

**Nanda nursing diagnosis pdf free pdf download online editor**

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**NURSING CARE PLAN**

| ASSESSMENT   | DIAGNOSIS                                       | INFERENCE   | PLANNING   | INTERVENTION  | RATIONALE   | EVALUATION  |
|--|---|---|--|---|---|---|
| <p>Subjective:</p> <p>"Natakatoko bigla na lang akong dingog" as verbalized by the patient.</p> <p>Objective:</p> <ul style="list-style-type: none"> <li>Restlessness.</li> <li>Increased tension.</li> <li>Feelings of helplessness.</li> <li>V/S taken as follows:<br/>T: 37.2<br/>P: 90<br/>R: 18<br/>Bp: 110/80</li> </ul> | <p>Fear related to change in health status.</p> | <ul style="list-style-type: none"> <li>Dysfunctional uterine bleeding is abnormal uterine bleeding in the absence of clinical or ultrasonographic evidence of structural abnormalities, inflammation, or pregnancy. Treatment is usually with oral contraceptives. Dysfunctional uterine bleeding (DUB), the most common cause of abnormal uterine bleeding, occurs most often in women &gt; 45 (&gt; 50% of cases) and in adolescents (20% of cases). The cause is usually estrogen</li> </ul> | <ul style="list-style-type: none"> <li>After 4 hrs. Of nursing interventions, the patient will report fear and anxiety are reduced to a manageable level.</li> </ul> | <p>Independent:</p> <ul style="list-style-type: none"> <li>Identify patient's perception of threat represented by the situation.</li> <li>Encourage patient to acknowledge and express fears.</li> <li>Provide opportunity for discussion of personal feelings or concerns and future expectations.</li> <li>Identify previous coping strengths of the patient and current areas of control or ability</li> </ul> | <ul style="list-style-type: none"> <li>Defines scope of individual problem, separate from physiological causes, and influences choice of intervention.</li> <li>Provides opportunity for dealing with concerns, clarifies reality of fears, and reduces anxiety level.</li> <li>Family members have individual responses to what is happening, and their anxiety may be communicated to patient, intensifying this emotion.</li> <li>Focuses attention on own capabilities, increasing sense of control.</li> </ul> | <ul style="list-style-type: none"> <li>After 4 hrs. Of nursing interventions, the patient was able to report fear and anxiety are reduced to a manageable level.</li> </ul> |

| NO | DATE | TIME | ASSESSMENT | INTERVENTION | EVALUATION |
|----|------|------|------------|--------------|------------|
| 1  |      |      |            |              |            |
| 2  |      |      |            |              |            |
| 3  |      |      |            |              |            |
| 4  |      |      |            |              |            |
| 5  |      |      |            |              |            |
| 6  |      |      |            |              |            |
| 7  |      |      |            |              |            |
| 8  |      |      |            |              |            |
| 9  |      |      |            |              |            |
| 10 |      |      |            |              |            |

