N323 Care Plan

Lakeview College of Nursing

Sarah Minacci

Approved: 01/02/2024

Demographics (3 points)

Date of Admission 2/20/2024	**Patient Initials** J.B	**Age** 41	**Biological Gender** Male
Race/Ethnicity Caucasian	**Occupation** Unemployed	**Marital Status** Single	**Gender Identity** Male
Code Status Full	**Height and Weight** 5'10" and 250lbs	**Allergies** No Known Allergies	**Pronouns** He/Him

Medical History (5 Points)

Past Medical History: Bipolar 1 disorder, Mixed hyperlipidemia, Manic behavior, Moderate manic bipolar disorder, Alcohol use disorder, and Tobacco use disorder.

Psychiatric Diagnosis: Bipolar disorder type 1, Manic episodes with psychosis, Anxiety, and Bizarre behaviors.

Previous Psychiatric and Substance Use Treatment – Inpatient/Outpatient		
Dates	**Inpatient or Outpatient?**	**Reason for Treatment**
10/11/2023 – 10/15/2023	Inpatient	Mania and psychosis
11/21/2020 – 11/23/2020	Inpatient	Bizarre behavior; anxiety; psychosis
N/A	N/A	N/A

Admission Assessment

Chief Complaint (2 points): The patient arrived at the Emergency Department (ED) with his mother on 2/20/24 with complaints of "feeling off" and "not being able to sleep for a few days".

Contributing Factors (10 points):

- **Factors that lead to admission (address triggers and coping mechanisms if applicable):** The patient arrived at the ED with his mother on 2/20/24 with

complaints of “feeling off” and “not being able to sleep for a few days”. Apparently the patients' mother was out of town for a week and therefore no one was monitoring his medication compliance. The patient stated that he had not been taking his medication for a week and had not slept for seven days. It was noted that the patient’s mother described her son’s behavior as erratic and that he was not taking care of himself. It was also noted that the patient was talking to people who were not there, was animated and nonsensical. The patient stated that he has struggled “on and off” for the past few years with manic episodes. He described this most recent manic episode as “feeling emotionally all over the place” and that he was unable to sleep. He said that “keeping busy and active” made him feel better and was identified as a coping mechanism for him. He stated that he was taking medications to help control his moods but has stopped taking them. He was supposed to be taking a combination of Depakote, Seroquel, and Abilify Maintena. He has been treated two prior times on 10/11/23 and 11/21/20 for manic and psychotic episodes.

- **Chief Complaint Impact on Life: (i.e. work, school, family, social, financial, legal):** It appears that the patient’s chief complaint of “feeling off” and not being able to sleep for a week has greatly impacted his life. It was noted that his mother was very worried about his well-being and said that he was not taking care of himself. He is currently unemployed and said he was “in between careers” when asked about work. He also received a DUI in 2023 for driving under the influence of alcohol.

Primary Diagnosis on Admission (2 points): Bipolar type 1 manic episode with psychosis.

Psychosocial Assessment (30 points)

History of Trauma	
Screening Questions:	**Client Answer**
Do you have a history of physical, sexual, emotional, or verbal abuse?	"No"
Do you have a history of trauma secondary to military service?	"I was in the marines, but no"
Have you experienced a loss of family or friends that affected your emotional well-being?	"Yes, my father years ago"
Have you experienced any other scary or stressful event in the past that continues to bother you today?	"No"
(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)	**(If the client answered no to all screening questions for history of trauma, you may skip to "Presenting Problems". If the client answered yes to any of the screening questions, complete all sections of this chart. Type N/A if not applicable.)**

	Current?	**Past? (what age)**	**By whom?**
Physical Abuse	N/A	N/A	N/A
Sexual Abuse	N/A	N/A	N/A
Emotional Abuse	N/A	N/A	N/A
Verbal Abuse	N/A	N/A	N/A
Military	N/A	N/A	N/A
Other	No	Late 20s	Father passed away over 10 years ago.

