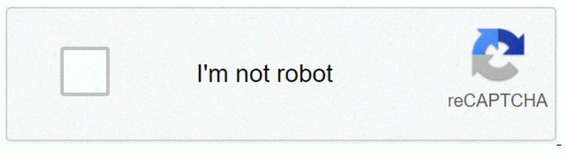
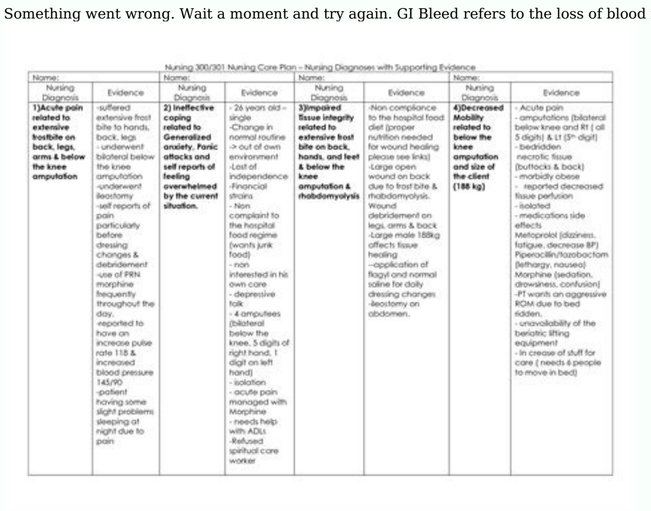


I'm not robot!

Nanda approved nursing diagnosis for gi bleed

Gi bleeding nursing intervention. Nanda gi bleed. Nanda nursing diagnosis for upper gi bleed. Nanda nursing diagnosis gi bleed.

Something went wrong. Wait a moment and try again. GI Bleed refers to the loss of blood from the gastrointestinal tract, which includes the esophagus, stomach, small intestine, or large intestine.



Nursing 300/301 Nursing Care Plan – Nursing Diagnoses with Supporting Evidence

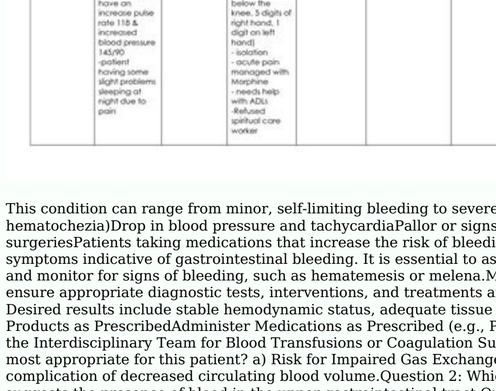
Name:		Name:		Name:		Name:	
Nursing Diagnosis	Evidence	Nursing Diagnosis	Evidence	Nursing Diagnosis	Evidence	Nursing Diagnosis	Evidence
1)Acute pain related to extensive frostbite on back, legs, arms & below the knee amputation	-suffered extensive frost bite to hands, back, legs - underwent bilateral below the knee amputation -underwent ileostomy -self reports of pain particularly before dressing changes & debridement -use of PRN morphine frequently throughout the day. -reported to have an increase pulse rate 118 & increased blood pressure 143/90 -patient having some slight problems sleeping at night due to pain	**2) Ineffective coping related to Generalized anxiety, Panic attacks and self reports of feeling overwhelmed by the current situation.**	- 26 years old – single -Change in normal routine -> out of own environment -Lost of independence -Financial strains - Non compliant to the hospital food regime (wants junk food) - non interested in his own care - depressive talk - 4 amputees (bilateral below the knee, 5 digits of right hand, 1 digit on left hand) - isolation - acute pain managed with Morphine - needs help with ADLs -Refused spiritual care worker	**3)Impaired Tissue integrity related to extensive frost bite on back, hands, and feet & below the knee amputation & rhabdomyolysis**	-Non compliance to the hospital food diet (proper nutrition needed for wound healing please see links) -Large open wound on back due to frost bite & rhabdomyolysis. Wound debridement on legs, arms & back -Large male 188kg affects tissue healing --application of flagyl and normal saline for daily dressing changes -Ileostomy on abdomen.	**4)Decreased Mobility related to below the knee amputation and size of the client (188 kg)**	- Acute pain - amputations (bilateral below knee and Rt (all 5 digits) & Lt (5th digit) - bedridden - necrotic tissue (buttocks & back) - morbidly obese - reported decreased tissue perfusion - isolated - medications side effects Metoprolol (dizziness, fatigue, decrease BP) Piperacillin/tazobactam (lethargy, nausea) Morphine (sedation, drowsiness, confusion) -PT wants an aggressive ROM due to bed ridden. - unavailability of the bariatric lifting equipment - In crease of stuff for care (needs 6 people to move in bed)

