N321 Care Plan #1

Lakeview College of Nursing

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Approved: 1/6/2021

Demographics (3 points)

Date of Admission 10/06/21	**Patient Initials** M.P	**Age** 77	**Gender** Female
Race/Ethnicity Caucasian	**Occupation** Retired	**Marital Status** Widowed	**Allergies** Acetaminophen, amoxicillin, aspirin, azelastine nasal, azithromycin, cephalexin, erythromycin, ibuprofen, Keflex, Maalox, morphine, Mylanta, oxytetracycline, penicillin, Pepcid, prevaad, sulfa drugs, triamanolone
Code Status Full Code	**Height** 5’4	**Weight** 65.2kg	

Medical History (5 Points)

Past Medical History: Acute UTI, Allergic conjunctivitis, Cobalamin deficiency, COPD, dehydration, fatigue, generalized anxiety disorder, HF w/ reduced ejection fraction, hyperlipidemia, mitral valve regurgitation, myocardial infarction, polio, post-polio myelitis syndrome, pressure ulcer of right foot stage 2, thyroid nodule, tobacco abuse, vitamin D deficiency, CHF

Past Surgical History: cholecystectomy laparoscopic possible cholangiogram; abdominal hysterectomy; cesarean section

Family History: Patient is unaware of her mother and father’s medical history

Social History (tobacco/alcohol/drugs): Tobacco: smokes about 10 or more cigarettes a day; Alcohol: Denies drinking; Drugs: Denies using

Assistive Devices: No assistive devices

Living Situation: Lives alone but has daily assistance and home nurses come to check on her and help her with daily living.

Education Level: Finished high school

Admission Assessment

Chief Complaint (2 points): Abdominal pain and SOB

History of present Illness (10 points): The patient was recently discharged and about last week the patient stated she was experiencing abdominal pain and trouble breathing (SOB). The patient that the location of her abdominal pain was around her gallbladder and in the middle of her stomach. She stated that the pain lasted pretty long and would randomly occur. With the abdominal pain, she was nauseous and achy. Some aggravating factors she stated was moving and sometimes the pain occurred by just laying down. Relieving factors were applying pressure and heat. The patient stated that she sometimes took ibuprofen.

Primary Diagnosis

Primary Diagnosis on Admission (2 points): Anemia

Secondary Diagnosis (if applicable): N/A

Pathophysiology of the Disease, APA format (20 points): Anemia is a condition when there is an insufficient amount of oxygen delivered to body tissues is also lessened due to a decrease of red blood cells. In this case, the patient has pernicious anemia which is due to bad absorption of vitamin B12 from the GI tract which is required in the formation of red blood cells (MayoClinic, 2019). Vitamin B is very important to the body, without it, it can affect hematopoiesis and the neurotransmitters (Capriotti, 2020). Risk factors of pernicious anemia is a diet with little to no natural vitamin food sources, pregnancy, intestinal problem such as surgery, (this patient recently

had her gallbladder removed), alcohol abuse, and certain prescription medications. Signs and symptoms, you will see in someone who has vitamin B anemia will include fatigue, exercise intolerance, dyspnea, weakness, and tachycardia (MayoClinic, 2019). This patient came into the ED complaining of dyspnea and fatigue, which are common indictors for pernicious anemia. On Monday the 11th, the patient showed no signs of tachycardia, but she did complain of being tired. According to Capriotti, “symptoms can develop slowly over time,” especially seen in nervous system changes like numbness and tingling can occur (Capriotti, 2020). During a physical examination, you should be aware of the skin, looking for pallor and at the palms of the hand, inspecting the tongue, listening for tachycardia, assessing the cranial nerves, assessing deep tendon reflexes, and changes mental changes such as depression (Capriotti, 2020). Diagnostic tools are important to be to distinguish pernicious anemia due to the very similar symptoms of other anemic disorders. When diagnosing be sure to pay attention to the CBC, looking for low hemoglobin, low hematocrit, low RBCs and high MCV. Other blood test such as bilirubin and antibody test can help determine pernicious anemia (MayoClinic, 2019). Pharmacological treatments include the administration of vitamin B 12 and hydroxocobalamin which replenishes the body stores, before administration be sure to assess folic acid levels (Capriotti, 2020). On Monday the 11th, she was not receiving any vitamin B12.