| Diagnosa Keperawatan/<br>Masalah Kolaborasi   | Rencana keperawatan  |   |
|---|--|---|
|   | Tujuan dan Kriteria Hasil  | Intervensi  |
| <p><b>Bersihan Jalan Nafas tidak efektif</b> berhubungan dengan:</p> <ul style="list-style-type: none"> <li>Infeksi, disfungsi neuromuskular, hiperplasia dinding bronkus, alergi jalan nafas, asma, trauma</li> <li>Obstruksi jalan nafas : spasme jalan nafas, sekresi tertahan, banyaknya mukus, adanya jalan nafas buatan, sekresi bronkus, adanya eksudat di alveolus, adanya benda asing di jalan nafas.</li> </ul> <p>DS:</p> <ul style="list-style-type: none"> <li>Dispneu</li> </ul> <p>DO:</p> <ul style="list-style-type: none"> <li>Penurunan suara nafas</li> <li>Orthopneu</li> <li>Cyanosis</li> <li>Kelainan suara nafas (rales, wheezing)</li> <li>Kesulitan berbicara</li> <li>Batuk, tidak efektif atau tidak ada</li> <li>Produksi sputum</li> <li>Gelisah</li> <li>Perubahan frekuensi dan irama nafas</li> </ul> | <p>NOC:</p> <ul style="list-style-type: none"> <li>Respiratory status : Ventilation</li> <li>Respiratory status : Airway patency</li> <li>Aspiration Control</li> </ul> <p>Setelah dilakukan tindakan keperawatan selama .....pasien menunjukkan keefektifan jalan nafas dibuktikan dengan kriteria hasil :</p> <ul style="list-style-type: none"> <li>Mendemonstrasikan batuk efektif dan suara nafas yang bersih, tidak ada sianosis dan dispneu (mampu mengeluarkan sputum, bernafas dengan mudah, tidak ada pursed lips)</li> <li>Menunjukkan jalan nafas yang paten (klien tidak merasa tercekik, irama nafas, frekuensi pernafasan dalam rentang normal, tidak ada suara nafas abnormal)</li> <li>Mampu mengidentifikasi dan mencegah faktor yang penyebab.</li> <li>Saturasi O2 dalam batas normal</li> <li>Foto thorak dalam batas normal</li> </ul> | <ul style="list-style-type: none"> <li>Pastikan kebutuhan oral / tracheal suctioning.</li> <li>Berikan O2 .....l/mnt, metode.....</li> <li>Anjurkan pasien untuk istirahat dan napas dalam</li> <li>Posisikan pasien untuk memaksimalkan ventilasi</li> <li>Lakukan fisioterapi dada jika perlu</li> <li>Keluarkan sekret dengan batuk atau suction</li> <li>Auskultasi suara nafas, catat adanya suara tambahan</li> <li>Berikan bronkodilator ;<br/>- .....<br/>- .....<br/>- .....</li> <li>Monitor status hemodinamik</li> <li>Berikan pelembab udara Kassa basah NaCl Lembab</li> <li>Berikan antibiotik ;<br/>.....</li> <li>Atur intake untuk cairan mengoptimalkan keseimbangan.</li> <li>Monitor respirasi dan status O2</li> <li>Pertahankan hidrasi yang adekuat untuk mengencerkan sekret</li> <li>Jelaskan pada pasien dan keluarga tentang penggunaan peralatan : O2, Suction, Inhalasi.</li> </ul> |

**NANDA Nursing Diagnosis for Depression**

Depression is a state of low mood and aversion to activity that can have a negative effect on a person's thoughts, behavior, feelings, world view and physical well-being.

**Symptoms**

- Sadness
- Loss of interest or pleasure in activities you used to enjoy
- Change in weight
- Difficulty sleeping or oversleeping
- Energy loss
- Feelings of worthlessness
- Thoughts of death or suicide

Depressed people may lose interest in activities that once were pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details, or making decisions, and may contemplate or attempt suicide. Insomnia, excessive sleeping, fatigue, loss of energy, or other signs or depressive problems that are resistant to treatment may be present. They may feel sad, anxious, empty, hopeless, worried, helpless, worthless, guilty, irritable, hurt, or restless.

**Depression in women**  
Rates of depression in women are twice as high as they are in men. This is due in part to hormonal factors, particularly when it comes to premenstrual syndrome (PMS), premenstrual dysphoric disorder (PMDD), postpartum depression, and perimenopausal depression. As for signs and symptoms, women are more likely than men to experience pronounced feelings of guilt, sleeplessness, irritability, and loss of interest in work and hobbies. Other signs and symptoms of depression in men include anger, aggression, irritability, reckless behavior, and substance abuse. Even though depression rates for women are twice as high as those in men, men are a higher suicide risk, especially older men.

**Depression in men**  
Depression is a loaded word in our culture. Many associate it, however wrongly, with a sign of weakness and excessive emotion. This is especially true with men. Depressed men are less likely than women to acknowledge feelings of sadness and hopelessness, instead, they tend to complain about fatigue, irritability, sleep problems, and loss of interest in work and hobbies. Other signs and symptoms of depression in men include anger, aggression, irritability, reckless behavior, and substance abuse. Even though depression rates for women are twice as high as those in men, men are a higher suicide risk, especially older men.

**NANDA Nursing Diagnosis for Depression**

- Risk for self-directed violence / Risk for Suicide
- Ineffective coping
- Hopelessness
- Social isolation

