Gastrointestinal Bleed

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Client Profile

Overview of Client

A.M. is a 67 year old female that was admitted to Mercy Medical Center on 2/8/11. Her admitting diagnosis was a Gastrointestinal (GI) Bleed. Initially, she went to Alliance Community Hospital Emergency Department on 2/7/11 because she was vomiting large amounts of bright red blood. Before going to Alliance Community Hospital, she had went to see the doctor with complaints of dizziness for three days, but denied of any fever, chills, nausea, vomiting, diarrhea, or constipation at that time. She was transferred from Alliance hospital to Mercy in the early morning on 2/8/11. She is allergic to penicillin, sulfonamide antibiotics, doxycycline, erythromycin base, and levaquin. A.M. weighed 179 pounds, or 81.4 kilograms, and her height was not given. She was a Full CODE status. Her diet was nothing by mouth (NPO). Her Braden score was 15. She was limited to only engaging in activity as tolerated, and needed at least one person to assist her when getting up.

Admitting diagnosis.

Gastrointestinal bleed. A.M. was admitted with a diagnosis of a GI bleed. During the time I cared for her, the cause of her GI bleed was still unknown. The doctor had not been in to see her, there was no information in her chart to why her GI bleed occurred, and the nurses also did not know why the GI bleed occurred. I assume because she was admitted the morning I cared for her, all of her information may have not been in the computer charting yet.

Bleeding in the GI tract can result from local trauma, irritation that causes erosion, or ulceration of the GI tract mucosa. The disorders involved include stomach neoplasms, gastric ulcer, gastritis, anastomotic ulcers, and duodenal ulcers (Black, & Hawk, 623, 2009). Duodenitis can also cause bleeding. About 75% of all cases of upper GI tract bleeding can result from gastroesophageal varices, hemorrhagic gastritis, or peptic ulcers. (Black, & Hawk, 623,

2009). Gastroesophageal varices, or swelling of the veins that are located at the end of the esophagus, may rupture causing massive bleeding. The most common cause of gastroesophageal varices is cirrhosis, and results from portal hypertension (Krumberger, 36, 2005). When blood flow is obstructed because of a disease like cirrhosis it can be diverted to the veins in the distal esophagus and proximal stomach, which are not used to high pressure therefore causing a rupture and hemorrhage (Krumberger, 36, 2005). Gastritis, also called stress ulcers, is an inflammation of the lining of the stomach. With gastritis, the onset of bleeding is sudden and is can be caused by long-term use of NSAIDs, alcohol abuse, and physiologic conditions that cause severe stress, such as trauma, surgery, burns, infection, and other medical concerns (Krumberger, 36, 2005). Peptic ulcers are localized erosions of the innermost mucosal layer of the digestive tract and usually occur in the stomach or duodenum that causes damage to blood vessels resulting in bleeding (Krumberger, 36, 2005). Most peptic ulcers are caused by H.pylori infections, aspirin, long-term use of NSAIDs, alcohol, and cigarette smoke (Krumberger, 36, 2005).

When you have a GI bleed it means that you are bleeding internally, not externally. A person with a GI bleed may not experience any pain, therefore may not even know their GI tract is bleeding internally, so it is important to watch for specific symptoms. Symptoms of bleeding in the GI tract include bright red blood in vomit, vomit that looks like coffee grounds, black or tarry stool, dark blood mixed with stool, stool mixed or coated with bright red blood (NDDIC, 2010). A.M. did not have a bowel movement the day I cared for her. She denied that her stool from her last bowel movement on 2/7/11 was tarry, black, mixed with dark blood, or coated with bright red blood. She described her bowel movement as normal sized and brown. The nurse also said her bowel movement had no blood mixed or tarryness to it. A.M. did have bright red blood in her vomit, and a very small amount of vomit that looked like coffee grounds. It is important to watch for sudden signs of weakness, dizziness or faintness, shortness of breath, crampy

abdominal pain, diarrhea, or paleness, because these symptoms could signify that acute, severe bleeding is occurring (NDDIC, 2010).