Pathophysiology References (2) (APA):

Capriotti, T. (2020). Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives. F.A. Davis.

Vitamin deficiency anemia (2019). *Mayo Clinic*. https://www.mayoclinic.org/diseases-conditions/vitamin-deficiency-anemia/diagnosis-treatment/drc-20355031

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	**3.90-4.98**	**3.06**	**4.13**	When a person has anemia, it is due to low red blood cell.
Hgb	**12.0-15.5**	**6.7-7.3**	**10.9**	Due to having anemia it is common to be lower than 12 when anemic *(Capriotti, 2020).*
Hct	**35-45**	**21.2-23.6**	**33.8**	
Platelets	**140-400**	**202**	**133**	Platelets are in RBC's, due to low RBC's, it can cause low platelet levels *(Capriotti, 2020).*
WBC	**4.0-9.0**	**4.7**	**4.8**	
Neutrophils	**40-70**	**79.2**	**57.7**	Increased neutrophils are due to an infection, but in this case, it could be due to the patient being a smoker or an noninfectious inflammation (hiatal hernia or bilateral pleural effusion). *(Morris, 2018).*
Lymphocytes	**10-20**	**12.6**	**24.0**	
Monocytes	**2-8**	**2.5**	**8.5**	Increased monocytes are due to infection, but I am not sure why this patient will have high monocytes.
Eosinophils		**N/A**	**N/A**	
Bands		**N/A**	**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-	**135-145**	**142**	**141**	

K+	**3.5-5.1**	**3.6**	**4.0**	
Cl-	**98-107**	**108**	**111**	High chloride is due to dehydration and heart failure which this patient has a history of heart failure and dehydration *(LabTestOnline, 2021*).
CO2	**22-29**	**18**	**25**	Low CO2 could be due to dehydration (*Capriotti, 2020*).
Glucose	**70-99**	**144**	**95**	High glucose levels without having diabetes can be due to have an illness or infection or a surgery. This patient recently had her gallbladder removed and suffers from polio and anemia *(MayoClinic*).
BUN	**6-20**	**21**	**15**	
Creatinine	**0.50-1.00**	**0.83**	**0.55**	
Albumin	**3.5-5.2**	**3.0**	**N/A**	Low albumin can be due to anemia (*Capriotti, 2020*).
Calcium	**8.4-10.5**	**7.1**	**7.1**	Low calcium is from a vitamin D deficiency which the patient has (*Capriotti, 2020*).
Mag	**1.3-2.1**	**N/A**	**N/A**	
Phosphate		**N/A**	**N/A**	
Bilirubin	**0.3-1.0**	**N/A**	**N/A**	
Alk Phos	**30-120**	**192**	**N/A**	Due to a gallbladder problem and this patient recently had her gallbladder removed (*Capriotti, 2020).*
AST	**0-32**	**15**	**N/A**	
ALT	**0-33**	**15**	**N/A**	
Amylase		**N/A**	**N/A**	
Lipase		**N/A**	**N/A**	
Lactic Acid		**N/A**	**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		**N/A**	**N/A**	
PT		**N/A**	**N/A**	
PTT		**N/A**	**N/A**	
D-Dimer		**N/A**	**N/A**	
BNP		**N/A**	**N/A**	
HDL		**N/A**	**N/A**	
LDL		**N/A**	**N/A**	
Cholesterol		**N/A**	**N/A**	
Triglycerides		**N/A**	**N/A**	
Hgb A1c		**N/A**	**N/A**	
TSH		**N/A**	**N/A**	

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	**Clear Yellow**	**Light yellow; cloudy**	**N/A**	
pH	**5-9**	**6.5**	**N/A**	
Specific Gravity	**1.003-1.030**	**1.010**	**N/A**	
Glucose	**Negative**	**Negative**	**N/A**	
Protein	**Negative**	**Negative**	**N/A**	

Ketones	**Negative**	**Negative**	**N/A**	
WBC	**0-5**	**12**	**N/A**	Patient has acute ATI's.
RBC	**0-4**	**1**	**N/A**	
Leukoesterase	**Negative**	**Negative**	**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	**Negative**	**Negative**	**N/A**	
Blood Culture	**Negative**	**N/A**	**N/A**	
Sputum Culture	**Negative**	**N/A**	**N/A**	
Stool Culture	**Negative**	**Positive**	**N/A**	Due to the patient's polyps and hiatal hernia.