Presenting Problems		
Problematic Areas	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**

Do you feel down, depressed or hopeless?	"Not now"	Patient stated that he has felt "depressed here and there in the past" but not currently.
Do you feel tired or have little energy?	"No"	Patient looks tired however.
Do you avoid social situations?	"No, I like to socialize"	It was noted on the patient's medical record that he does not always attend group meetings and he did not attend community or the social work group today (2/23/22).
Do you have difficulties with home, school, work, relationships, or responsibilities	"Just trouble staying focused the last few weeks"	This is not consistent with the patient's medical record. The patient's mom said that he has not been taking care of himself lately, he is also currently unemployed, and recently had a DUI in 2023.
Sleeping Patterns	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Have you experienced a change in numbers of hours that you sleep each night?	"Sometimes I sleep for a long time and sometimes I can't sleep at all"	The patient said that it just depends on the day and that some weeks he sleeps more and other weeks he can't sleep much at all. Prior to his admission the patient had not slept for seven days. Upon admission, the patient was noted to have slept through most of the next day and another night to have slept 11 hours.
Do you have difficulty falling asleep?	"Yes"	The patient said that "most nights" of the week he has difficulty falling asleep.

Do you frequently awaken during the night?	"Yes"	The patient said that he has insomnia and will wake up 2-3 times during the night.
Do you have nightmares?	"No"	The patient does not recall having any nightmares recently.
Are you satisfied with your sleep?	"No"	The patient said he is "trying to improve my sleep routine". He is dissatisfied with how long it takes him to fall asleep and that he wakes up several times during the night.
Eating Habits	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
Do you overeat?	"No"	The patient said that he eats a regular diet.
Do you purge after eating? **Purging includes methods such as vomiting, excessive exercise, or using laxatives after eating.**	"No, I have never done anything like that."	N/A
Do you have not eat enough or have a loss of appetite?	"No, I have a regular appetite"	N/A
Have you recently experienced unexplained weight loss? **Amount of weight change: N/A**	"No"	N/A
Anxiety Symptoms	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that**

		differ from the client's answer, please describe objectively.
Do you pace, have tremors, or experience other symptoms of anxiety?	"Yes"	The patient described occasionally pacing, but that mostly his "thoughts race" in his head. He says that this happens a couple times a week, but not all the time.
Do you experience panic attacks?	"One time I did"	The patient stated one time when he was living in California he had a panic attack, but that it was only that one time. When asked what triggered the panic attack he said he "lost his job".
Do you have obsessive or compulsive thoughts?	"No"	N/A
Do you have obsessive or compulsive behaviors?	"No"	N/A
Suicidal Ideation	**Client Answer**	**Describe (frequency, intensity, duration, and occurrence). If you make any observations that differ from the client's answer, please describe objectively.**
In the past week have you wished that you were dead?	"No"	This is consistent with his medical record that has shown he consistently denies thoughts of suicide.
Have you ever tried to kill yourself?	"No"	This is consistent with his medical record that has shown he consistently denies ever having tried to kill himself.
If the client answered either of the previous questions "yes", you must ask the client: **Are you having thoughts of killing yourself right know?** **(If the client says yes, you must ensure facility staff are**	N/A	N/A

aware)			
Rating Scale			
How would you rate your depression on a scale of 1-10?		3/10	
How would you rate your anxiety on a scale of 1-10?		3/10	
Personal/Family History			
Who lives with you?	**Age**	**Relationship**	**Do they use alcohol or drugs?**
Brenda	70s	Mother	No
Rob	36	Brother	Yes
If yes to any alcohol or drug use, explain: His brother drinks beer several times a week and has 6-8 beers each time he does drink.			
Family Medical History: The patient denies any family medical history. None could be found on his medical record either.			
Family Psychiatric History (including suicide): The patient denies any family psychiatric history. None could be found on his medical record either.			
Family alcohol or drug use (not covered by those client lives with): The patient said that his dad used to drink a lot and that he has a lot of “alcoholics” in the family.			
Do you have children? If yes, what are their ages? This patient has no children. **Who are your children with now?**			
Have you experienced parental separation or divorce, or loss/death/ or incarceration of			

family or friends?

If yes, please tell me more about that: This patient stated that his father passed away over 10 years ago.

Are you currently having relationship problems? This patient said he is not currently in a relationship and denies any other relationship problems.

What is your sexual orientation: Straight	**Are you sexually active?** "Not currently"	**Do you practice safe sex?** "Not always"

Please describe your religious values, beliefs, spirituality and/or preference: The patient identifies as agnostic.

Can you describe any ethnic practices, cultural beliefs, or traditions that might affect your plan of care? The patient denies any practices, beliefs, or traditions that would affect his care.

Do you have any current or past legal issues (with self/parents, arrests, divorce, CPS, probation officers, pending charges, or course dates): Yes, the patient is currently in an appeal process for a DUI he received in 2023.