This condition can range from minor, self-limiting bleeding to severe, life-threatening hemorrhage.Complaints of abdominal pain or discomfortFeeling lightheaded or dizzyHistory of recent gastrointestinal surgery or proceduresReports of previous episodes of GI bleedingPresence of blood in vomit (hematemesis)Blood in the stool (melena or hematochezia)Drop in blood pressure and tachycardiaPallor or signs of anemiaSigns of hypovolemia such as thirst, decreased urine output, and cool clammy skinPositive guaiac test indicating the presence of occult blood in the stoolUpper GI Bleed vs. Lower GI BleedOlder adultsIndividuals with a history of gastrointestinal diseases or surgeriesPatients taking medications that increase the risk of bleedingIndividuals with coagulation disordersThose with a history of alcohol abuseAnemiaHypovolemiaHypotensionFluid and electrolyte imbalancesImpaired tissue perfusionAcute painThe nursing diagnosis of GI Bleed should be considered when a patient presents with signs and symptoms indicative of gastrointestinal bleeding. It is essential to assess the individual thoroughly and gather relevant subjective and objective data to support the diagnosis. Prompt medical intervention is crucial in managing this condition.GI Bleed Nursing DiagnosisThese will will formulate a GI bleed nursing care plan.Assess vital signs frequently and monitor for signs of bleeding, such as hematemesis or melena.Monitor laboratory values, including hemoglobin and hematocrit levels, coagulation studies, and blood typing and cross-matching.Encourage the patient to report any changes in pain, dizziness, or the presence of blood in the stool or vomit.Collaborate with the healthcare team to ensure appropriate diagnostic tests, interventions, and treatments are implemented.Tissue Perfusion: CardiopulmonaryFluid BalanceHemodynamic ControlPain LevelKnowledge: Medication ManagementKnowledge: Treatment RegimenThe expected outcomes may vary based on the severity of the GI bleed and the patient's overall health. Desired results include stable hemodynamic status, adequate tissue perfusion, restoration of fluid balance, relief of pain, understanding of medication management, and adherence to the treatment regimen.Nursing Interventions for GI Bleed.Monitor Vital SignsAssess Bleeding and Hemodynamic StatusAdminister Intravenous Fluids and Blood Products as PrescribedAdminister Medications as Prescribed (e.g., Proton Pump Inhibitors, Antiemetics, Hemostatic Agents)Provide Patient and Family EducationFacilitate Endoscopic Interventions or Surgical Consultation as IndicatedMonitor and Manage Potential Complications (e.g., Anemia, Hypovolemia, Electrolyte Imbalances)Collaborate with the Interdisciplinary Team for Blood Transfusions or Coagulation SupportProvide Emotional Support and Education to the Patient and FamilyPromote Safety Measures and Fall PreventionQuestion 1: A patient with a history of peptic ulcers is admitted to the hospital with signs and symptoms of gastrointestinal bleeding. Which nursing diagnosis is most appropriate for this patient? a) Risk for Impaired Gas Exchangeb) Ineffective Tissue Perfusionc) Risk for Deficient Fluid Volumed) Acute PainAnswer: c) Risk for Deficient Fluid VolumeRationale: The patient with gastrointestinal bleeding is at risk for deficient fluid volume due to ongoing blood loss. This nursing diagnosis focuses on the potential complication of decreased circulating blood volume.Question 2: Which of the following is a defining characteristic of GI bleeding?a) Feverb) Cyanosisc) Black, tarry stools (melena)d) Abdominal distensionAnswer: c) Black, tarry stools (melena)Rationale: Melena, which refers to black, tarry stools, is a characteristic sign of gastrointestinal bleeding and suggests the presence of blood in the upper gastrointestinal tract.Question 3: A patient with GI bleeding is experiencing hypotension and tachycardia.
Which intervention should the nurse prioritize?a) Administering pain medicationb) Providing emotional supportc) Assessing for signs of ongoing bleedingd) Assisting with ambulationAnswer: c) Assessing for signs of ongoing bleedingRationale: The priority intervention is to assess for signs of ongoing bleeding to determine the extent of the hemorrhage and intervene promptly. Hypotension and tachycardia may indicate significant blood loss.Question 4: Which related factor increases the risk of GI bleeding?a) Regular exerciseb) Chronic alcohol abusec) Adequate fluid intaked) High-fiber dietAnswer: b) Chronic alcohol abuseRationale: Chronic alcohol abuse can contribute to the development of gastrointestinal ulcers and increased susceptibility to GI bleeding.Question 5: The nurse is caring for a patient with suspected GI bleeding.
Which laboratory test is most important to assess the patient's blood loss?a) Complete blood count (CBC)b) Electrocardiogram (ECG)c) Urinalysis d) Blood glucose levelAnswer: a) Complete blood count (CBC)Rationale: The CBC provides essential information about the patient's hemoglobin and hematocrit levels, which can indicate the extent of blood loss and the need for further interventions such as blood transfusions.Ackley, B. J., Ladwig, G. B., Makic, M. B., Martinez-Kratz, M. R., & Zanotti, M. (2020). Nursing diagnoses handbook: An evidence-based guide to planning care.

