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Immediate safety needs during altered mood, cognition or behaviour Acute mania

Mental Health Nursing | Focused diagnosis-based template

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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

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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.

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Focused nursing-problem template

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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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 patient-specific reassessment: 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.

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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

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

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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

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