Lab Correlations Reference (1) (APA):

Lakeview College of Nursing, "Tab: Diagnostics: Lab"

Capriotti, T. (2020). Davis Advantage for pathophysiology: Introductory concepts and clinical perspectives. F.A. Davis.

Hypergylcemia. *Mayo Clinic*. https://www.mayoclinic.org/diseases conditions/hyperglycemia/symptoms-causes/syc-20373631

Lab Test Online (2021). https://labtestsonline.org/?s=

Morris, Y.S., (2018). Understanding Neutrophils: Function, Counts, and More. Healthline. https://www.healthline.com/health/neutrophils#high-levels

Diagnostic Imaging

All Other Diagnostic Tests (5 points): Chest X-ray: cardiomegaly and mild pulmonary edema

CT abdominal: bilateral pleural effusions

Echo: 40-45% ejection fraction

EGD: hiatal hernia, polyps, duodenitis

ECG: ventricular rate: 110; PR interval: 148; QRS duration: 124; P-R-T: 78-29; sinus tach and left atrial enlargement; **Abnormal**

Diagnostic Test Correlation (5 points): The bilateral pleural effusions show why the patient was having abdominal pain. The reasoning for a positive occult test would be due to a hiatal hernia and polyps.

Diagnostic Test Reference (1) (APA): Sarah Bush Cerner

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

Home Medications (5 required)

Brand/Generic	**Albuterol**	**Potassium chloride**	**Betamethasone topical**	**Diazepam**	**Protonix**
Dose	**90 mcg/ inhalation**	**20 mcg 1/2tab**	**1 application**	**5 mg 1 tab**	**40mg 1 tab**
Frequency	**2 puff Q6H, PRN**	**BID**	**BID**	**TID, PRN**	**Daily**
Route	**Inhalation**	**PO**	**Topical**	**PO**	**PO**
Classification	Androgenic bronchodilator; Beta2 agonists	Electrolyte cation; Electrolyte replacement	Glucocorticoid; Immunosuppressant (anti-inflammatory)	Benzodiazepine; anticonvulsant	Antiulcer agent; proton pump inhibitor
Mechanism of Action	Acts on beta 2 adrenergic	Potassium ions participate in a	Binds to intracellular	May potentiate effects of	Binds to an enzyme in the

	receptors to relax the bronchial smooth muscle. It also inhibits the release of immediate hypersensitivity mediators from mediators from cells, especially mast cells.	number of essential physiological processes, including the maintenance of intracellular tonicity; the transmission of nerve impulses; the contraction of cardiac, skeletal, and smooth muscle; and the maintenance of normal renal function.	glucocorticoid receptors and suppresses inflammatory and immune responses.	gamma-aminobutyric acid bind to specific benzodiazepine receptors in cortical and limbic areas of the CNS.	presence of acidic gastric pH, preventing the final transport of hydrogen ions into the gastric lumen
Reason Client Taking	COPD	Low potassium	Inflammation	Muscle relaxation	High risk of ulcers
Contraindications (2)	overactive thyroid gland; diabetes	Taking amiloride or triamterene; Acute dehydration	Hypersensitivity to betamethasone; live virus vaccines	Myasthenia gravis; hypersensitivity to diazepam	Hypersensitive or pregnant
Side Effects/Adverse Reactions (2)	Chest pain; dizziness	Nausea, vomiting; Hyperkalemia	Fatigue; Arrhythmias	Anxiety; Hypotension	Headache, abdominal pain
Nursing Considerations (2)	Monitor respiratory rate and oxygen saturation; Check lung sound before and after	Monitor for and report signs of GI ulceration; Monitor I&O ratio	Expect prescriber to order baseline ophthalmologic exam before; Determine if latent or active amebiasis has been ruled out.	Monitor patient for adverse effects; Use diazepam cautiously with patients that have hepatic impairment.	Monitor GI improvement and signs of hyperglycemia

