N431 Care Plan #1

Lakeview College of Nursing

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Demographics (3 points)

Date of Admission	Patient Initials	Age	Gender
6-09-2021	N.P.	86	Female
Race/Ethnicity	**Occupation**	**Marital Status**	**Allergies**
Caucasian	Retired	Single	No Known Allergies (NKA)
Code Status	**Height**	**Weight**	
DNR	5'6"	122.2lbs	

Medical History (5 Points)

Past Medical History: Hypertension, Anemia, Depression, Anxiety, Asthma, Chronic Obstructive Pulmonary Disease, Hypothyroidism. Type 2 Diabetes. Hyperlipidemia. Osteoarthritis. Atrial Fibrillation

Past Surgical History: Tubal ligation.

Family History: No known issues on the paternal side. Patient reports mother having a history of heart disease.

Social History (tobacco/alcohol/drugs): Patient reports smoking tobacco. She reports smoking a pack a day for over 20 years. The patient has not smoked for the last two years. She denies the use of smokeless tobacco. She denies the use of illegal drugs. She denies the use of alcohol.

Assistive Devices: N/A

Living Situation: Patient lives at home alone. Her son checks on her once a week. Her daughter-in-law helps her with bathing at home.

Education Level: The patient has a high school education.

Admission Assessment

Chief Complaint (2 points): "I just don't feel good."

History of present Illness (10 points):

On June 9th, 2021, the client reports waking up and feeling not well. She remembers getting out of bed and feeling strange. She explained this feeling as "I felt so tired and just not like myself." This feeling was all over her body and not defined to just one spot or area. She said it was constant. She described this sensation as just being tired and lethargic. The client said she called her son to tell him, and he would be over shortly. She rested on the couch and avoiding moving too much. She said that moving made it seem worse. She reports having her son take her to the emergency department for treatment, and then she was admitted to the hospital.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Acute Blood Loss Anemia

Secondary Diagnosis (if applicable): N/a

Pathophysiology of the Disease, APA format (20 points):

Anemia is defined strictly as a decrease in the client's red blood cell (RBC) mass. The function or purpose of the red blood cells is to deliver the needed oxygen from the lungs and to the tissues and transport carbon dioxide from the tissues back to the lungs. This is achieved by utilizing hemoglobin (Hgb), known as a tetramer protein. It is known that hemoglobin helps to carry hydrogen ions and carbon dioxide in addition to carrying oxygen. For anemia, a decrease in the number of red blood cells carrying oxygen and carbon dioxide thus impairs the body's ability for proper gas exchange. The reduction may result from acute or chronic blood loss, increased destruction of the red blood cells, or a situation in which the body has decreased RBCs. In men, anemia is typically defined as a lab hemoglobin level of less than 13.5 gram/100 ml and then in women as a lab hemoglobin of less than 12.0 gram/100 ml (Pagana et al., 2018).

There are many signs and symptoms seen with anemia. That is due to the many different forms of anemia. This student nurse will only be focusing on those caught with acute blood loss anemia. It is noted that some clients with anemia may have virtually no symptoms. Those who do have symptoms may feel rather tired, become easily fatigued, have a pale appearance, possess a feeling of a heart-racing episode, feel short of breath, and have a concerning worsening heart problem (Hinkle & Cheever, 2018). My client has the feeling of tiredness as she said that was the main reason for the trip to the hospital.

Anemia can be detected with a blood test called a complete blood cell count (CBC). The one performed initially on my client showed decreased red blood cells, hemoglobin, and hematocrit. These are typical values seen with someone who is experiencing acute blood loss anemia. The provider will look at these values and will continue to monitor them to adjust the treatment. The treatment for anemia varies greatly and depends on the particular cause of the anemia.

First, the underlying cause of their anemia needs to be identified and then corrected. If the client suddenly loses a high blood volume, they may be treated with specific fluids, a blood transfusion, oxygen, and possibly even iron to help their body build new red blood cells. In doing this, the medical team will continue to monitor the CBC to see an increase and if it was effective. Chronic blood loss is often treated by identifying the source of bleeding, stopping the bleeding, and, if necessary, providing a secondary treatment for iron deficiency anemia (Hinkle & Cheever, 2018).

