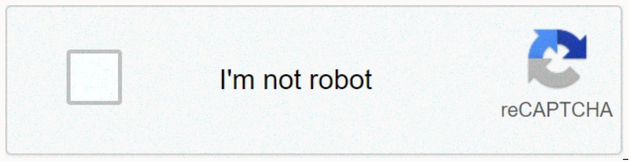

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Nursing diagnosis knowledge deficit related to smoking

~ Nursing Diagnosis, Results and Interventions home ~ Hypertension, or high blood pressure, is an issue that affects millions of people worldwide. If not treated properly, hypertension can lead to serious problems, including a heart attack or a heart attack. This means that it is mandatory to have an effective care plan as well as an accurate nursing diagnosis for hypertension. After explaining what hypertension is, what causes, and what common symptoms, this guide also explains six basic hypertension nursing diagnoses. For each diagnosis, the definition of NANDA is explained by potential evidence and the desired results, as well as steps to be taken for nursing intervention. Nursing Diagnosis for Hypertension: What is it? Normal blood pressure when blood pressure is 120/80 mmHg is often lower. When a patient diagnoses hypertension, the medical term for high blood pressure, blood pressure is 140/90 mmHg most of the time. Hypertension has several levels: Normal Blood Pressure: 120/80 Prehypertansion lower: 120-139/80-89 Scene 1 Hypertension: 140-159/90-99 Scene 2 Hypertension: 160+/100+ Hypertension, Heart work can be dangerous because it can increase the risk of heart failure, stroke and hardening, making it more difficult to pump blood into the body. What Causes Hypertension? The cause of hypertension is not often known. Primary (or essential) hypertension is when there is no known cause of hypertension or evidence to link it to a specific cause. Primary hypertension is about 90% of all hypertension cases. Secondary hypertension has an identifiable cause of high blood pressure. Potential causes of hypertension (primary or secondary) are: overweight or obese Smoking Genetics / hypertension family history A diet of salt consuming high 1-2 alcoholic beverages one day Stress Old Age exercise Deficiency Sleep apnea Kidney disease Thyroid disorders Thyroid disorders Signs and Symptoms of Hypertension Do not always cause symptoms; In fact, I don't know that about a third of people with hypertension exist because of any or several symptoms. Below are some of the most common symptoms of hypertension: Headache Ringing or buzzing in the ears Fatigue Irregular heartbeat Confusion or dizziness Nosebleed Blurred vision Difficult vision Chest pain Once nursing care plans for hypertension Blood for hypertension, it is important to follow the appropriate nursing diagnosis and nursing care plan for hypertension to reduce the effects of hypertension and maintain the patient's health and high quality of life. Below are six nursing care plans for hypertension. These six care plans cover the main issues related to hypertension. Each of them has its own nursing diagnosis, NANDA definition, possible evidence signs, results and nursing interventions. Use NANDA definition and potential evidence to determine the right nursing care plan for hypertension. Some patients may require more than one care plan. Diagnosis of Hypertension nursing #1: Reduced Cardiactic Flow Risk NANDA Definition: Insufficient blood pumped by the heart to meet the body's metabolic demands. Possibly Evidence: N/A. This intervention is used to prevent cardia flow reduction. Desired Results: Shows static cardiyak rhythm and speed. Maintain blood pressure at an acceptable interval. Take action that lowers blood pressure and cardiyak load. Interventions: Check the patient's laboratory data (cardiyak markers, blood cell count, electrolytes, ABGs, etc.) to identify contributing factors. Monitor and record blood pressure on both arms and thighs Measure blood pressure on both sides. Breath sounds and heart rhythm auscultation. Observe the patient's skin color, temperature and capillary filling time. If necessary, advise the patient on reducing sodium intake. Take medication if necessary. Hypertension Nursing Diagnosis #2: Acute Pain (Usually Headache) NANDA Definition: No matter what the person says, no matter what the pain is, whenever the person says it exists; an unpleasant sensory and emotional experience caused by actual or potential tissue damage, or described with an expected or predictable end and duration from mild to severe, with a sudden or slow intensity in terms of such damage. Probably Proven By: Throbbing pain at the beginning of patient reports, most often on awakening. Changes in appetite. The patient reports neck stiffness, blurred vision, dizziness, nausea and/or vomiting. Desired Results: The patient state that they no longer suffer from headaches and appear comfortable and painless. Interventions: Determination of the severity of pain, its characteristics such as where it is found and how long it has been going on. Pay attention to the patient's attitude to pain and the history of substance abuse. Promote rest during severe pain attacks. Recommend embossing methods such as neck and back massage, applying cold cloths to the forehead and avoiding bright lights. Limit how much the patient moves. Supply medicine if necessary. Diagnosis of Hypertension nursing #3: Definition of Activity Intolerance NANDA: Insufficient physiological or psychological energy to withstand or complete the necessary or desired daily activities. Probably Proven By: Patient reporting weakness or fatigue. Abnormal heart rate as a result of activity. Exertional discomfort or dyspnea. Isoemian electrocardiogram (ECG) changes; dysrrhythmia. Desired Results: The patient participates in the necessary and/or desired activities. It