Hospital Medications (5 required)

Brand/Generic	**Aspirin**	**Atorvastatin**	**Plavix**	**Famotidine**	**Furosemide**
Dose	**81mg 1 tab**	**40mg 2 tab**	**75mg 1 tab**	**20mg 1 tab**	**20mg 1 tab**

Frequency	**Daily**	**Daily**	**Daily**	**BID**	**Daily**
Route	**PO**	**PO**	**PO**	**PO**	**PO**
Classification	NSAID; Salicylate	HMG-CoA reductase inhibitor; Antihyper-lipidemia	Antiplatelet agent;	Antiulcer agent; Histamine- 2 blocker	Antihypertensive;
Mechanism of Action	Blocks activity of cyclooxygenase needed for prostaglandin which is important in inflammatory response. Acts on heat regulating center in the hypothalamus	Reduces plasma cholesterol and lipoprotein levels by inhibiting HMG-CoA reductase and cholesterol synthesis in the liver.	Clopidogrel is an inhibitor of platelet activation and aggregation through the irreversible binding of its active metabolite to the P2Y12 class of ADP receptors on platelets.	Reduces HCl formation by preventing histamine from binding with H2 receptors on the surface of partial cells.	Inhibits sodium and water reabsorption in the loop of Henle and increases urine formation.
Reason Client Taking	To prevent clots	Hyperlipidemia	Reduce an MI	Duodenitis	Treat HF
Contraindications (2)	Active bleeding; current or recent GI bleed	Active hepatic disease; Hypersensitivity to atorvastatin.	Hypersensitivity to Plavix; Increase risk for bleeding due to clotting disorder	Hypersensitivity to famotidine and other H2 receptor	Anuria and hypersensitivity to furosemide
Side Effects/Adverse Reactions (2)	Decreased iron blood level; confusion	Abnormal dreams; depression	Pale skin; seizure	Anxiety; dizziness	Dizziness and thromboembolism
Nursing Considerations (2)	Don’t crush and ask about tinnitus	Expect liver function test before and after;	Monitor patient for low platelet count;	Shake famotidine for 5-10 seconds; Instruct patient	Be aware of pt allergic and obtain pts weight before

		Tell patient to take at the same time every day.	Monitor for signs of bleeding	to avoid smoking or alcohol.	

Medications Reference (1) (APA):

Jones & Bartlett Learning. (2020). *2020 Nurses drug handbook.* Burlington, MA

Assessment

Physical Exam (18 points)

GENERAL (1 point): **Alertness:** **Orientation:** **Distress:** **Overall appearance:**	 Alert and responsive A&O X4 No visible signs of distress Overall appearance was appropriate
INTEGUMENTARY (2 points): **Skin color:** **Character:** **Temperature:** **Turgor:** **Rashes:** **Bruises:** **Wounds:** . **Braden Score: 14** **Drains present: Y☐ N ☒** **Type:**	 Skin color is usual for ethnicity Supple Warm Elastic turgor No rashes No bruises Very tiny ulcer on upper left hip Braden score:14
HEENT (1 point): **Head/Neck:** **Ears:** **Eyes:** **Nose:** **Teeth:**	 Normocephalic, no deviation of trachea No drainage, grey-pink tympanic membrane No drainage, symmetrical, pink conjunctiva No septum deviation, polyps, turbinate Patient has no teeth and does not wear dentures
CARDIOVASCULAR (2 points): **Heart sounds:** **S1, S2, S3, S4, murmur etc.** **Cardiac rhythm (if applicable):** **Peripheral Pulses:** **Capillary refill:** **Neck Vein Distention: Y ☐ N ☒** **Edema Y ☒ N ☐**	 S1/S2 heart sounds heard No murmur or gallops heard Steady rate and rhythm Peripheral pulses 3+ Capillary refill 2 sec Swelling on right foot

