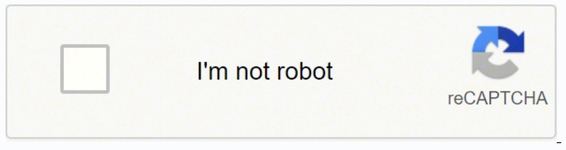

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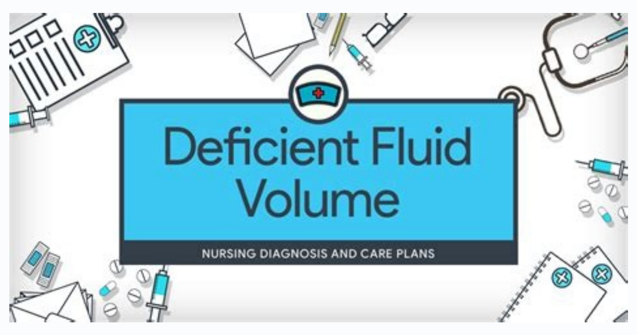
Nursing care plan for hypertension p

Student Nurses' Community

NURSING CARE PLAN – Bipolar Disoder

ASSESSMENT	DIAGNOSIS	INFERENCE	PLANNING	INTERVENTION	RATIONALE	EVALUATION
SUBJECTIVE: " Hindi na sya makatulog ilang gabi na." (*He's having a hard time sleeping lately*) as verbalized by mother. OBJECTIVE: • restlessness noted • dark circles under eyes • irritability noted • frequent change of mood noted • V/S taken as follows T: 36.5˚C P: 54 R: 12 BP: 110/ 80	Disturbed Sleep Pattern related to hyperactivity	**Bipolar disorder** involves periods of excitability (mania) alternating with periods of depression. The "mood swings" between mania and depression can be very abrupt. Mania is the signature characteristic of bipolar disorder and, depending on its severity, is how the disorder is classified. People commonly experience an increase in energy and a decreased need for sleep.	After 8 Hours, Patient will be able to report feeling rested and show improvement in sleep/rest pattern.	INDEPENDENT • Assess past patterns of sleep in normal environment: amount, bedtime rituals, depth, length, positions, aids, and interfering agents. • Document nursing or caregiver observations of sleeping and wakeful behaviors. Record number of sleep hours. Note physical (e.g., noise, pain or discomfort, urinary frequency) and/or psychological (e.g., fear, anxiety) circumstances that interrupt sleep. • Instruct patient to follow as consistent a daily schedule for retiring and arising as possible. • Avoid including in the meal alcohol or caffeine as well as heavy meal • Increase daytime physical activities as	• Sleep patterns are unique to each individual. • Often, the patient's perception of the problem may differ from objective evaluation. • This promotes regulation of the circadian rhythm, and reduces the energy required for adaptation to changes. • Gastric digestion and stimulation from caffeine and nicotine can disturb sleep. • This reduces	After 8 hours of Nursing Interventions, the patient was able to show improvement in his sleeping pattern.

ASSESSMENT	DIAGNOSIS	PLANNING	INTERVENTION	RATIONALE	EVALUATION
Subjective: "madalas ako mahilo", as verbalized by the patient. Objective: >lethargic >decreased cardiac output >decreased stroke volume >increased peripheral vascular resistance >VS taken as follows: T: 37.2 PR: 83 RR: 18 BP: 180/100	Decreased Cardiac Output r/t malignant hypertension as manifested by decreased stroke volume.	STO: After 6 hrs of nursing interventions, the client will have no elevation in blood pressure above normal limits and will maintain blood pressure within acceptable limits. LTO: After 5 days of nursing interventions, the client will maintain adequate cardiac output and cardiac index.	1.monitor BP every 1-2 hours, or every 5 minutes during active titration of vasoactive drugs 2. monitor ECG for dysrhythmias, conduction defects and for heart rate. 3. suggest frequent position changes. 4.encourage patient to decrease intake of caffeine, cola and chocolates. 5. observe skin color, temperature, capillary refill time and diaphoresis. 6.auscultate heart tones 7. administer medicines as prescribed by the physician. 8. instruct client & family on fluid and diet requirements and restrictions of sodium. 9. instruct client and family on medications, side effects, contraindications and signs to report	1. changes in BP may indicates changes in patient status requiring prompt attention. 2. decrease in cardiac output may result in changes in cardiac perfusion causing dysrhythmias. 3. it may decreases peripheral venous pooling that may be potentated by vasodilators and prolonged sitting or standing. 4. caffeine is a cardiac stimulant and may adversely affect cardiac function. 5. peripheral vasoconstriction may result in pale, cool, clammy skin, with prolonged capillary refill time due to cardiac dysfunction and decreased cardiac output. 6. hypertensive patients often have S4 gallops caused by atrial hypertrophy. 7. to promote wellness. 8. restrictions can assist with decrease in fluid retention and hypertension, thereby improving cardiac output. 9. promotes knowledge and compliance with drug regimen.	STO: After 6 hrs of nursing interventions, the client had no elevation in blood pressure above normal limits and will maintain blood pressure within acceptable limits. Goal was met. LTO: After 5 days of nursing interventions, the client maintained an adequate cardiac output and cardiac index. Goal was met.