Pathophysiology References (2) (APA):

Hinkle, J.L., & Cheever, K. H. (2018). *Brunner & Suddarth's textbook of medical-surgical nursing* (14th ed.). Wolters Kluwer Health Lippincott Williams & Wilkins.

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

Laboratory Data (15 points)

CBC Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason for Abnormal Value
RBC	3.80-5.30 10(6)/mcL	3.37	4.0	An insufficient supply of healthy red blood cells due to Anemia. Can also be due to excessive bleeding (Pagana et al., 2018).
Hgb	12.0-15.8 g/dL	8.3	9.8	An insufficient supply of healthy red blood cells due to Anemia. Also, bone marrow problems due to the possibility of cancer can cause a decrease in Hgb (Pagana et al., 2018).
Hct	36.0-47.0%	26.9	29.2	An insufficient supply of healthy red blood cells due to Anemia. Can also be due to Vitamin or mineral deficiencies. (Pagana et al., 2018).
Platelets	140-440 10(3)/mcL	257	304	
WBC	4.00-12.00 10(3)/mcL	3.50	3.80	A decreased WBC count can be caused by the possibility of cancer or other diseases that damage bone marrow (Pagana et al., 2018).
Neutrophils	47.0-73.0%	59.1	68.7	
Lymphocytes	18.0-42.0%	27.2	23.1	
Monocytes	4.0-12.0%	10.0	8.0	
Eosinophils	0.0-5.0%	2.6	2.1	
Bands	45-74	N/a		

Chemistry Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab	Normal Range	Admission Value	Today's Value	Reason For Abnormal
Na-	133-144 mmol/L	140	141	
K+	35-5.1 mmol/L	3.7	3.9	
Cl-	98-107 mmol/L	103	99	
CO2	21-31 mmol/L	37	30	It is caused by hypoventilation or disordered breathing where not enough oxygen enters the client's lungs and not enough carbon dioxide is emitted. The client has a possible cancerous mass in her lungs and is a former smoker (Pagana et al., 2018).
Glucose	70-99	83	92	
BUN	7-25 mg/dL	18	17	
Creatinine	0.50-1.00 mg/dL	0.7	0.66	
Albumin	3.5-5.7 g/dL	3.6	4.1	
Calcium	8.6-10.3 mg/ dL	9.1	9.2	
Mag	1.6-2.6 mg/dL	1.6	1.9	
Phosphate	2.8 to 4.5 mg/dL	N/A		
Bilirubin	0.2-0.8 mg/dL	N/A		
Alk Phos	34-104 U/L	58	59	
AST	13-39 U/L	14	15	

ALT	7-52 U/L	9	14	
Amylase	23-85 units per liter (U/L)	N/A		
Lipase	11-82 U/L	N/A		
Lactic Acid	0.5-2.0 mmol/L	N/A		
Troponin	0.000-0.040 ng/mL	N/A		
CK-MB	5 to 25 IU/L.	N/A		
Total CK	22 to 198 U/L	N/A		

Other Tests Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
INR	0.8-1.1	N/A		
PT	11-12.5 sec	N/A		
PTT	60-70 sec	N/A		
D-Dimer	<0.4 mcg/ML	N/A		
BNP	<100 pg/ml	N/A		
HDL	40 mg/dL or higher	N/A		
LDL	<100 mg/dL	N/A		
Cholesterol	<200 mg/dL	N/A		
Triglycerides	<150 mg/dL	N/A		
Hgb A1c	4-5.6%	N/A		
TSH	0.5-5.0 mlU/L	3.3	3.4	

Urinalysis Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Lab Test	Normal Range	Value on Admission	Today's Value	Reason for Abnormal
Color & Clarity	No range	N/A		
pH	5.0-9.0	N/A		
Specific Gravity	1.003-1.030	N/A		
Glucose	negative	N/A		
Protein	negative	N/A		
Ketones	negative	N/A		
WBC	0-5/hpf	N/A		
RBC	0-2/hpf	N/A		
Leukoesterase	negative	N/A		

Arterial Blood Gas Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Today's Value	Explanation of Findings
pH	7.35-7.45	N/A	
PaO2	80-100 mmHg	N/A	
PaCO2	35-45 mmHg	N/A	
HCO3	22.0-26.0	N/A	

SaO2	95-100%	N/A	

Cultures Highlight All Abnormal Labs—Explanations must be in complete sentences and contain in-text citations in APA format.