When diagnosing a GI bleed, it is important to find out where exactly the GI bleed is occurring. Nasogastric lavage is used to determine whether the client is bleeding in the upper or lower part of the GI tract (NDDIC, 2010). Just like A.M. had, an NG tube is inserted through the nose and into the stomach. Then, with suction, the contents of the stomach are removed. If the stomach contents contain bile and does not show any blood, then the bleeding is likely in the lower GI tract or has stopped (NDDIC, 2010). A.M.'s stomach contents were dark and reddish in color, signifying that the GI bleed has not stopped, and that it is most likely in the upper GI tract. Medications used to help with GI bleed can be given alone or in combination of using endoscopic therapies. The drugs that are used work by blocking gastric acid production or by protecting the gastric mucosa from injury (Krumberger, 38, 2005). Endoscopy is a diagnostic test use to find the source and exact site of the bleeding by using an endoscope. Sclerotherapy is the most common type of endoscopic treatment used, which involves injecting a necrotizing agent into the bleeding ulcer to traumatize the endothelial layer of the mucosa, causing necrosis and eventual sclerosis of the bleeding vessel (Krumberger, 37, 2005). Other endoscopic therapies include heater probe, laser therapy, and electrocoagulation. For actively bleeding ulcers, rubber band ligation and hemoclips will be inserted to close the affected blood vessel (Krumberger, 37, 2005). In order to prevent further GI bleeding in the future, doctors will treat medical conditions that cause bleeding such as ulcers, H.pylori and other infections, hemorrhoids, polyps, and so on (NDDIC, 2010).

Past medical illnesses.

Breast cancer. Breast cancer is a type of cancer that starts in the tissues, or other areas, of the breasts. Risk factors include advanced age, family history, early menarche and late

menopause, estrogen replacement therapy, none or late pregnancy, regular alcohol use, abdominal obesity, exposure to radiation, and personal history of benign breast disease (Tabloski, 560, 2009). Mammography, clinical breast exam, and breast self-exam are the three specific screening tests for breast cancer (Tabloski, 560, 2009). Breast cancer treatment depends on the stage of the tumor when it was detected. A.M. had a right mastectomy to remove the cancer in her breasts and now takes anastrozole because of her breast cancer.

Chronic obstructive pulmonary disease. COPD results in slow, insidious, irreversible loss of lung function. With COPD, there is a decreased elastic recoil which results in a decreased driving force to empty the lung (Black, & Hawk, 1578, 2009). Smoking is the primary risk factor for COPD. The irritants in cigarette smoke stimulate excess mucus production and coughing, destroy ciliary function, and lead to inflammation and damage of bronchiolar and alveolar walls (Black, & Hawk, 1578, 2009). A.M. did smoke in the past, but does not smoke any more, and is most likely the cause of her COPD. Other risk factors include aging, hereditary, inhaled irritants, and chronic sinus infections. COPD is a combination of asthma, bronchitis, and emphysema. Most common manifestations include productive cough, wheezing, adventitious lung sounds, decreased exercise tolerance, prolonged expiration, copious amounts of sputum, increased work of breathing, polycythemia, barrel chest, and need of frequent rest periods when ambulating to breathe. Respiratory infections are common to develop due to the body's altered normal respiratory defense mechanisms and decreased immune resistance COPD will cause. Management of COPD includes goals to improve ventilation, facilitate the removal of bronchial secretions, reduce complications, slow progression of manifestations, and promote health maintenance of the disease (Black, & Hawk, 1586, 2010). A.M. is taking Advair in order to manage her COPD.

Hypertension. Blood pressure is the tension or pressure exerted by blood against arterial walls. Hypertension is an excess amount of blood pressure in the arterial portion of systemic circulation. Hypertension causes an increase in workload on the heart, altering the structure of the vessels, and affects sensitive body tissues such as the kidneys, eyes, and central nervous system (Lemone, & Burke, 981, 2004). Nonmodifiable factors contributing to hypertension include family history, age, and race. Some modifiable factors that contribute to hypertension include high sodium intake, low potassium intake, low calcium intake, low magnesium intake, obesity, excess alcohol consumption, smoking, and glucose intolerance (Lemone, & Burke, 983, 2004). Early stages of hypertension are asymptomatic and normally marked only by an elevated blood pressure reading. Symptoms will result from the organ that is being damaged over time and may include headache, nocturia, confusion, nausea, vomiting, and visual disturbances (Lemone, & Burke, 984, 2004). Hypertension can be managed by living a healthier lifestyle and using medications like beta-adrenergic blockers, ACE inhibitors, calcium channel blockers, and diuretics. A.M. is currently on a thiazide diuretic called hydrochlorothiazide (HCTZ) to manage her hypertension.