Table 2 – Simple frequency (f) and percentage (%) distribution of defining characteristics in CRD patients undergoing HD who presented the nursing diagnosis *impaired spirituality*. Ribeirão Preto, 2008 (n=33)

Defining characteristics	Frequency	
	f	%
Expresses behavioral alteration: anger	29	87.9
Incapable of expressing creativity	29	87.9
Expresses alienation	28	84.8
Questions suffering	27	81.8
Feels abandoned	25	75.8
Expresses lack of serenity	25	75.8
Feeling of temporality	24	72.7
Expresses lack of hope	22	66.7
Expresses behavioral alteration: crying	22	66.7
Expresses feeling of guilt	21	63.6
Refuses integration with significant others	21	63.6
Expresses lack of meaning/purpose in life	19	57.6
Expresses lack of courage	19	57.6
Requests spiritual assistance	18	54.5
Feeling of grief	17	51.5
Expresses lack of love	16	48.5
Expresses despair	16	48.5
Does not take interest in nature	15	45.5
Presents disorder or concern with the system of beliefs and/or God	9	27.3
Expresses anger with God	7	21.2
Incapable of experiencing transcendence	5	15.2

St. Louis, MO: Elsevier. Gulanick, M., & Myers, J. L. (2022). Nursing care plans: Diagnoses, interventions, & outcomes. St. Louis, MO: Elsevier.Ignatavicius, D.



NURSING CARE PLAN

ASSESSMENT	DIAGNOSIS	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
Subjective: "Napansin ko na bigla na lang bumigat ang timbang ko" (*I noticed that I gained a lot of weight*) as verbalized by the patient. Objective: • Variations in blood pressure. • Edema • V/S taken as follows: T: 37.1 P: 78 R: 20 BP: 140/90	Decreased cardiac output related to decreased venous return.	Preeclampsia is a common problem during pregnancy. The condition — sometimes referred to as pregnancy-induced hypertension — is defined by high blood pressure and excess protein in the urine after 20 weeks of pregnancy. Often, preeclampsia causes only modest increases in blood pressure. Left untreated, however, preeclampsia can lead to serious — even fatal — complications for both mother and baby.	• After 8 hours of nursing interventions, the patient will participate in activities that reduce blood pressure or cardiac work load.	*Independent:* • Monitor blood pressure of the patient. Measure in both arms or thighs three times, 3-5 minutes apart while patient is at rest, then sitting, then standing for initial evaluation. • Observe skin color, moisture, temperature and capillary refill time. • Note dependent or general edema. • Provide calm, restful surroundings, minimize environmental activity or noise. • Maintain activity restrictions.	• Comparison of pressures provides a more complete picture of vascular involvement or scope of the problem. • Presence of pallor, cool, moist skin and delayed capillary refill time may be due to peripheral vasoconstriction • May indicate heart failure, renal or vascular impairment. • Help reduce sympathetic stimulation, promotes relaxation. • Reduces physical stress and tension that affect blood pressure and course of	• After 8 hours of nursing interventions, the patient was able to participate in activities that reduce blood pressure or cardiac work load.

D., Workman, M.

Table 1 - Analogy of nursing problems/phenomena/diagnoses identified in patient files at a family planning service, presenting exact and partial concordance with ICNP, version Beta 2