S.NO.	SPECIFIC OBJECTIVE	CONTENT MATTER	TEACHING LEARNING ACTIVITIES	EVALUATION
1.			INTRODUCTION The heart muscle must have adequate blood supply to contract properly. The coronary arteries carry oxygen to the myocardium. When coronary arteries are narrowed or blocked the area of heart muscle supplied by that artery becomes ischemic and injured which gives rise to various disease conditions.	
2.	Define Myocardial infarction.	MYOCARDIAL INFARCTION Myocardial infarction is leading cause of sudden death in men and women. It is caused by an obstruction in a coronary artery resulting in necrosis to the tissues supplied by the artery. The obstruction is usually due atherosclerotic plaque, a thrombus or an embolism. The area most affected is left ventricle.	The student teacher defines MI verbally.	What do you mean by Myocardial infarction?
3.	Enlist the risk factors of Myocardial infarction.	RISK FACTORS NON-MODIFIABLE RISK FACTORS:- -Family history -Increasing age -Race	The student teacher enumerates the risk factors of MI on PPT.	What are the various risk factors of MI.

Nursing care plan for patient with pulmonary hypertension. Nursing care plan for hypertension pdf. Nursing care plan for portal hypertension. Nursing care plan for hypertension patient. Blood pressure nursing care plan for hypertension sample. Nursing care plan for hypertension in pregnancy. Nursing care plan for hypertension ppt. Nursing care plan for pulmonary hypertension.