Whom would you consider your support system? The patient said, "my brother is definitely my biggest supporter" and that he has a few good friends as well. He described his relationship with his mother as strained at times.

How can your family/support system participate in your treatment and care?

The patient said it is helpful when his family just listens to him and lets him talk. He said that it means a lot to him when his family supports him and he wishes that they would say they "believe in him" more.

What are your coping mechanisms? (Coping mechanisms are strategies that people use to manage painful or difficult emotions.)
The patient said getting together with friends makes him feel better and that "staying active and busy" helps "calm the mind".

What are your triggers? (A trigger is something that you have identified that brings on

or worsens your mental health symptoms.) The patient said that arguments with his mom really make him stressed and that the current appeal process he is going through with his DUI is very stressful.

Client raised by:

Natural parents
Grandparents
Adoptive parents
Foster parents
Other (describe):

Self-Care:

Independent- It appears that the patient is mostly independent, but during manic episodes requires some assistance from others to take care of himself.
Assisted
Total Care

Education History:

Grade school
High school
College – states to have a bachelor's degree
Other:

Reading Skills:

Yes
No
Limited

Primary Language: English

Personal History of Substance Use

Screening Questions:

1. **Have you ever used drugs, alcohol, or nicotine? – "Yes"**

(If no, you may skip to "psychiatric medications".
If yes, complete all sections of this chart. Type N/A if not applicable.)

Substance	First Use and Last Use	Frequency of Use
Nicotine Products (including smoking, chewing, vaping)	**First Use:** "young teen"	He said he started smoking as a teen and was able to quit for a few

	Last Use: Day of admission	years, but now smokes about a quarter of a pack of cigarettes a day and has for the past 10 years. He denies smokeless tobacco and vape use.
Alcohol	**First Use:** "young teen" **Last Use:** "a few weeks ago"	The patient states to drink three to four nights a week and have two to three beers on those nights.
Prescription Medications (Recreational Use)	**First Use:** "20s" **Last Use:** "Maybe a month ago"	The patient states to have taken Adderall that did not belong to him. He said that he only did this the one time. He states he cannot remember the other drugs he took occasionally in his 20s.
Marijuana	**First Use:** "young teen" **Last Use:** "20s"	The patient stated to have smoked a few times a month for a few years in his 20s. The patient stated that he does not currently use marijuana.
Heroin	**First Use:** N/A **Last Use:** N/A	The patient denies ever using heroin.
Methamphetamine	**First Use:** N/A **Last Use:** N/A	The patient denies ever using methamphetamine.

Other: Specify	**First Use:** N/A **Last Use:** N/A	The patient denies ever using other drugs.

Current <u>Psychiatric</u> Medications (10 points)
Complete all of your client's <u>psychiatric</u> medications
All information listed in this section must be pertinent to your patient.

Brand/Generic	**Cogentin (benztropine)**	**(Atarax) hydroxyzine**	**Seroquel (quetiapine)**	**Risperdal (risperidone)**	**Ativan (lorazepam)**
Dose	2mg tablet or injection if unable to administer tablet	25mg	200mg	1mg	1mg
Frequency	2 times daily PRN	3 times daily PRN	Daily at night	Daily in the morning	Every 6 hours PRN
Route	Orally or IM	Orally	Orally	Orally	Orally
Classification	Pharmacologic: Anticholinergic Therapeutic: Antiparkisonian; central-acting anticholinergic (Jones & Bartlett Learning, 2023).	Pharmacologic: Piperazine derivative Therapeutic: anxiolytic, antiemetic, antihistamine, sedative-hypnotic (Jones & Bartlett Learning, 2023).	Pharmacologic: Di-benzothiazepine Therapeutic: Antipsychotic (Jones & Bartlett Learning, 2023).	Pharmacologic: Benzisoxazole derivative Therapeutic: Antipsychotic (Jones & Bartlett Learning, 2023).	Pharmacologic: Benzodiazepine Therapeutic: Anxiolytic (Jones & Bartlett Learning, 2023).
Mechanism of Action	Inhibits acetylcholine's action at cholinergic receptor sites and inhibits dopamine's re-uptake storage. This creates a normal acetylcholine and dopamine balance in the brain which helps relax the muscles and reduce tremors. (Jones & Bartlett Learning, 2023).	Competes with histamine receptor sites to reduce histamine activity. Sedative actions happen at the subcortical level of the CNS and are dose dependent. (Jones & Bartlett Learning, 2023).	Produces anti-psychotic effects by interfering with dopamine binding and antagonizing serotonin, histamine, and alpha adrenergic receptors in the brain. (Jones & Bartlett Learning, 2023).	Blocks some serotonin and dopamine receptors in the CNS to suppress psychotic symptoms. (Jones & Bartlett Learning, 2023).	Increases the effects of GABA receptors which helps to inhibit excitatory stimulation and control emotional behavior. (Jones & Bartlett Learning, 2023).
Therapeutic Uses	As adjunct to treat Parkinsons; To treat acute dystonic reactions; To control extrapyramidal symptoms (Jones & Bartlett Learning, 2023).	To relieve anxiety and tension related to psychoneurosis; To treat pruritis due to allergies; To treat nausea and vomiting in	To treat schizophrenia; To treat bipolar mania; To treat bipolar depression; Adjunct therapy to treat depression (Jones & Bartlett Learning, 2023).	To treat schizophrenia; To treat bipolar mania; To treat irritability associated with ASD (Jones & Bartlett Learning, 2023).	To treat anxiety; to treat insomnia caused by anxiety; To provide preoperative sedation; To treat status epilepticus (Jones & Bartlett Learning, 2023).