Test	Normal Range	Value on Admission	Today's Value	Explanation of Findings
Urine Culture	No growth	N/A		
Blood Culture	No growth	N/A		
Sputum Culture	No growth	N/A		
Stool Culture	No growth	N/A		

Lab Correlations Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest Xray on 6-20-2021

Diagnostic Test Correlation (5 points): An ill-defined region approximately 5.8 x 3.8cm mass in the right perihilar region. This mass has not changed in size since 12-18-2019. This is worrisome for neoplastic process (Pagana et al., 2018). The patient wants to not attempt to treat or further examine the mass. The client understands the situation as it has been explained to her by the physician and is not wanting to treat it.

Diagnostic Test Reference (1) (APA):

Pagana, K. D., Pagana, T. J., & Pagana, T. N. (2018). *Mosby's diagnostic and laboratory test reference* (14th ed.). Mosby.

Current Medications (10 points, 1 point per completed med)
10 <u>different</u> medications must be completed

Home Medications (5 required)

Brand/ Generic	duloxetine - Cymbalta	levothyroxine - Synthroid	Insulin Aspart - Novolog	Ipratropium-albuterol - DuoNeb	spironolactone - Aldactone
Dose	35 mg	70 mcg	12 units	3 mL	50 mg
Frequency	4 x daily	every morning before breakfast	4x daily	4 x daily PRN	daily
Route	Oral	Oral	Subcutaneous	Nebulization	Oral
Classification	Anti-depressant	Thyroid hormone replacement	Insulin	Bronchodilator	diuretic
Mechanism of Action	Inhibits dopamine, and serotonin to elevate the client's mood	Replaces thyroid hormone by controlling DNA and protein synthesis	Stimulates glycogen synthesis	Stimulates adenyl cyclase	Attaches to receptors within the walls of the cells preventing sodium and water reabsorption
Reason Client Taking	Depression	Hypothyroidism	Diabetes	COPD	Hypertension
Contraindications (2)	Hepatic insufficiency; uncontrolled angle-closure glaucoma	Acute MI; adrenal insufficiency	Low blood sugar, hypersensitivity	Hypersensitivity to atropine; hypersensitivity to any components	Acute renal insufficiency; hyperkalemia
Side Effects/Adverse Reactions	Agitation; Restlessness	Hot flash; arrhythmias	weight gain, swelling in the client's hands or feet.	Body aches; and a cough	Diarrhea; whole muscle weakness

(2)					
Nursing Considerations (2)	Do not give in patients with severe renal impairment; Avoid stopping the medication abruptly.	Monitor blood glucose; Not to be used for weight loss.	Monitor glucose levels; educate on how to administer the medication properly.	Use caution in patients with hepatic or renal diseases; use caution in patients with narrow-angle glaucoma	May crush and mix with an approved syrup for patients who have trouble swallowing; Evaluate blood pressure for effectiveness
Key Nursing Assessment(s)/ Lab(s) Prior to Administration	Monitor serum sodium level; Obtain baseline blood pressure	assess the TSH level.	Check the blood glucose prior to administration. Follow the prescribed instructions.	Assess the client's respirations and lung sounds. Check the O2 percentage.	Evaluate potassium level; evaluate the baseline blood pressure
Client Teaching needs (2)	Do not chew or crush; Avoid excess alcohol consumption.	Take at least thirty minutes before breakfast; take with a full glass of water.	Inject before meals; store at room temperature or in fridge if approved.	Effects should last 5 hours; do not expose this product to the eyes	Take with meals or milk; avoid hazardous activities as effects are unknown.

