Bipolar Disorder Nursing Care Plan

Patient Identification

Name:

•	Age:
•	Gender:
•	Date of Birth:
•	Medical Record Number:
As	ssessment Findings
•	Describe the patient's bipolar disorder symptoms (e.g., mania, depression, mixed episodes) in detail, including their severity, duration, and impact on daily life.
•	Identify potential risk factors for developing or exacerbating bipolar disorder, such as family history, substance abuse, or traumatic events.
•	Assess the patient's overall mental and physical health, including any co-existing conditions or medications.
•	Evaluate the patient's psychosocial functioning, including their social support system, occupational status, and living arrangements.
Di	agnostic Impression
•	Clearly state the diagnosis of bipolar disorder based on the DSM-5 criteria.
•	Specify the type of bipolar disorder (e.g., bipolar I, bipolar II, or unspecified bipolar disorder).
•	Document any additional mental health diagnoses

Nursing Diagnoses • Identify specific nursing diagnoses related to the patient's bipolar disorder, such as: Anxiety Social isolation Noncompliance with treatment Risk for self-harm or suicide **Goals and Objectives Interventions** Outline evidence-based interventions to address the patient's symptoms, improve their functioning, and promote overall well-being. • Consider a combination of interventions, including:

Psychoeducation about bipolar disorder

Support groups and social engagement

□ Crisis management plan

Mood stabilizer medication management

Psychotherapeutic interventions (e.g., CBT, IPT)

Lifestyle modifications (e.g., regular exercise, sleep hygiene, healthy diet)

Evaluation Criteria

 Outline evidence-based interventions to address the patient's symptoms, improve their functioning, and promote overall well-being.
Regularly monitor the patient's symptoms, functioning, and adherence to treatment plan.
Use standardized assessment tools to track progress over time.
Documentation
Discharge Planning