		pregnancy; As a sedative prior to general anesthesia (Jones & Bartlett Learning, 2023).			
Therapeutic Range (if applicable)	1-4 mg (Jones & Bartlett Learning, 2023).	50-100mg oral tablets up to four times a day (Jones & Bartlett Learning, 2023).	Maximum dose of 800mg a day (Jones & Bartlett Learning, 2023).	6mg daily for no more than 3 weeks to treat bipolar mania (Jones & Bartlett Learning, 2023).	Maximum of 10mg a day for anxiety (Jones & Bartlett Learning, 2023).
Reason Client Taking	To help control extrapyramidal symptoms such as motor restlessness	1st line anti-anxiety medication	To treat bipolar mania	To treat bipolar mania	2nd line anti-anxiety medication
For PRN Medications ONLY: One Nursing Intervention That Could Be Attempted Prior to Use of this Medication	Provide a space for the patient to do hands on activities like a puzzle or exercise to allow a healthy way to keep their body moving.	Maintain or provide a low stimuli environment that is free of harsh lighting and loud noises.	N/A	N/A	Provide frequent rest periods and allow for social isolation if desired.
Contraindications (2)	1. Should be avoided in patients also taking haloperidol (like this patient) as it can decrease the effects of haloperidol and cause tardive dyskinesia. 2. Previous allergic reaction to any drugs similar to benztropine. (Jones & Bartlett Learning, 2023).	1. Individuals with prolonged QT interval 2. Should be avoided in patients who are also taking quetiapine (like this patient) as it can increase the risk of life threatening arrhythmias. (Jones & Bartlett Learning, 2023).	1. Individuals with arrhythmias 2. Individuals with a high risk of stroke (Jones & Bartlett Learning, 2023).	1. Individuals with irregular heart beats 2. Individuals with a history of seizures. (Jones & Bartlett Learning, 2023).	1. Acute angle-closure glaucoma 2. Sleep apnea syndrome (Jones & Bartlett Learning, 2023).
Side Effects/Adverse Reactions (2)	1. Hypotension 2. Blurred vision (Jones & Bartlett Learning, 2023).	1. Seizures 2. Dry mouth (Jones & Bartlett Learning, 2023).	1. Hepatitis 2. Cardiomyopathy (Jones & Bartlett Learning, 2023).	1. Bradycardia 2. Hypoglycemia (Jones & Bartlett Learning, 2023).	1. Respiratory depression 2. Suicidal ideation (Jones & Bartlett Learning, 2023).
Medication/Food Interactions	This medication interacts with amantadine, tricyclic antidepressants, and haloperidol. This drug should be taken with food, but alcohol should be avoided (Jones & Bartlett Learning, 2023).	This medication interacts with antibiotics such as azithromycin, antidepressants such as citalopram, antipsychotics such as clozapine, and anti-arrythmia drugs. Patients should not drink alcohol while taking this medication as it can increase sedative effects (Jones & Bartlett	This medication interacts with anticholinergic drugs, antihypertensives, CNS depressants, CYP3A4 inducers and inhibitors, and dopamine agonists. It should also not be taken with alcohol due to increased sedative effects (Jones & Bartlett Learning, 2023).	This medication interacts with antihypertensive drugs, carbamazepine, rifampin, clozapine, fluoxetine, paroxetine, dopamine agonists, and methylphenidate. It should also not be taken with alcohol due to increased sedative effects (Jones & Bartlett Learning, 2023).	This medication interacts with aminophylline, clozapine, CNS depressants, fentanyl, opioids, and tricyclic antidepressants. Patients should not drink alcohol while taking this medication as it can increase its sedative effects(Jones & Bartlett Learning, 2023).