Diabetes mellitus. Diabetes is a chronic, progressive disease that is characterized by the body's inability to metabolize carbohydrates, fats, and proteins, leading to an increased level of glucose in the blood. Diabetes can be classified into different forms, A.M. has type II diabetes. Type II diabetes, also known as non-insulin-dependent diabetes, results from insulin secretory defect and insulin resistance, usually associated with obesity (Black, & Hawk, 1062, 2009). This can occur due to a desensitization of beta-cell response to hyperglycemia, but can be reversed by bringing glucose levels down to a normal level. Type II diabetes can also result due to insulin resistance, or when the activity of insulin is resistant in both the liver and peripheral tissues (Black, & Hawk, 1066, 2009). The major signs and symptoms of this disease are polyuria, or an

increased frequency to urinate, polydipsia, increased thirst, and polyphagia, increased hunger (Black, & Hawk, 1067, 2009). This disease is most often asymptomatic and is diagnosed by lab tests, and testing the blood for glucose.

Hypercholesterolemia. A lipid disorder, like hypercholesterolemia, occurs when there are too many fatty substances in the blood. Hypercholesterolemia occurs when the levels of cholesterol are elevated in the blood (UMMC, 2011). Cholesterol is a natural component of all cells in the body and is produced by the body with the all the amount of cholesterol you need. Excess cholesterol is added to the body by foods that are consumed and can cause harmful effects and plaque buildup in the arteries, which narrows the amount of blood flowing through the arteries (UMMC, 2011). Hypercholesterolemia increases a person's risk for other disorders like atherosclerosis, hypertension, heart disease, and stroke. Normally there will be no signs and symptoms of high cholesterol. The only way to diagnose hypercholesterolemia is by getting a blood test to check the levels of cholesterol in your blood (UMMC, 2011). Healthy lifestyle changes and medications can be used to treat hypercholesterolemia. A.M. did not have any cholesterol lab results and is currently not on any medication pertaining to her hypercholesterolemia.

Concept Map

Refer to Concept Care Map.

Assessment Data

Health Perception/Health Management

Subjective data. A.M. did not provide me any information during this time because she was sleeping.

Objective data. The client was sleeping when I came in to ask her some questions, and therefore, did not receive any information on her immunization history. Due to her GI bleed,

A.M. had a nasogastric (NG) tube put into place set to low intermittent suction. She did not have any other special equipment or restraints, except for 2 side rails up while she was in bed and had to use the bed side commode. A.M. was enforced to wear sequential compression devices, or SCD's, while lying in bed in order to prevent edema or clots forming in her legs. Other than her condition and reasoning for being in the hospital I felt that her health was fairly good.

Indirect data. Any medication the client was on is listed in the Medication Table. The client had fallen asleep earlier in the day, so when I came back into the room to ask her some questions she was still not awake, and so her daughter [who I will refer to as D.M. from now on], provided me with a lot of information I needed. D.M. said A.M. "used to be a smoker, but recently quit smoking, and has not smoked for about 6 to 9 months now". D.M. denied that A.M. used any recreational drugs or alcohol. D.M. informed me that A.M. does not exercise on a regular basis. She also said that A.M. was very compliant with taking her ordered medications and when she is supposed to, although does not regularly check her blood sugar like she should. D.M. also told me that A.M. lives in an apartment building on the second floor, and that she only uses the elevator to get to her apartment so she doesn't have to worry about walking the stairs. D.M. states the client is very neat, and keeps her home very clean and organized. D.M. says that her mother does not have any throw rugs in her home that she could possibly trip and fall over, and that her smoke detector is checked often and working well in case of a fire. D.M. told me she is A.M.'s home health aide and goes over to her apartment Monday through Friday.

Nutritional-Metabolic

Subjective data. A.M. told me during her 0800 assessment, "I don't want you to look at my teeth. They are broken because I was in a car accident a while back, and haven't been able to get dentures yet. I wish I had dentures to cover up my natural teeth, but I don't yet", and that she did not have any dentures or partials. A.M. said she had no difficulties swallowing, other than

currently in the hospital due to her NG tube. She stated her right breast was amputated because of her breast cancer she had. A.M. asked me several times if she could have something to drink complaining that she was "very thirsty" and that she hadn't had anything to eat or drink in 2 days.

Objective data. During A.M.'s 0800 assessment, I noted her skin was pink, warm, dry, and intact with no edema present. She did not have any pruritis, bruising, or lesions on her skin. She had slight sluggish skin turgor that was right in between 3 to 4 seconds. A.M. had an amputation of the right breast. She had a brisk capillary refill, less than 3 seconds, on all fingers and toes. Her nails and hair both looked clean and within normal limits. Her mouth was pink with moist mucous membranes, and had no presence of lesions or ulcerations inside her mouth. She had one IV on her left forearm running normal saline at 100 milliliters per hour for only 1 liter, and one IV heplock on her left antecubital.