Hospital Medications (5 required)

Brand/Generic	simvastatin - Zocor	Calcium- carbonate (Vitamin D)	warfarin - Coumadin	enoxaparin (Lovenox)	metoprolol succinate (Toprol-xl)
Dose	20 mg	600-200 mg	7 mg	80 mg	25 mg
Frequency	every evening	Daily	every evening	Every 24 hrs	Daily
Route	Oral	Oral	Oral	Subcutaneous	Oral
Classification	Anti-hyperlipidemic	Calcium replacement	Anticoagulant	antithrombotic	Antihypertensive
Mechanism of	Interrupts the	increases	Prevents	binds with and	stimulates beta

Action	pathway for cholesterol synthesis causing less to form	intracellular and extracellular calcium to maintain homeostasis	coagulation by interfering with vitamin k dependent clotting factors	inactivates clotting factors	receptor sites to decrease cardiac excitability
Reason Client Taking	hyperlipidemia	Vitamin D deficiency & bone density replacement	Atrial Fibrillation	Thin blood/ prevent clot	hypertension
Contraindications (2)	Active hepatic disease; breastfeeding	hypercalcemia; hypophosphatemia	Bleeding or bleeding tendencies; severe hepatic or renal disease	active major bleeding; thrombocytopenia	acute heart failure; cardiogenic shock
Side Effects/Adverse Reactions (2)	Abdominal pain; heartburn	hypotension; irregular heartbeat	Loss of consciousness ; weakness	bloody stools; dyspnea	back pain; blurred vision
Nursing Considerations (2)	Use cautiously in elderly patients; Give 1 hour before or 4 hours after giving bile sequestrant	Store at room temperature; protect from heat, moisture, and direct light	Avoid IM injections; monitor for bleeding	do not give via IM injection; watch closely for bleeding	use cautiously in patients with angina or hypertension; monitor patients with peripheral vascular disease
Key Nursing Assessment(s)/Lab(s) Prior to Administration	Obtain liver enzymes; monitor lipoprotein level	Check serum calcium level	Negative pregnancy test result; Monitor PT-INR	serum potassium level. Check Pt-INR.	Assess ECG
Client Teaching needs (2)	Take drugs in the evening; follow a low-fat diet	Shake bottle well before each use if liquid; take separate from other prescribed drugs	Take drugs exactly as prescribed; Do not take 2 doses at once if you miss one	do not rub the site after giving injection; Do not expel air bubble.	take with food at the same time each day; notify the provider if pulse is lower than 60 beats/min

Medications Reference (1) (APA):

2019 Nurse's drug handbook (Eighteenth edition. ed.). (2019). Jones & Bartlett Learning.

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert x3 Oriented x3 No apparent distress Appearance is appropriate.
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score:** 14 **Drains present: Y☐ N[redacted]** **Type:**	 Pale, No jaundice. Dry and Intact. Warm to touch <3 seconds None A bruise on her lower left leg. None None N/A
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Midline and symmetrical Clean; no hearing devices used by client. Wears glasses; good extraocular movements. midline, no drainage. No abrasion or edema. Teeth and gums appear healthy and intact. Tongue is slight red. Client reports having a dry mouth at times.
CARDIOVASCULAR (2 points): **Heart sounds:** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N [redacted] Edema Y ☐ N [redacted]** **Location of Edema: N/A**	 Clear S1, S2; no murmur, gallop, or rub detected. 3+ bilateral pulses. <3 seconds No edema noted.
RESPIRATORY (2 points):	

Accessory muscle use: Y☐ N ■ **Breath Sounds: Location, character**	Diminished breath sounds. No labored breathing. Regular respiratory pattern. Lung aeration is equal.
GASTROINTESTINAL (2 points): **Diet at home:** **Current Diet** **Height:** **Weight:** **Auscultation Bowel sounds:** **Last BM:** **Palpation: Pain, Mass etc.:** **Inspection:** **Distention:** **Incisions:** **Scars:** **Drains:** **Wounds:** **Ostomy: Y ☐ N ■** **Nasogastric: Y ☐ N ■** **Size:** **Feeding tubes/PEG tube Y ☐ N ■** **Type:**	Normal Diet. Normal Diet. 5'6" 122.2lbs Able to auscultate in all four quadrants. Bowels are normoactive. Pt stated "yesterday." Inspection is normal. No distention, incisions, scars, drains, or wounds.
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ■** **Dialysis: Y ☐ N ■** **Inspection of genitals:** **Catheter: Y ☐ N ■** **Type:** **Size:**	yellow No strong odor noted. 150 mL Most recent. Did not inspect genitals.
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☐ N ☐** **Fall Risk: Y ■ N☐** **Fall Score: 35** **Activity/Mobility Status:** **Independent (up ad lib) ■** **Needs assistance with equipment ☐**	Nail bed is slight pink color. Skin warm to touch. Client is independent but with standby assistance. She is considered a fall risk due to age and medical conditions. ROM is active. Strength – 5 (Normal) in all areas. No use of supportive devices.

