Nurses Content
Downloaded from nursescontent.com



# Acute mania Response monitoring

Mental Health Nursing | Response monitoring

**For educational purposes only.**

Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

## Clinical assessment

Subjective: Little sleep, racing thoughts and feeling unusually energetic.

Objective findings and required checks: Pressured speech, distractibility and impulsive behaviour; safety and medical contributors need assessment.

Physical examination and investigations: Assess mental state, risk, sleep, intake, substances and medicine-related or medical causes.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

## Clinical focus and pathophysiology

Acute mania: Mood elevation can impair judgment, sleep and the ability to meet basic needs.

## Medical / surgical management

Use a calm consistent approach, reduce stimulation and support rest, hydration and prescribed treatment.

## Illustrative drug and treatment study



Nurses Content For educational purposes only. 1 / 7

Nurses Content
Downloaded from nursescontent.com



| Medicine / treatment | Purpose | Nursing checks |
| --- | --- | --- |
| Prescribed mood stabilizer | Treat the assessed mood episode | Check drug-specific tests, interactions and toxicity |
| prescribed antipsychotic | Manage selected acute symptoms | Monitor sedation, movement effects and metabolic risks. |

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.



Nurses Content For educational purposes only. 2 / 7

Nurses Content
Downloaded from nursescontent.com



# Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Compare the current assessment with the documented baseline and identify benefit, harm or lack of response.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Ask: Ask directly about safety, self-harm, aggression and access to harmful means. Assess: Assess risk, observation needs and environmental hazards collaboratively. | Immediate safety needs during altered mood, cognition or behaviour. Possible factors: reduced judgment, severe distress or loss of control. Validate against the patient's assessment. | Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Immediate risks are addressed using the least restrictive appropriate care plan. Longer-term: Before the clinically approved transition or agreed follow-up: A collaborative safety and follow-up plan is documented before transition. | 1. Escalate imminent danger immediately and maintain observation according to risk and local policy. Rationale: Timely support protects life and prevents unobserved deterioration. 2. Use de-escalation, respectful communication and proportionate environmental safeguards. Rationale: Dignity and reduced stimulation can support safer engagement. 3. Review risk with the multidisciplinary team and document changes and handover. Rationale: Risk is dynamic and requires continuity across staff and settings. 4. Use a calm consistent approach, reduce stimulation and support rest, hydration and prescribed treatment. Rationale: Mood elevation can impair judgment, sleep and the ability to meet basic needs. The condition-specific plan addresses the underlying problem while response is monitored. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |



Nurses Content For educational purposes only. 3 / 7

Nurses Content
Downloaded from nursescontent.com



| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Ask: Ask about usual sleep, current disruption and daytime fatigue. Assess: Record sleep pattern, symptom triggers and environmental disturbance. | Sleep disrupted by symptoms or the care environment. Possible factors: discomfort, anxiety or interrupted routines. Validate against the patient's assessment. | Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Reports improved rest during the next planned sleep period. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies practical sleep-supporting routines for recovery. | 1. Identify pain, breathlessness, anxiety and medicine-related causes of poor sleep. Rationale: Treating contributors is more useful than assuming a single cause. 2. Cluster non-urgent care and reduce light and noise when safe. Rationale: A predictable environment protects opportunities to sleep. 3. Use relaxation strategies and review prescribed sedating medicines carefully. Rationale: Rest should improve without avoidable oversedation or falls. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |
| Ask: Ask about usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings. | Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment. | Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements. | 1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support. | Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |
| Ask: Ask what the learner already knows and wants to understand. Assess: | Learning needs about the condition and care plan. Possible factors: new | Short-term: At the next scheduled reassessment, with its interval chosen for acuity: Explains the | 1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few | Record the baseline and reassessed finding, the time |



Nurses Content For educational purposes only. 4 / 7

Nurses Content
Downloaded from nursescontent.com



| Assessment: subjective / objective | Nursing diagnosis: original problem wording | Short- and longer-term goals | Nursing interventions with rationale | Evaluation |
|---|---|---|---|---|
| Use teach-back or demonstration to identify specific gaps. | information, complex treatment or limited prior teaching. Validate against the patient's assessment. | most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs. | condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain relapse signs, sleep routines, medicine monitoring and planned follow-up after stabilization. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care. | and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement. |



Nurses Content For educational purposes only. 5 / 7

Nurses Content
Downloaded from nursescontent.com



## Health education and continuing care

Explain relapse signs, sleep routines, medicine monitoring and planned follow-up after stabilization.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

## Urgent warning signs

**Escalating aggression, exhaustion, severe dehydration, psychosis or inability to maintain safety needs urgent review.**

## Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

## Quick Revision

- Mood elevation can impair judgment, sleep and the ability to meet basic needs.

- Priority concerns: Immediate safety needs during altered mood, cognition or behaviour; Sleep disrupted by symptoms or the care environment; Nutritional intake below current needs; Learning needs about the condition and care plan.

- Escalating aggression, exhaustion, severe dehydration, psychosis or inability to maintain safety needs urgent review.

- Explain relapse signs, sleep routines, medicine monitoring and planned follow-up after stabilization.

**Exam / viva: Which observations demonstrate response, and which findings would require revising or stopping the current intervention?**

## References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025



Nurses Content For educational purposes only. 6 / 7

Nurses Content
Downloaded from nursescontent.com



https://wtcs.pressbooks.pub/nursingmhcc/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023

https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council

https://www.indiannursingcouncil.org/gazette-notification

Original cases and care-plan wording by Nurses Content. Linked sources support further study; source terms and local clinical requirements apply. Prepared 23 November 2026. Not independently clinically peer reviewed.

## Rights and reuse

Delivered by Nurses Content. Copyright claims apply only to original material owned by its authors. Medical facts, statutory exceptions and third-party/open licence rights remain unaffected. See the website's /policies/reuse/ page for terms.



Nurses Content For educational purposes only. 7 / 7