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Upper gastrointestinal bleeding Initial assessment

Adult Health Nursing | Initial assessment

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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.

Patient profile and history

54-year-old man with suspected upper GI blood loss. Care stage: At the first supervised assessment.

Medical history: Hematemesis and dizziness developed during the current episode. Prior dyspepsia is reported; NSAID, anticoagulant and alcohol exposure require direct review. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Vomiting blood and feeling faint.

Objective findings and required checks: Possible tachycardia and postural symptoms; urgent circulation assessment is required.

Physical examination and investigations: Trend observations, blood count, coagulation, renal tests and blood-group testing; prepare for ordered endoscopy.

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

Clinical focus and pathophysiology

Upper gastrointestinal bleeding: Bleeding from an upper GI lesion can reduce circulating volume and cause shock.

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Medical / surgical management

Activate urgent bleeding care, quantify losses, maintain prescribed fasting and prepare ordered access and treatment.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed proton pump inhibitor	Part of selected upper-GI bleeding management	Verify indication and administration
prescribed blood products	Restore indicated blood components	Follow identity, compatibility and reaction-monitoring procedures.

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

Nursing process - ADPIE

Assessment

Vomiting blood and feeling faint. Possible tachycardia and postural symptoms; urgent circulation assessment is required. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize bleeding or vulnerability to further blood loss; insufficient fluid replacement for current losses; reduced circulation to vulnerable tissues; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Activate urgent bleeding care, quantify losses, maintain prescribed fasting and prepare ordered access and treatment. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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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: 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 about bleeding, dizziness, bruising and relevant medicines. Assess: Assess blood loss, circulation, consciousness and ordered coagulation or blood counts.	Bleeding or vulnerability to further blood loss. Possible factors: tissue injury, altered coagulation or treatment effects. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Blood loss is recognized promptly and circulation is supported by the emergency or treatment plan. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies bleeding warning signs and medicine-related precautions.	1. Quantify visible loss where possible and escalate active significant bleeding immediately. Rationale: Underestimating blood loss can delay life-saving care. 2. Prepare ordered access, investigations and treatment while monitoring perfusion. Rationale: Coordinated response supports rapid stabilization. 3. Avoid unnecessary traumatic procedures and apply appropriate bleeding precautions. Rationale: Reducing additional injury limits preventable blood loss. 4. Activate urgent bleeding care, quantify losses, maintain prescribed fasting and prepare ordered access and treatment. Rationale: Bleeding from an upper GI lesion can reduce circulating volume and cause shock. 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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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition.	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 dizziness, chest discomfort, fatigue and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	Reduced circulation to vulnerable tissues. Possible factors: altered blood flow or cardiac function. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately. Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem.	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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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the 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.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few 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. After stabilization explain cause-specific treatment, medicine precautions and recurrent bleeding action. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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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Health education and continuing care

After stabilization explain cause-specific treatment, medicine precautions and recurrent bleeding action.

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

Ongoing hematemesis, shock, altered consciousness or respiratory compromise is an emergency.

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

- Bleeding from an upper GI lesion can reduce circulating volume and cause shock.

- Priority concerns: Bleeding or vulnerability to further blood loss; Insufficient fluid replacement for current losses; Reduced circulation to vulnerable tissues; Learning needs about the condition and care plan.

- Ongoing hematemesis, shock, altered consciousness or respiratory compromise is an emergency.

- After stabilization explain cause-specific treatment, medicine precautions and recurrent bleeding action.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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