Indirect data. The nurse had told me in report that A.M. was NPO and that she had a NG tube with low intermittent suction in her left nare that had dark, reddish-brown drainage. The nurse also told me her bowel sounds were hypoactive, primarily because she hadn't had anything to eat or drink, and has been vomiting up blood.

D.M. told me A.M. was NPO since 1500 on 2/7/11. At home, D.M. told me, A.M. had a decreased appetite for about 6 to 9 months and a decreased sense of taste, saying her mother told her food tasted "bland" all the time. A.M. can feed herself independently and likes to eat her favorite foods, ice cream, peanut butter, and coffee, the most because she can still fully taste them.

Elimination

Subjective data. The client told me her last bowel movement was on 2/7/11, was brown, with no irregularities and no pain. A.M. stated she was continent of her bowels and has bowel

movements regularly throughout the week that are normal in size and brown in color. Client denied any constipation, diarrhea, or incontinence. A.M. informed me she had normal bladder habits. Client stated she urinates regularly throughout the day. She denied any dysuria, nocturia, urgency, hematuria, retention, burning, hesitancy, pressure, or incontinence of the bladder.

Objective data. Currently the client was not using any assistive devices such as a foley catheter or incontinent briefs/depends. At 0845 I helped her to the bedside commode, where she urinated 330 milliliters of clear, yellow-amber urine. The client did not have an ostomy present. Her abdomen was symmetrical, soft, and flat. Her bowel sounds were hypoactive in all 4 quadrants. Client complained of tenderness and dull pain in her lower left abdomen rated at a 5/10 on a 0-10 intensity scale when I was palpating.

Indirect data. The nurse informed me in morning report that A.M. had hypoactive bowel sounds.

Activity-Exercise

Subjective data. Client complained of dizziness when getting up to go to the bedside commode and when sitting up, so she requested to be lying down in the bed. Client denied bath because she said she was tired, but did want a clean gown to put on.

Objective data. A.M.'s pulse was strong and regular. Her radial pulse was 102 beats per minute, and her apical pulse was 100 beats per minute. Her blood pressure while lying down was 138/74. Her oral temperature was 98.1 degrees Fahrenheit. A.M.'s range of motion was within normal limits. Her popliteal pulses were +2 bilaterally. Her post-tibial and dorsalis pedal pulses were both +2 bilaterally. Her chest was symmetrical with regular respirations at a rate of 18 per minute. She spit up a small amount of blood-tinged sputum at 0900. At 0930 she had 180 milliliters of moderately dark red emesis. Her lungs were clear bilaterally for anterior and posterior sides of the chest. Her pulse oxygenation was at 94% on room air.

Indirect data. D.M. stated that the client could independently provide her own self-care at home. She said A.M. was fully independent when feeding herself, bathing herself, dressing herself, toileting by herself, mobilizing in and out of bed by herself, transferring herself, and ambulating herself. D.M. said she noticed that her mother wanted assistance from someone while shopping, cooking, and maintaining her home. D.M. stated that A.M. was recently depressed because of 2 recent deaths, so she does not necessarily need assistance, but "wants" assistance with those 3 activities. D.M. said A.M. did not use any assistive devices such as crutches, bedside commode, or walker at home. Although while in the hospital, the nurse told me that A.M. will need assistance of one person, and will need to use the bedside commode. D.M. said A.M.'s gait was usually normal, but recently she had noticed that her mom been kind of unsteady while walking.

Sleep-Rest

Subjective data. A.M. was sleeping during the time I had asked about sleeping, rest, and relaxation patterns.

Objective data. While A.M. was sleeping I noticed that her respirations were still regular and they only slightly decreased to about 16 per minute.

Indirect data. D.M. explained that A.M. did not have normal sleeping habits. She stated that A.M. gets about 6 to 8 hours of sleep, but does not go to sleep at a normal time and does not wake up at a normal time. She said that A.M. naps throughout the day because that is when she sleeps the best and feels most rested after waking up. D.M. stated her mother sleeps the worst at night and never wakes up feeling rested. D.M. denied A.M. of having insomnia, and that A.M. never uses any methods to promote sleep, just simply goes to sleep when she is tired.