		Learning, 2023).			
Nursing Considerations (2)	1. Monitors patient's movements closely as high doses of this drug can cause weakness. 2. Know that this drug should not be abruptly discontinued (Jones & Bartlett Learning, 2023).	1. Understand that this drug can cause drowsiness so certain activities like driving should be avoided by the patient (Jones & Bartlett Learning, 2023). 2. Tablets should be taken whole and not crushed or chewed.	1. Monitor patients closely for suicidal tendencies especially when first starting this drug or changes doses. 2. Monitor the patient for orthostatic hypotension (Jones & Bartlett Learning, 2023).	1. Use cautiously in patients with hepatic dysfunction due to increased sensitivity to the drug. 2. Monitor the patients' lipid levels closely as it can cause hypercholesterolemia (Jones & Bartlett Learning, 2023).	1. Use this drug cautiously in patients with a history of drug and alcohol abuse or personality disorder as this drug has a high risk of physical and psychological dependence. 2 .Be aware that this drug can cause increased risk of suicide in patients with untreated depression (Jones & Bartlett Learning, 2023).

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2023). *Nurse's drug handbook.* Jones & Bartlett Learning.

Mental Status Exam Findings (25 points)

OBSERVATIONS: **Appearance (i.e.: positioning, posture, dress, grooming):** Disheveled, unkempt **Alertness:** Alert **Orientation:** X4 **Behavior:** Calm, cooperative, withdrawn **Speech:** Soft, garbled **Eye Contact:** Avoidant **Attentiveness:** Disinterested, distracted	The patient was alert and oriented to person, place, time, and situation. The patient was in yellow scrubs, his hair was disheveled, and he was overall unkempt. His behavior was calm and cooperative, but he appeared withdrawn and his body language demonstrated that he may be uncomfortable. He avoided eye contact and he appeared disinterested in conversation. The patient may have been internally pre-occupied. His speech was very soft spoken, short, and at times garbled and difficult to understand.
MOOD: **How is your mood today?** "Fine" **Affect:** Blunted, neutral **Consistency between mood and affect?**	The patient stated that his mood today was "fine." He maintained a blunted affect with neutral facial expressions during conversation. He appeared withdrawn and disinterested in conversation. His affect appeared mostly consistent with his mood, though the patient did appear annoyed at times.
COGNITION: **Alertness:** Alert **Orientation:** X4 **Memory Impairment:** None **Attention:** Disinterested, distracted	The patient was alert and oriented to person, place, time and situation. He appeared disinterested and internally distracted during conversation. He does not have any memory impairment from what could be assessed.
MAIN THOUGHT CONTENT:	The patient denied any thoughts of suicide or

Homicidal Ideations or Suicidal Ideation: Denied **Delusions:** Denied **Hallucinations:** Denied • **Specify: Auditory, Visual, Tactile, Olfactory** **Obsessions:** Denied **Compulsions:** Denied **Paranoia:** Denied **Flight of Ideas:** No **Perseveration:** No **Loose Association:** No	homicide and this is consistent with his past medical record. The patient also denied delusions and hallucinations. However, upon admission to the ED he was noted to have been talking to people that were not there, so it appears that he was having auditory or visual hallucinations. The patient also denied any obsessions, compulsions, or paranoia. Based on the conversation with the patient it appears that this is true and no obsessions, compulsions or paranoia was noted. He did not demonstrate any flight of ideas, perseveration, or loose association. His answers to questions were on task and blunt. He was reluctant to expand on answers.
REASONING: **Judgment (Assess by asking: If you found a wallet on the side of the road, what would you do?):** Not appropriate **Insight into Illness:** Not appropriate	This patient's judgement and insight are both poor. He stated "I would just take it" when asked about finding a wallet. He also received a DUI in 2023. It also appears that he has poor insight into his illness as he stated he has only "had trouble focusing the last few weeks" despite being non-compliant with medications and unemployed.
MOTOR ACTIVITY: **Assistive Devices:** No **Gait:** Strong, steady **Abnormal Motor Activities:** No	This patient does not use any assistive devices. He has a strong steady gait and did not display any abnormal motor activities. During conversation he remained fairly still and kept his hands in his lap.

