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Bleeding or vulnerability to further blood loss Upper gastrointestinal bleeding

Adult 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: 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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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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 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: At the next patient-specific reassessment: 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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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

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.
- 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: 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/

Health Alterations - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/healthalts/

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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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