Needs support to stand and walk☐	
NEUROLOGICAL (2 points): **MAEW: Y ☐ N☐** **PERLA: Y ☐ N☐** **Strength Equal: Y ☐ N ☐** **if no -** **☐ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	Client is orientated to person, place, situation, and time. Normal cognition. Speech is clear. No LOC.
PSYCHOSOCIAL/CULTURAL (2 points): **Coping method(s):** **Developmental level:** **Religion & what it means to pt.:** **Personal/Family Data (Think about home environment, family structure, and available family support):**	Speaks with her pastor, talks with her son. Cognitive. Client can read and write. The client can form a full structured sentence. Latter-Day Saints; Helps her with coping. Very spiritual. Client receives support from her son; talks on the phone with other family members frequently and receives care from her son and daughter-in-law. Client can make decisions on her own but likes to have her son involved.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0800	**80**	**134/68**	**16**	**97.0**	**95% on 3L**
1100	**82**	**136/72**	**17**	**97.4**	**96% on 3L**

Vital Sign Trends: Trend is stable.

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0800	Numerical 1-10	**Lower Back**	**3**	**“It feels tight.”**	**Vitals checked, Informed the**

					nurse, and administered PRN Tylenol.
1100	Numerical 1-10	**N/A**	**0**	**"Not in pain right now."**	**N/A**

IV Assessment (2 Points)

IV Assessment	**Fluid Type/Rate or Saline Lock**
Size of IV: **Location of IV:** **Date on IV:** **Patency of IV:** **Signs of erythema, drainage, etc.:** **IV dressing assessment:**	**The client does not have an IV currently.**

Intake and Output (2 points)

Intake (in mL)	**Output (in mL)**
500ml – Oral **640ml – Oral**	**300ml – Urine** **150ml - Urine**

Nursing Care

Summary of Care (2 points)

Overview of care: The nurse will continue with current plan of care. The client and her family are waiting to hear back from case management to see what happens next. Will continue to monitor vitals and pain. The student nurse and registered nurse will continue to monitor the CBC and watch for signs and symptoms of infection. The health care staff will also continue to promote a safe and welcoming environment for the client to express her feelings on the current situation.

Procedures/testing done: No – Client declined further testing. The team wanted to do a colonoscopy.

Complaints/Issues: The client had no issues or complaints during the clinical.

Vital signs (stable/unstable): Vitals were stable.

Tolerating diet, activity, etc.: Client is tolerating diet and prefers soft foods and liquids. The client is a standby assist when out of bed. The client's activity level is important to her as she wants to return home.

Physician notifications: The physician wants to speak with case management and her son as he is not sure he feels safe allowing her to return home alone.

Future for patient: The nurse will continue with the current treatment plan. We are still awaiting news from case management.

Discharge Planning (2 points)

Discharge location: Still being determined.

Home health needs (if applicable): N/a

Equipment needs (if applicable): N/a

Follow up plan: Client will need to follow up with primary care physician.

Education needs: Depends on what happens. Safety at home may be a teaching point. If the client goes to hospice or a nursing home, information to her and her family on the program plan and what to expect.