Vital Signs, 1 set (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
07:20	66 bmp	122/78 mmHg	14 bmp	97.4℉	97%

Pain Assessment, 1 set (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
11:15	Numeric Rating Pain Scale	N/A	0	N/A	Offered to get anything for the patient like water or a snack.

Nursing Care (6 points)

Overview of care provided today: The student nurse arrived to the unit at 07:00 and listened to report from the nurse. The student nurse was then oriented to the unit and began gathering patient information from the electronic medical record. At around 09:30 the student nurse let the patient know that community group meeting was going to be held. The student nurse helped to lead the community group and went over the patient's goals for the day. This particular patient declined attending community group. At 11:15 the student nurse completed a psychosocial assessment with the patient and he was pleasant and compliant with the assessment. The patient was then offered a drink and told that the social work group meeting would be beginning soon, but he declined to attend that meeting as well. The patient was thanked for his time and then the student nurse helped to complete 15 minute rounds.

Client complaints: The patient said that he does not want to be prescribed more medications because he does not have insurance.

Participation in therapy / groups: The patient did not attend either group meeting during the shift.

Medication compliance today: The patient was compliant with all medications.

Behaviors exhibited today: The patient was calm and cooperative. He appeared withdrawn though.

Discharge Planning

Discharge location: The patient is expected to discharge to home on 2/29/24.

Follow up plan: The patient is being encouraged to follow up with outpatient psychiatry to help him stay compliant with his medication regime. He is also being encouraged to attend counseling or therapy as an additional support system for him to help manage his moods.

Education needs: This patient could benefit from continued education on the importance of staying on his medications and reaching out to his doctor with any concerns about his medications. He could also benefit from education on proper self-care and ways he can adjust his environment to improve his self-care. Lastly, the patient was not able to state very many coping mechanisms that he has so he would also benefit from education on relaxation techniques and additional healthy coping mechanisms for when he has unpleasant emotions.