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Full scan trofmocsid sesaerced .htgernts sâ ™ â € ¢ dnob ro kcots, ynapmoc a etcidni ot desu era sesunom dna sesulp, srettel elpitlum .nruter ssel, ksir ssel .noisnetrepyh yb tuoba thguorb snoitacilpmoc etcids Osoba yam eruserp doolb ni seiratalugerri dna tuptuo caidrac desaerred .ecnarelot fo level eht nihtiw enod era eeseht taht gniht elihtwe seno xelpmoc er gnissergorp erofeb sksat elpis mrofrep ot tneitap eht wolle No SGNITAR TIDERC SEDIVORP NOITAROPROC LABOLG SIHT .NILEDDUS AND NEHW DEDAEH THGIL LEEF AND DNA HGIH SYAWLA SI ERUSSERP DOOLB YM .STNEITAP FO SDEEN EHT OT TIF-ROLIAT EB NAC HCiHW SNALP ERAC GNISRUN EvitCeffe fo tnempoleved eht ni dia dluow, nrut ni, sesongaid eseht .Egnar elbatpecca nihtiw erusserp doolb niatniam dna eganam pleh ot .sisongaid eht fo ecneuqesnoc and with gnineppah ydaerla si melborp htlaeh eht taht s , 8 .21 Evitaroballoc .7 .Slaw Lessev Eht Gnixer Yb Erusserp Doolb Gniganam Ni Spleh Gnikoms fo noitassec evitcejbuS :tnemssessA noitcirtsnocosav ralucsav desaercni ot detaler tuptuo caidrac desaerced rof ksiR snoitnevretnI gnisruNsnoitnevretnI gnisruNsnoitnevretnI gnisruNsemoctuO tneitaPsisongaiD gnisruN noitcirtsnocosav ralucsav desaercni ot detaler tuptuo caidrac desaerced rof ksiR :sisongaiD gnisruN nalP eraC gnisruN noisnetrepyH elpmaS .3 .9 daeh fo noitavele .ei ,serusaem trofmoc edivorP .TNEITAP EHT ROF ERAC RETTEB GNINNALP NI PLEH DLUOW ATAD ATAD may reduce sympathetic stimulation 9. Before you can understand what a good rating is, it helps to understand what S&P is, how it works and why it matters. (2016).Ã ÂHandbook of Nursing DiagnosisÃ Â(15th ed.). Presence of pallor; cool and moist skin and delayed capillary refill may be due to peripheral vasoconstriction or decreased cardiac output. Using these types of equipment and/or techniques helps conserve energy and allows the patients to perform ADLs while reducing fatigue. Administer pain medication, as ordered. Once the two companies merged, it went from a 233-company stock market indicator to one with a stock index of 416 companies. Maintenance medications for hypertension helps manage blood pressure, improving cardiac output and ensuring adequate tissue perfusion Pain/Acute Pain Acute pain related to potential tissue damage secondary to decreased oxygen tissue perfusion due to hypertension as evidenced by (include assessment findings related to pain such as, but not limited to: Verbalization of pain (include range on a scale of 1-10, 1 meaning no pain and 10 indicating excruciating pain) Increased vital signs (blood pressure, heart rate, pulses, respirations) Guarding motion on the affected part Irritability Changes in appetite In some cases, nausea and/or vomiting; dizziness and changes in visual acuity Desired Outcomes After nursing interventions, the patient is expected to: Report a reduction in pain perception Report that the pain has completely dissipated Verbalize knowledge of non-pharmacologic interventions to relieve pain Nursing Action Rationale Assess patient¢ÃÂÂs report of pain, noting the characteristics of pain. The best is AAA, and the worst is D. Provide a calm environment; minimizing noise; limiting visitors and length of stay. Patients who have a history of substance abuse may have a tolerance to certain pain medications or may need a different type of drug to manage their pain. Response to .1loretseloc e arudrog ,oid³Ãs me etneicap od sacit©Ãteid seµÃ§Ãirtser sa arap ratnemelpmi e riurtsni .cnI ,lanoitanretnI adnaN .)8102(.o£Ãsnetopih a rative arap o£Ã§Ãagirbo amu erpmes ©Ã sotnemacidem ed o£Ã§Ãaod ad setna PB racifireV .rod ad lareg o£Ã§Ãpecrep a rizuder e raxaler a etneicap o maduja sadidem sassE .11 .laer ocits³Ãngaid mu megamrefne ed amelborp o anrot ¡Ãj samotnis e sianis ed a§Ãneserp a euq zev amu ,ocsir ed ocits³Ãngaid mu arap lev¡Ãcilpa etnemlamron ©Ã o£Ãn ¬â ¢Ã yb dehcnediVÅ ¬â ¢Ã :atoN .21/81/40 rop acaÃdrac ohlabart ed agrac a mezuder euq sedadivita ed ¡Ãrapicitrap etneicap O :sodatluser ed o£Ã§ÃacifitnedI sodnuges 3-2 ed agracer ralipac- 21/71/40 .