Location of Edema:	
RESPIRATORY (2 points): **Accessory muscle use: Y☐ N ☒** **Breath Sounds: Location, character**	No use of accessory muscles, unlabored, regular pattern and respirations Bilateral clear bronchovesicular breath sounds Equal lung aeration posterior and anterior
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:**	Diet at home is normal Current diet is a regular diet 162.6 cm 65.2 kg Hyperactive in all four quadrants Twice last night (3/29), Pt. pad appeared to have red/blood stains in the morning (3/29) Sharp pain upon palpation (LLQ, RLQ) Skin warm and color usual for ethnicity No distention observed No incisions observed No scars observed No drain observed No wounds observed
GENITOURINARY (2 Points): **Color:** **Character:** **Quantity of urine:** **Pain with urination: Y ☐ N ☒** **Dialysis: Y ☐ N ☒** **Inspection of genitals:** **Catheter: Y ☒ N ☐** **Type:** **Size:**	Light yellow Cloudy Unable to determine the amount of urine since external catheter was not on and the patient urinated in the bed Appropriate for age
MUSCULOSKELETAL (2 points): **Neurovascular status:** **ROM:** **Supportive devices:** **Strength:** **ADL Assistance: Y☒ N ☐** **Fall Risk: Y ☒ N☐** **Fall Score: 60** **Activity/Mobility Status:**	Nail bed pink, capillary refill: 3 sec on all four extremities Active ROM on two extremities No use of supportive devices Patient is unable to use legs Fall Score: 60 The patient is on bed rest

Independent (up ad lib) ☐ **Needs assistance with equipment** ☐ **Needs support to stand and walk** ☐	The patient denies the use of any assistive devices (wheelchair) to get around.
NEUROLOGICAL (2 points): **MAEW: Y ☒ N☐** **PERLA: Y ☒ N☐** **Strength Equal: Y ☐ N ☒ if no -** **Legs ☒ Arms ☐ Both ☐** **Orientation:** **Mental Status:** **Speech:** **Sensory:** **LOC:**	A&O X4 Cognition is appropriate Speech is clear and appropriate Sensory is appropriate Alert and awake answers questions appropriately
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):**	Patient is mature and is aware of their state of health. Patient lives at home alone and has daily care takers and home nurses visit every day. Her daughter is her main support system.

Vital Signs, 2 sets (5 points)

Time	Pulse	B/P	Resp Rate	Temp	Oxygen
0730	**70**	**104/42**	**18**	**36.6**	**98% room air**
1100	**72**	**100/54**	**18**	**97.5**	**98% room air**

Pain Assessment, 2 sets (2 points)

Time	Scale	Location	Severity	Characteristics	Interventions
0730	**numeric**	**N/A**	**0**	**N/A**	**N/A**
1100	**numeric**	**N/A**	**0**	**N/A**	**N/A**

IV Assessment (2 Points)

IV Assessment	Fluid Type/Rate or Saline Lock
Size of IV: 20 **Location of IV:** left wrist **Date on IV:** 10/08/21 **Patency of IV:** Patent **Signs of erythema, drainage, etc.:** No drainage or signs of phlebitis **IV dressing assessment:** No blood or redness	Saline lock Aspirated, flushes easily Dry and intact

Intake and Output (2 points)

Intake (in mL)	Output (in mL)
240 mL	**Unable to determine due to not having an external catheter. The patient just urinated on the bed.**

Nursing Care

Summary of Care (2 points)

Overview of care: Patient is stable and ANO x4. Patient had minimal complaints of abdominal pain throughout the shift. Patient reported pain a 0/10 on a numeric scale. Patient will be turned about every two hours to reduce the risk of making her ulcer worse. She received her morning medications which consisted of a Nicotine patch to help her nicotine cravings.

Procedures/testing done: The patient received an abdominal CT, an ECHO which revealed a heart ejection of 40-45%, a chest x-ray, an EGD for the abdominal pain, and a ECG.

Complaints/Issues: The patient expressed that she was not being heard or treated properly. She stated, “The nurses make it seem like I am lazy, since I do not want to be moved, but I know my limit and have tried previously.”