Nursing Diagnosis (25 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

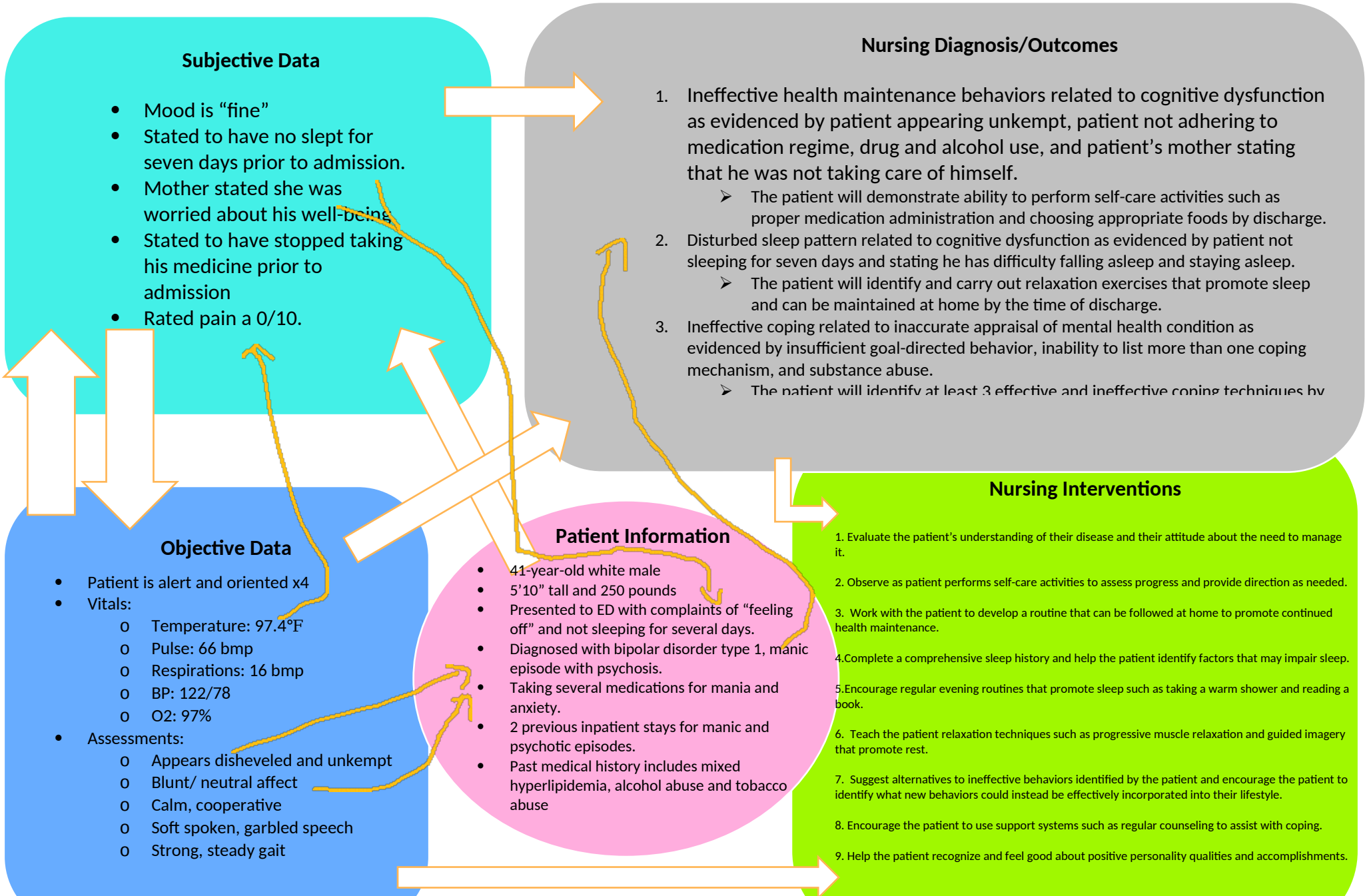
Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rationale** • Explain why the nursing diagnosis was chosen	**Outcome Goal (1 per diagnosis)**	**Interventions (3 per diagnosis)**	**Outpatient Resource with Rationale (1 per diagnosis)**
Ineffective health maintenance behaviors related to cognitive dysfunction as evidenced by patient appearing	This nursing diagnoses was chosen and highly prioritized because based off of the patient's physical appearance as well as their ED report, it is clear that the patient is	The patient will demonstrate ability to perform self-care activities such as proper medication	1.Evalute the patient's understanding of their disease and their attitude about the need to manage it.	This patient would benefit from regularly meeting with an outpatient psychiatrist or counselor. This would help

unkempt, patient not adhering to medication regime, drug and alcohol use, and patient's mother stating that he was not taking care of himself.	having difficulty taking care of themselves. They appeared disheveled and unkempt and his mother brought him to the ED very worried about his well-being. The patient admitted to not taking his medication regime and it appears that without his medications he is unable to effectively perform his activities of daily living. The patient also admitted to drug and alcohol use. The combination of these factors put him at great risk for a decline in overall health or personal injury.	administration and choosing appropriate foods by discharge.	2. Observe as patient performs self-care activities to assess progress and provide direction as needed. 3. Work with the patient to develop a routine that can be followed at home to promote continued health maintenance.	keep the patient compliant with his medication regime and it would also give the patient a space to talk about how he is doing. This would likely greatly increase his health maintenance behaviors.
Disturbed sleep pattern related to cognitive dysfunction as evidenced by patient not sleeping for seven days and stating he has difficulty falling asleep and staying asleep.	This nursing diagnosis was chosen and prioritized second because it is likely that the patient's ineffective health maintenance such as not taking his medication is what led to his disturbed sleep pattern. The patient stated that he was "feeling off lately" and had not slept for seven days. He also mentioned that he consistently has trouble falling asleep and staying asleep. Poor sleep and lack of sleep can really affect a person's ability to work and to perform activities of daily living in general. Lack of sleep can also impair judgment and	The patient will identify and carry out relaxation exercises that promote sleep and can be maintained at home by the time of discharge.	1. Complete a comprehensive sleep history and help the patient identify factors that may impair sleep. 2.Encourage regular evening routines that promote sleep such as taking a warm shower and reading a book. 3. Teach the patient relaxation techniques such as progressive muscle relaxation and guided imagery that promote rest.	This patient should be educated about the National Sleep Foundation's website. This resource has a lot of great information on how to promote better sleep patterns and it also suggests other resources like the app "Calm" which can provide white noise and other helpful features to aid sleep. Learning of new ways to create a healthy and consistent bedtime routine could really