Cognitive-Perceptual

Subjective data. The client denied any numbness or tingling in the upper and lower extremities and was able to orient which limb I was lightly touching when her eyes were closed. She rated her pain as a 5 on a 0-10 intensity scale and said that it was constant mainly in her throat and when she swallowed because of her nasogastric tube in place. A.M. said the pain began when her nasogastric tube was put in and that nothing had been able to alleviate the pain. She said that her pain was constantly affecting her throat and increased whenever she swallowed. Also, the client complained of pain in her lower left abdomen while I was palpating the stomach.

Objective data. A.M. was alert and oriented to person, place, time, and situation. She was calm at first, but I noticed she was becoming anxious during her 0800 assessment. PERRLA. A.M. had strong right and left hand grasps, strong pedal and leg pushes bilaterally, and normal reflexes. I noticed the client had some trouble hearing me speak when I was on her left side, because she would try to turn her right side more towards me so she could hear me better. When I was on her right side she seemed like she could hear me fine and did not have to turn her head to hear me better. The client's touch and smell were within normal limits. Her ability to communicate, read, and speak was clear, along with her ability to make decisions. I noticed she was very anxious and was prominent on her choices and decisions when asked something, without hesitation.

Indirect data. D.M. stated A.M. had been forgetful lately, and had been putting items out of place where they did not originally go in her home. D.M. said had noticed A.M. was having a difficult time with short term memory; she didn't remember when she had new things explained to her and had difficulty understanding new things. D.M. stated that A.M. has impaired hearing in her left ear. They were going to go get her hearing aid on 2/8/11, but unfortunately her health issues that happened the day before prevented them from going to get A.M.'s hearing aid.

Self-Perception/Self-Concept

Subjective data. The client had stated many times during her morning assessment how she did not want anyone looking at her teeth, because of their appearance, they made her feel self-conscious.

Objective data. The client appeared anxious and somewhat tired during her 0800 assessment. She was lying in her bed, and around 0945 she fell asleep. She denied a bath. She did not have any redness of her face or muscle tenseness. She kept eye contact with me whenever speaking to her and answered questions readily.

Indirect data. D.M. told me A.M. was so tired and fell asleep due to insufficient sleep the night before and feeling exhausted. D.M. stated that A.M's normal anxiety level was usually a 10 on a 0 to 10 intensity scale. She said that A.M. is very anxious all the time and paranoid of other people. A.M. is always really nervous about other people's perceptions of her. She said that A.M. views herself negatively and is unsure if her current illness will result in a change of body function, structure, or image.

Role-Relationship

Subjective data. The client and D.M. both asked me when the doctor would be in to see them because they hadn't seen him all night. A.M. and D.M. had been wondering all night and day about the cause of A.M.'s GI bleed or if any surgery would be needed.

Objective data. The doctor never came in to see A.M. during the time I was caring for her. Even when I left the floor at 1200, the doctor had still not been in. Her daughter was in the room with A.M. the entire time I was there.

Indirect data. D.M. said A.M. lives alone, but the apartment she lives in has call lights in the bedrooms, bathrooms, and has a lifeline, or piece of technology she can push in case she needs immediate medical attention. A.M. used to be married, and is now divorced. She has had 3 children total. A.M. is currently retired. D.M. stated that A.M. gets support from her children and

one grandson, which helps her most often. A.M. has 8 grandchildren and 3 grandchildren. D.M. said A.M. used to love family interaction and seeing her great/grandchildren, but has been withdrawn the past couples months. D.M. informed me A.M. does not have many friends and because of her teeth, does not go out a lot; she would be completely alone if her family was not there for her.

Sexuality-Reproductive

Subjective data. Client was sleeping when I needed to ask questions about sexuality and reproductive systems.

Objective data. I did not notice any presence of lesions or rashes that could possibly signify presence of a sexually transmitted infection, or disease.

Indirect data. D.M. told me A.M. had 3 total children, and one of them had recently passed away. D.M. did not know any information regarding A.M.'s last menstrual period, menopause year, history of vaginal bleeding, last pap smear, history of sexually transmitted diseases, or any problems/concerns with sexual functioning.

Coping-Stress Tolerance

Subjective data. The client was sleeping when needed to ask questions about coping with stress.

Objective data. Like I stated before, A.M. seemed anxious during her assessment and due to the fact she did not know the cause of her GI bleed.