uses defined techniques to improve effectiveness tolerance. A measurable increase in tolerance to activity is reported. A signs of intolerance are noticed. Interventions: Pay attention to each of the factors that contribute to fatigue (age, health, disease, etc.). Evaluate the degree of activity intolerance of the patient and when it occurs. Monitor how the patient can respond to activity (pulse, heart rate, chest pain, dizziness, extreme fatigue, etc.). Explain energy protection techniques (shower chairs, sitting for brushing teeth, etc.). Assess emotional factors that may contribute to activity intolerance (such as depression or anxiety). Encourage the patient to engage in self-care and progressive activities as much as possible. Hypertension Nursing Diagnosis #4: Ineffective Coping NANDA Definition: Inability to make a valid assessment of stressors, inadequate options of applied responses and/or inability to use available resources. Probably By Proven By: Sick states can't handle it/she; the patient wants help. Don't worry, irritability, anxiety and/or depression as a result of the diagnosis of hypertension. Destructive behaviors such as overeeding, loss of appetite; Excessive smoking/alcohol and/or alcohol use Desired Results: The patient may determine ineffective coping techniques and consequences. Verbally inadulates awareness of their own coping abilities. Describes potential stressful situations and take steps to prevent or change them. It shows the use of effective coping skills. Interventions: Determine specific areas where the patient has difficulty coping. Assess the effectiveness of the patient's existing coping skills and where improvements can be made. It helps the patient to cope with certain stresses and how to deal with them. Work with the patient to develop a care plan and encourage participation in the plan. Help the patient identify and start planning the necessary lifestyle changes. Encourage the patient to assess their priorities and goals in life. Diagnosis of Hypertension nursing #5: Unbalanced Nutrition (More Than Body Needs) NANDA Definition: Intake of nutrients that exceed metabolic needs. Probably By Proven By: The patient's weight is ideally 10-20% more than his height and frame. Reported or observed dysfunctional eating habits. Desired Results: The patient understands the relationship between hypertension and obesity. Starts/maintains a suitable exercise program. It shows changes in eating habits, such as food selection and/or quantity, to reduce a healthier body weight. Interventions: Evaluate the patient's understand of the relationship between hypertension and obesity. Discuss the relationship between hypertension and obesity with the patient. Discuss reduced calorie intake, as well as limited salt, sugar and fat intake. Set the patient's desire to lose weight. Help the patient create a realistic exercise plan. Help the patient create a realistic nutrition plan. A feeding of the patient direct, if you Hypertension Nursing Diagnosis #6: Lack of Knowledge NANDA Definition: Absence or lack of cognitive information on a particular subject. Probably Proven By: Verbalization of the problem. Because the patient needs information or more information or doesn't understand the information provided. The patient follows the wrong instructions. The patient appears agitated, hostile or upset when the situation and ways to manage it are discussed. Desired Results: The patient can express his/her knowledge about hypertension management and treatment. The patient uses medication to correctly prescribe and understand the side effects. Interventions: Determine what information the patient currently understands. Assess being ready to learn and blocking. If possible, include the patient's partner. Explain the nature of hypertension, how it affects different parts of the body and how it can be treated. Avoid using the regular term BP. Instead, use the term good control to define the patient's BP within the desired limits. Discuss with patient changes to manage hypertension. Discuss the importance of maintaining a stable weight. Discuss the need for a low-calorie diet, order low sodium. It helps you create a program for the patient to take medication. Direct the patient to other resources that can be used to better understand and manage hypertension. Review: Diagnosis and Hypertension Hypertension Treatment, the medical term for high blood pressure, is an issue that can have serious and long-term health effects if not managed properly. Therefore, it is important to have an effective nursing care plan for hypertension. Although it is often difficult to determine the cause of hypertension, high blood pressure can cause weight, smoking, high sodium intake, and/or genetics, as well as other factors. Some symptoms of hypertension may include headache, dizziness, fatigue, difficulty breathing, and/or chest pain, although it does not show any symptoms in some patients with hypertension. There are six basic nursing diagnoses for hypertension. Risk of cardia flow Acute pain (usually headache) Activity intolerance Unbalanced nutrition (more than body requirements) It is important to know the information gap for each nursing diagnosis for hypertension, nanda definition, evidence possible symptoms, desired outcome and nursing interventions. What's next? Thinking of a career in health care? Read our full guide to obtaining a health management diploma, along with explanations of what levels of competence you need for different careers. Career.

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