Nursing problems/phenomena/diagnoses found in the files	ICNP terms
1) Health improving behavior	Health seeking behavior
- Family planning	Family planning
- Breast self-exam	Self-inspecting of the breasts
- Regular exercise	Frequent exercising
2) Risk for altered health maintenance	Risk for absence of health seeking behavior
- Lack of financial resources to:	Insufficient financial resources
- attend the family planning service	Family planning
- purchase the prescribed contraceptive method	Contraceptive use
3) Altered health maintenance	Absence of health seeking behavior
- Breast self-exam	Self-inspecting of the breasts
- Provoked abortion	Pregnancy interruption
- Use of contraceptive method	Contraceptive use
- Smoking	Tobacco use
- Drug use	Drug use
4) Altered sexuality patterns:	Altered/ impaired sexual intercourse
- Absence of orgasm	Absence of pleasure/ impaired sexual relation
- Dyspareunia	Dyspareunia
5) Sleep pattern disorder/Impaired sleep	Disturbed/ impaired sleep
- Insomnia	Insomnia
- Fatigue	Fatigue
- Sleep interruption	Interrupted sleep
6) Knowledge deficit/lack of knowledge related to:	Knowledge deficit/ absence of knowledge
- Breast self-exam	Self-inspecting of the breasts
- Contraceptive method	Contraceptive use
- Menstruation	Menstruation
- Body hygiene	Self care: hygiene
7) Leisure deficit/absence of leisure	Deficit/ absence of leisure activity
8) Anxiety	Anxiety
9) Age (over 35)/menopause	Female ageing
10) Potential to increase spiritual well-being	Increased spiritual well-being
11) Effective therapeutic regimen control	Effective therapeutic regimen management
12) Constipation	Constipation
13) Altered vaginal elimination/vaginal discharge /candidiasis/vulvovaginitis	Altered vaginal elimination/vaginal discharge/candidiasi s/vulval/vaginal infection
14) Body image disorder	Disturbed/ impaired body image
15) Hypertension	Hypertension
16) Altered nutrition: more than body requirements/ overweight/ obesity	Altered nutrition / excessive food intake / overweight/ obesity
17) Altered family process	Altered family process
18) Altered nutrition: less than body requirements	Altered nutrition/Insufficient food intake
19) Ineffective individual coping strategies	Ineffective problem coping strategies
20) Disturbed self-esteem	Disturbed self-esteem
21) Low self-esteem (situational)	Low self-esteem
22) Risk for infection/ multiple partners	Risk for infection/ promiscuity
23) Varicose veins	Impaired vascular function
24) Menstrual delay/ amenorrhea/absence of menstruation	Absence of menstruation
25) Ineffective therapeutic regimen control	Ineffective therapeutic regimen management
26) Cervicitis/ ectropion/ red area	Altered mucous membrane
27) Altered patterns of urinary elimination / dysuria	Altered urinary elimination
28) Perceived constipation	Constipation
29) Fear	Fear
30) Despair	Despair
31) Impaired physical mobility	Impaired mobility
32) Impaired skin integrity/ galls/ skin injuries	Altered integumentary system
33) Menstruated/ menstruation	Menstruation
34) Grieving	Grief
35) Altered nutrition: risk for more than body requirements	Risk for/ altered nutrition/ excessive food intake
36) Risk for violence	Risk for violence
37) Sexual dysfunction	Inadequate/ impaired sexual function
38) Self-care deficit: bathing-hygiene/ precarious hygiene/ lack of hygiene	Self care: hygiene deficit/ absence/ impaired hygiene
39) Vulvovaginal itching	Vulval/ vaginal itching
40) Stress incontinence	Urinary incontinence/ stress incontinence
41) Ineffective protection	Compromised immune system
42) Ineffective family coping strategies: disabled	Ineffective coping strategies
43) Spiritual distress	Spiritual distress
44) Pain	Pain
45) Increased uterine volume	Increased uterus
46) Altered fluid volume: less than body requirements	Altered fluid volume/ deficient fluid intake

L., Rebar, C. R., & Heimgartner, N. M. (2018). Medical-surgical nursing: Concepts for interprofessional collaborative care. St. Louis, MO: Elsevier. Silvestri, L. A. (2020). Saunders comprehensive review for the NCLEX-RN examination. St. Louis, MO: Elsevier. These are the nursing books and resources that we recommend.NurseStudy.net is a participant in the Amazon Services LLC Associates Program. Included below are affiliate links from Amazon at no additional cost from you. We may earn a small commission from your purchase. Please see our Privacy PolicyThe Nursing Diagnosis Handbook E-Book: An Evidence-Based Guide to Planning Care This is an excellent reference for nurses and nursing students. While it is a great resource for writing nursing care plans and nursing diagnoses, it also helps guide the nurse to match the nursing diagnosis to the patient assessment and diagnosis.This handbook has been updated with NANDA-I approved Nursing Diagnoses that incorporates NOC and NIC taxonomies and evidenced based nursing interventions and much more.Please follow your facilities guidelines and policies and procedures. The medical information on this site is provided as an information resource only and is not to be used or relied on for any diagnostic or treatment purposes. This information is not intended to be nursing education and should not be used as a substitute for professional diagnosis and treatment.