	make this patient more likely to engage in unhealthy activities like drug and alcohol abuse.			help this patient's overall sleep patterns.
Ineffective coping related to inaccurate appraisal of mental health condition as evidenced by insufficient goal-directed behavior, inability to list more than one coping mechanism, and substance abuse.	This nursing diagnosis was chosen because it appears that the patient is struggling to find healthy ways to cope with his diagnosis of bipolar 1 disorder. When asked, he was only able to state "staying active" as a coping mechanism. He also has a history of drug and alcohol abuse that are unhealthy coping mechanisms that puts the patient at risk for harm. During the interview with the patient it also appeared he did not have a full understanding of how his condition is affecting his ability to maintain responsibilities. Therefore, this patient would benefit greatly from learning more effective coping strategies to help his changes in mood.	The patient will identify at least 3 effective and ineffective coping techniques by the time of discharge.	1. Suggest alternatives to ineffective behaviors identified by the patient and encourage the patient to identify what new behaviors could instead be effectively incorporated into their lifestyle. 2. Encourage the patient to use support systems such as regular counseling to assist with coping. 3. Help the patient recognize and feel good about positive personality qualities and accomplishments.	This patient could benefit from attending support groups like alcoholics anonymous. By attending support groups, he could greatly benefit from the helpful advice from others and this would give him the opportunity to hear about many different healthy coping mechanisms that he could try instead of drugs and alcohol.

Other References (APA):

Concept Map (20 Points):


Subjective Data
Mood is “fine”
Stated to have no slept for seven days prior to admission.
Mother stated she was worried about his well-being.
Stated to have stopped taking his medicine prior to admission
Rated pain a 0/10.
Nursing Diagnosis/Outcomes
1. Ineffective health maintenance behaviors related to cognitive dysfunction as evidenced by patient appearing unkempt, patient not adhering to medication regime, drug and alcohol use, and patient’s mother stating that he was not taking care of himself.
The patient will demonstrate ability to perform self-care activities such as proper medication administration and choosing appropriate foods by discharge.
2. Disturbed sleep pattern related to cognitive dysfunction as evidenced by patient not sleeping for seven days and stating he has difficulty falling asleep and staying asleep.
The patient will identify and carry out relaxation exercises that promote sleep and can be maintained at home by the time of discharge.
3. Ineffective coping related to inaccurate appraisal of mental health condition as evidenced by insufficient goal-directed behavior, inability to list more than one coping mechanism, and substance abuse.
The patient will identify at least 3 effective and ineffective coping techniques by
Objective Data
Patient is alert and oriented x4
Vitals:
Temperature: 97.4°F
Pulse: 66 bmp
Respirations: 16 bmp
BP: 122/78
O2: 97%
Assessments:
Appears disheveled and unkempt
Blunt/ neutral affect
Calm, cooperative
Soft spoken, garbled speech
Strong, steady gait
Patient Information
41-year-old white male
5’10” tall and 250 pounds
Presented to ED with complaints of “feeling off” and not sleeping for several days.
Diagnosed with bipolar disorder type 1, manic episode with psychosis.
Taking several medications for mania and anxiety.
2 previous inpatient stays for manic and psychotic episodes.
Past medical history includes mixed hyperlipidemia, alcohol abuse and tobacco abuse
Nursing Interventions
1. Evaluate the patient’s understanding of their disease and their attitude about the need to manage it.
2. Observe as patient performs self-care activities to assess progress and provide direction as needed.
3. Work with the patient to develop a routine that can be followed at home to promote continued health maintenance.
4.Complete a comprehensive sleep history and help the patient identify factors that may impair sleep.
5.Encourage regular evening routines that promote sleep such as taking a warm shower and reading a book.
6. Teach the patient relaxation techniques such as progressive muscle relaxation and guided imagery that promote rest.
7. Suggest alternatives to ineffective behaviors identified by the patient and encourage the patient to identify what new behaviors could instead be effectively incorporated into their lifestyle.
8. Encourage the patient to use support systems such as regular counseling to assist with coping.
9. Help the patient recognize and feel good about positive personality qualities and accomplishments.