Nursing Diagnosis (15 points)
Must be NANDA approved nursing diagnosis and listed in order of priority

Nursing Diagnosis • Include full nursing diagnosis with "related to" and "as evidenced by" components	**Rational** • Explain why the nursing diagnosis was chosen	**Intervention (2 per dx)**	**Evaluation** • How did the patient/family respond to the nurse's actions? • Client response, status of goals and outcomes, modifications to plan.
Impaired gas exchange related to decreased hemoglobin, red blood cells, and hematocrit as evidenced by the client being on a 3L nasal cannula and 02 reading of 95%.	Client has a history of smoking, COPD, and Asthma. She has decreased RBC, Hct, and Hgb from anemia. Airway and breathing are the top priority.	1.Careful monitoring of vitals and oxygen. Will assess respirations and monitor for complications. 2. Monitor CBC, looking primarily at RBC, Hgb, and Hct.	Vitals will be taken per facility policy. The nurse and student nurse have been monitoring lab values and will continue to watch for changes. The nursing team will report to the provider if needed for any changes. Client is compliant and understand the importance of these steps. Goal met.
Fatigue related to decreased hemoglobin and diminished oxygen-carrying capacity of the blood, as evidenced by the inability to maintain the usual level of physical activity.	The main reason the client went to the hospital was because she was fatigued. This is a huge safety risk for someone who is older and living alone.	1.Assist the client in developing a schedule for daily activity and rest. Stress the importance of frequent rest periods. 2. Monitor CBC, looking mostly at RBC, Hgb, and Hct.	The nurse and student nurse explained the importance of conserving energy and planning activities. The client understands and agrees. The client understands to call for assistance and she understands why she is a standby assist when out of bed. The health care team will continuously monitor for changes in lab values. Goal met.
Risk for infection related to chronic diseases as evidenced by low white blood cell count.	The clients white blood cell count is low. She is at an increased risk for infection because of this low lab value. She has multiple respiratory diseases and is not currently in a good state of health.	1. Continuous monitoring of CBC. 2.Education on proper hand washing, avoiding crowds, and ill people.	The student nurse and registered nurse provided education on the importance of taking precautions based on her WBC count. The health care team will continue to monitor for changes in the client's CBC. Goal met.
Anxiety related to current health situation and condition as evidenced by provider not feeling comfortable allowing the client to	The provider does not feel comfortable with her returning home alone. She has been	1.Assist the client to explore feelings and welcome conversation about the current	The nurse and nursing student provided a calm, supportive environment and allowed the client to express her feelings and concerns

return home alone.	denied from hospice and she is not wanting to go to the nursing homes. Client has also been diagnosed with anxiety and depression.	situation. 2. Make a referral to psychiatry if appropriate per hospital policy.	about the current situation. Case management is involved and trying to find the best plan of action. If appropriate, the nurse can inquire with the physician about a psych consult. This might be appropriate as the client is facing a challenging situation of what to do next. Goal met.

Other References (APA):

Concept Map (20 Points):

Subjective Data

"I felt so tired and just not like myself."

“I do not want to go to a nursing home.”

“I know that I need someone in the room with me to get out of bed because I can get weak.”

Nursing Diagnosis/Outcomes

Impaired gas exchange related to decreased hemoglobin, red blood cells, and hematocrit as evidenced by the client being on a 3L nasal cannula and 02 reading of 95%.
OUTCOME – Client maintains an oxygen saturation of 92% or greater.

Fatigue related to decreased hemoglobin and diminished oxygen-carrying capacity of the blood, as evidenced by the inability to maintain the usual level of physical activity.
OUTCOME – Client can plan out her ADL’s and show how she can conserve energy.

Risk for infection related to chronic diseases as evidenced by low white blood cell count.
OUTCOME – Client can teach back the information on neutropenic precautions.

Anxiety related to current health situation and condition as evidenced by provider not feeling comfortable allowing the client to return home alone.
OUTCOME – Client can freely talk about feelings and become involved in plan of care.

Objective Data

Chest Xray – Mass found back in 2019 but has not changed in size. It is still at risk for neoplastic process.

Decreased WBC count.
Decreased Hemoglobin
Decreased Hematocrit
Decreased Red blood Cell count.

Patient Information

The client is an 86-year-old female who lives at home alone. She was admitted to the hospital with Acute Blood Loss Anemia.

Nursing Interventions

1.Careful monitoring of vitals and oxygen. Will assess respirations and monitor for complications.
2. Monitor CBC, looking primarily at RBC, Hgb, and Hct
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.Education on proper hand washing, avoiding crowds, and ill people.

Assist the client to explore feelings and welcome conversation about the current situation.

2. Make a referral to psychiatry if appropriate per hospital policy.