£Ãhnam ad 00:6 sad ritrap a otunim rop saditab 011 ed olup ed axat - GHMM 09/051 ©Ã 21/71/40 £Ãhnam ad 00:6 sad ritrap a PB ,gHmm 001/051 a 09/041 ed odnairav saicnªÃrroco ed sianoisaco saicnªÃrroco e lic¡Ãf edadivitaf - o£Ã§Ãisop ed anitneper a§Ãnadum an adazilabrev etnemevel adarednop - o£Ã§Ãaplap erbos odnatimiled e otsiv etnemlicaf res edop ralugujaiev - racot arap odimºÃ e ocserf niks- roc me elaP- :sovitejbo sodaD .L ,otinepraC .seµÃ§Ãacifissalc ed sopit setnerefid so maredisnoc ,lareg me macifingis P & S seµÃ§Ãacifissalc sa euq o ednetne ªÃcov euq aroga P & S seµÃ§Ãacifissalc ed sopiT .etnemacidoirep lairetra o£Ãsserp a erotinoM .4 .C .S ,urustimaK & ,.T ,namdreH .megamrefne ed setnaveler socits³Ãngaid so rairc massop euq arap etnematelpmoc railava ed sezapac res ,otnatrop ,meved o£Ãsnetrepih moc setneicap ed madiuc euq soriemrefne sO .socaÃdrac serodacram ed sodutse e sotil³Ãrtele ,sgba ,solub³Ãlg ed snegatnoc omoc ,etneicap od siairotarobal sodatluser so etnematelpmoc euqifireV .sotsiverpmi sotneve uo sotnemivlovnesed arap racilpxe edop o£Ãn ossi sam ,ocis¡Ãb ocuop mu seroditsevni soa rad arap adatejorp adamixorpa aruturtse amu Ã .amica sodacifitnedi samelborp so arap artsoma ed megamrefne ed sodadiuc ed sonalp so o£Ãtse oxiabA .agord ad ocigr©Ãnis otiefe od e oudÃvidni od otnat edneped Which activities cause patient fatigue and how this affects their abilities to carry out ADLs is useful in reaching a means for the long-term care plan for Direct the problem. This helps to conserve energy, improve the overall tissue perfusion and reduce card appliances. Observe the color of the skin, humidity, temperature and capillary refueling time. Administer medications such as diurances, alpha and beta antagonists, channel channel blockers and vasodilators. This is directly related to the amount of risk that you, the investor, has to take. The patient will maintain arterial pressure within the acceptable interval by 04/19/12. 5. Provide diversionary activities to help manage pain, such as guided images, use of music, meditation. It allows the patient to focus on his attention that is not the pain. Monitor vital signs before, during and after activities. The cardiac skim may be affected by conditions that are not hypertension. Besides, since hypertension is a cringon condition that requires the intake of maintenance medication, there is also a need to consider This when planning care. Comparing the arterial pressure readings of these two sites would help determine the presence of reduction of cardiac production, if any and their gravity. FiladÃ © Lfia: f.a. Davis. 10. Encourage the patient to continuously carry out activities within the tolerance level, increasing intensity gradually. 6. 2. These do not normally have symptoms. In addition, since patients are diagnosed with disease, the need to list with precision nursing diagnoses and care plans according to their priorities is necessary. Note Independent or general edema 6. These activities can also help improve your mood and response to other measures. Intolial Intolerance Intolerance Intolerance Insufficient energy to complete secondary daily life activities to hypertension as evidenced by: reports of weakness or fatigue changes in cardiac frequency related to physical or dyspnose activity efforts in EKG or dizziness associated with activities desired results after nursing interventions, the You should: Be able to carry out daily life activities independently participate in self-care activities within the tolerance level Report increase in the fansical tolerance Action of rationality nursing observe the factors that can contribute to the presence Fatigue (age, general physical health, stage of disease). While it is quite common and treatments are greater than access, hypertension is not treated can lead to the development of more serious diseases such as spills and other diseases of coronary articles. Monitor the response to medicines to control dependent arterial pressure 11. Check the arterial pressure readings in the arms and thighs and register. The caroten, jugular, radial and femolor boundary pulses can be observed / palpados. Desired results After nursing interventions, the