Indirect data. D.M. stated that A.M. will show signs like clenching her fists, rocking back and forth, biting her fingernails, and begin to cry when she is stressed. D.M. said the primary ways A.M. dealt with stress was by praying, calling her daughter, and reading the Bible. D.M. explained that A.M. will be friendly with other people, but might not directly look at them because she is so self-conscious about her teeth. A.M. was not worried about hospitalization

charges because, her daughter told me, they are covered under Medicaid and Medicare. D.M. informed me that A.M. had experienced 2 deaths within the past year, one being her husband she was divorced from, passed away in April and the other being her 2nd daughter who passed away in July from a brain tumor. D.M. was very hesitant to speak, and said she did not want to talk about the death of her father at all because it was too upsetting for her.

Value-Belief

Subjective data. The client was sleeping when asking questions on values and beliefs.

Objective data. I noticed A.M. had 2 necklaces with a Cross on each one.

Indirect data. Daughter said A.M. is very spiritual and is Catholic. She said A.M. used to go to church, but recently has not been going because of worry about what people will think about her appearance, including what people will think about her teeth. D.M. was unsure about her mother's religious restrictions or if she had any at all.

Laboratory Information & Diagnostic testing

Refer to Laboratory Results Table. No diagnostic tests were ordered at that time. A.M. only had a Type & Screen blood test ordered to see what her blood type and Rh factor was in case she would need a blood transfusion, if she lost too much blood. It was ordered that she got 2 units of packed red blood cells.

Medication Information

Refer to Medication Table.

Analysis

Priority Nursing Diagnosis #1

Nursing Diagnosis:	Risk for Complications of GI bleeding related to active fluid loss as evidenced by hemoptysis, hematemesis, and nasogastric tube with suctioning.
Short term Goal:	The client will not show any worsening signs or symptoms resulting from her GI bleed within the next four hours.

Interventions:	1. **Intervention:** Monitor vital signs, particularly blood pressure and pulse every 2 hours. 2. **Intervention:** Monitor gastric pH, maintaining it to less than 5, every 2 hours.
Evaluation of Goal:	The client's gastric pH remained less than 5 and her vital signs were within normal limits, no hypotension or further tachycardia was noted.
Long term Goal:	The nurse will manage complications of the client's GI bleeding during her hospital stay.
Interventions:	1. **Intervention:** Monitor for signs and symptoms of worsening GI bleeding such as nausea, hematemesis, blood in stool, decreased hematocrit or hemoglobin, hypotension, tachycardia, diarrhea, constipation, or anorexia as needed. 2. **Intervention:** Monitor for occult blood in gastric aspirates and bowel movement as needed.
Evaluation of Goal:	The client did not show any occult blood in gastric aspirates or bowel movements. The client did not show any further signs of worsening GI bleeding listed above, and the nurse did not note any further signs of GI bleeding by the end of her hospital stay.

**The interventions listed above are supported from Nursing Diagnosis Application to Clinical Practice Edition 13.*

Primary Nursing Diagnosis #2

Nursing Diagnosis:	Anxiety Related to threat to self-concept secondary to appearance as evidenced by anxiousness during assessment, client's statements of embarrassment about her teeth, and her daughter's explanation of A.M.'s worry about what other people think of her.
Short term Goal:	Client will report that her present level of anxiety has reduced to a 4 on a scale on 0-10 within 4 hours.
Interventions:	1. **Intervention:** Stay with the client reminding the client that feelings are not harmful as needed. 2. **Intervention:** Convey empathetic understanding to client with quiet presence, touch, allowing crying, or talking as needed. 3. **Intervention:** Provide reassurance that a solution can be found, such as dentures for example when the client is talking about her teeth, and as needed with other problems the client might vocalize about.
Evaluation of Goal:	The client showed a more relaxed body expression and reported that she felt less anxious, at about a 3 on anxiety level, with the hopes of finding solutions to the problems that cause her the most anxiety.
Long term Goal:	Client will express increased psychological and physiological comfort by end of hospital stay as evident by describing own anxiety and coping patterns that help best with reducing anxiety.
Interventions:	1. **Intervention:** Assess for unmet needs or expectations, encouraging recall and description of what the client experiences immediately before feeling anxious and as needed. 2. **Intervention:** Help the client to reduce or eliminate problematic coping mechanisms as needed.

	3. **Intervention:** When the client can learn, determine usual coping mechanisms such as reading, discussing problems, praying, or seeking social support as needed.
Evaluation of Goal:	The client discussed the coping patterns that work the best to reduce her anxiety, discussed problematic coping mechanisms she recognized were causing her more anxiety, reported her overall anxiety level decreased significantly, and she felt more comfortable with herself by the end of her hospital stay.

**The interventions listed above are supported from Nursing Diagnosis Application to Clinical Practice Edition 13.*

Resources

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