	- will reduce anxiety that can reduce HR and rapid respiration

Collaborative Care: Nursing

3. What nursing priority (ies) will guide your plan of care? *(Management of Care)*

Nursing PRIORITY:		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
Safety	- Ensure safety for pt, others and staff	- Pt will not harm self & others.
Provide a routine for client	- a part of management of care	- Pt will participate in activities and comply to medication
Limit setting	- Provide limitation, especially when pt. is being disruptive	- Pt - will respect others & will be self-aware
Provide direction, redirection, clear instructions and use therapeutic communication	- Provide easier communication between nurse and client and promotes cooperation	- Pt. will cooperate with the staff

4. ***What psychosocial/holistic care PRIORITIES need to be addressed for this patient?***
(Psychosocial Integrity/Basic Care and Comfort)

Psychosocial PRIORITIES:		
PRIORITY Nursing Interventions:	**Rationale:**	**Expected Outcome:**
CARING/COMFORT: *How can you engage and show that this pt. matters to you?* **Physical comfort measures:**	Be present and give full attention when interacting with patient. offer presence even without talking or having a conversation. Encourage adequate sleep and comfort measures such as warm/cold temperature, proper lightings.	The patient will trust the nurse. and will have a professional nurse-client relationship
EMOTIONAL SUPPORT: *Principles to develop a therapeutic relationship*	acknowledge pt's emotions. Redirect patient when having negative thoughts, remaining calm and using soft but firm tone.	The pt will recognize aggrevating factors and triggers through the help of nurse & staff
SPIRITUAL CARE/SUPPORT:	assess pt's new willingness for spiritual care ask if pt practices religion/spiritual beliefs	The pt will be able to express his/her religion/beliefs
CULTURAL CARE/SUPPORT: (If Applicable)	assess pt's cultural preferences & practices and incorporate it to care.	The pt will have the care and cultural preference that can help w/ getting better

5. ***What educational/discharge priorities need to be addressed to promote health and wellness for this patient and/or family?*** *(Health Promotion and Maintenance)*

- Manage medications with reminders, alarms, or log.
- Follow-up with primary care provider for routine check-up.
- Call 911 in case of emergency
- Join support group or therapy.
- Know triggers and how to manage/avoid them.
- Have adequate rest & sleep
- Tell someone if an episode is about to come.
- Follow a routine, it will give the patient sense of direction and accomplishment.