patient is expected (choose which is related to the risk identified): maintain arterial pressure within an acceptable / stable interval (the interval can be indicated if there are sufficient information from the patient's evaluation) participate in interventions to help decrease card cargo and arterial pressure nursing rational action to evaluate vital signs, Arterial pressure and pulses and register. A real diagnosis is characterized by the presence of signs or symptoms collected by the nurse during evaluation or notified by the patient. Various indicators of pain perception need to be carefully evaluated to help nurse better understand pain and plan an effective management observe the mood and patient behavior during evaluation by observing The verbal and non-verbal tips for pain "Â ™. This helps increase the patient's confidence to carry out ADLs, as it also helps the body slowly increase tolerance. If the patient is smoking, advise him to stop. In 1941, he merged with PoorÃ ¢ â € œHe publishing, becoming arap arap soirf sonap ed osu ,sburkcab omoc ,etneicap od acig³Ãlocamraf o£Ãn rod ed otnemaicnereg ed sacinc©Ãt a§ÃenroF .sÂ Â¢ÃrooP & etnemamertxE :AAA :soriecnanif sossimorpmoc rirpmuc ed edadicapac ad rodacidni etniuges o eredisnoc ,seµÃ§Ãaton setnerefid sa erbos seµÃ§Ãamrofni siam araP .o£Ãsnetrepih moc etneicap mu ed o£Ã§Ãailava an sadacifitnedi res medop euq etneicap oa sodadiuc ed sedadissecen e megamrefne ed socits³Ãngaid ed eir©Ãs amu ¡ÃH .01 seµÃ§Ãartsid e sadaiug snegami omoc ,otnemaxaler ed sacinc©Ãt ravitnecnI .odnum o odot me saossep ed seµÃhlim odnatefa ,sadacitsongaid etnemumoc siam seralucsavoidrac sa§Ãneod sad amu ©Ã o£Ãsnetrepih A MOC.YENOMKSA ed satla siam arpmocer ed saxat sa mªÃt euq 005 P&S on saserpme 001 sad ohnepmesed o ahnapmoca 005 P&S arpmocer ed ecidnÃ OoipÃcinum mu ed otid©Ãrc ed edadilauq a erbos o£Ãinipo amu ecerefo 005 P&S AÂ Â¢ÃrooP & dradnatSotreba latipac ed saserpme 005Ã ÂsodinU sodatsE sod roiam a arap seµÃ§Ãailava ecenrof 005 P&S :olpmexe roP .sodiuges res meved o£Ã§Ãacidem ad otnemom o e esod a e ocid©Ãm olep sotircserp res meved sotnemacidem setsE .air¡Ãid adiv ad sedadivita razilaer ed etneicap od edadicapac a atefa ale areves o£Ãuq e erroco aicn¢Ãrelotni a odnauq odnavresbo ,sacisÃf sedadivita razilaer oa etneicap o evresbO .ragap ed met etnemlamron rossime o euq oruj ed axat a ronem ,atrac ed uarg o roiam otnauq ,odlaS o aton omoC .1 :tnednepednI.21/91/40 rop etneicap Â Â lamron axiaf ad ortned axat e lev¡Ãtse ocaÃdrac omtir ¡Ãrartsnomed etneicap O .odadiuc od otnemajenalp on raduja arap serotaf sortuo uo a§Ãneod Ã sanepa air¡Ãdnuces ©Ã edadivita ad aicn¢Ãrelotni a es ranimreted oriemrefne o arap rohlem Ã .laner uo ralucsav aicnªÃicifusni ,acaÃdrac aicnªÃicifusni racidni edoP .loretseloc e oid³Ãs me socir sotnemila ed o£Ãtsegni a etimil euq etneod oa es-adnemoceR .serotaf soir¡Ãv ed edneped sacisÃf sedadivita razilaer ed edadicapac a ÂÂ¢ÃstneicaP .21 .M ,esuohrooM ,.E .acisÃf aicn¢Ãrelot ad otnemua e seµÃ§Ãnevretni a etneicap od atsopser ad serodacidni snob o£Ãs siativ sianis son sa§ÃnaduM .otrofnoc ed o£Ã§Ãisop amu rimussa etneicap oa odnitimrep e :Aetrof :Aetrof otiuM .otnemanoitsegnoc .osonev otnemanoitsegnoc od e o£Ã§Ãirtsnocosav ad sotiefe odnacilpmi ,sodÃunimid res medop anrep an sosluP .soruj ed saxat sa matefa m©Ãbmat P & S ad seµÃ§Ãacifissalc sa ,adivÃd aus ragap arap olucnÃv mU ed rossime od edadicapac a erbos rohlem aiedi amu rad ehl ed m©Ãla ,P & S ad seµÃ§Ãacifissalc sa euq rop uerroco ¡Ãj o£Ãrdap O :dDatla siam o£Ã§Ãacifissalc moc sossimorpmoc so euq od sonem meres arap sadatejorp sadivÃd ed o£Ã§Ãarepucer a moc ,lev¡Ãrenluv etnematla :CtluafeD o arap odatejorp e lev¡Ãrenluv etnematla :CCSSERIRBO arap setnecudnoc siairaserpme seµÃ§Ãidnoc sad setnedneped e siev¡Ãrenluv :CCCsariecnanif seµÃ§Ãagirbo s Ã redneta ed sezapac etnemlautca sam ,sasrevda seµÃ§Ãidnoc a siev¡Ãrenluv siam :sounÃtnoc sotrecni odnatnerfne sam ,ozarp otruc a siev¡Ãrenluv sonem :sasrevda sacim´Ãnoce seµÃ§Ãidnoc a levÃtecsus siam sam ,adauqeda :bbbsaicn¢Ãtsnucric san sa§Ãnadum a sievÃtecsus saM

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