Vital signs (stable/unstable): Throughout the morning shift her vitals were stable.

Tolerating diet, activity, etc.: She tolerated her meals well, but did not like being turned, she insisted that she stayed lying on her left side. The nurse stated that the patient will sometimes refuse certain medications, other than this, she took her medications.

Physician notifications: On 10/11/2021, the physician stated that she stables enough to be discharged.

Future plans for patient: This patient will go back home under the supervision of home care workers and home nurses.

Discharge Planning (2 points)

Discharge location: After discharge the patient will go back home.

Home health needs (if applicable): The patient already has home health caregivers and a home nurse that help her with daily living.

Equipment needs (if applicable): The patient should be in a wheelchair or a power chair to get around, but the patient refuses and will continue to be on bedrest.

Follow up plan: The patient should meet with her primary doctor to check on her ulcer.

Education needs: This patient would need to be educated on the importance of being turned frequently.

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

Nursing Diagnosis	Rational	Intervention (2 per dx)	Evaluation
• Include full nursing diagnosis with "related to" and "as evidenced by" components	• Explain why the nursing diagnosis was chosen		• How did the patient/family respond to the nurse's actions? • Client response, status of goals and

			outcomes, modifications to plan.
1. Fatigue related to decreased hemoglobin as evidence by SOB.	Patient has low hemoglobin and has anemia which will explain her fatigue.	**1.** Assess the specific cause of fatigue. **2.** Monitor hemoglobin, hematocrit, RBC counts	1.Patient has anemia which could cause her fatigue and since she is bedridden, it can cause SOB upon movement. 2. On admission both the patients Hgb and RBC were low. By the 11th her RBCs went into normal range but her Hgb were still low.
2. Risk for bleeding related to low RBCs as evidence by anemia	The patient has anemia.	**1.** Monitor platelet count **2.**Monitor stool and urine for occult blood	1. Patient has a low platelet count, but physician was not worried. 2. Patient had a positive stool test due to hiatal hernia.
3. Decreased cardiac output related to inadequate RBC's pumped to the heart as evidence by low blood pressure.	This diagnosis was chosen because the patient has low blood pressure and pedal edema in the right foot.	1. Assess legs and feet every 4-6 hours 2. Monitor pulse oximetry	1. Patient did have some swelling in her right foot but did not want to be turned or further assessed. 2. The patients O2 was constantly in normal range never went below 95%.

Other References (APA):

Concept Map (20 Points):

Subjective Data

Chief complaint: Abdominal pain and SOB

- Patient stated the pain was near her gallbladder and her mid-stomach
- The patient stated that the pain is sharp and achy.
- The patient stated that she has pain along the right side of her ribs.

Objective Data

- Vital Signs
- Temp: 97.5
- Weight: 65.2kg
- Pulse: 72
- SpO2: 98% room air
- B/P: 100/54

Patient Information

A 77-year-old patient came to the ED with a history of polio, complaining of abdominal pain and trouble breathing (SOB). The patient that the location of her abdominal pain was around her gallbladder and in the middle of her stomach. She stated that the pain lasted pretty long and would randomly occur.

Nursing Diagnosis/Outcomes

1. **Fatigue related to decreased hemoglobin as evidence by SOB.**
- Patient has anemia which could cause her fatigue and since she is bedridden, it can cause SOB upon movement.
- On admission both the patients Hgb and RBC were low. By the 11th her RBCs went into normal range but her Hgb were still low.

2. **Risk for bleeding related to low RBCs as evidence by anemia**
- Patient has a low platelet count, but physician was not worried.
- Patient had a positive stool test due to hiatal hernia

3. **Decreased cardiac output related to inadequate RBC's pumped to the heart as evidence by low blood pressure.**
- Patient did have some swelling in her right foot but did not want to be turned or further assessed.
- The patients O2 was constantly in normal range never went below 95%.

Nursing Interventions

1. Assess the specific cause of fatigue
2. Monitor hemoglobin, hematocrit, RBC counts

1. Monitor platelet count
2. Monitor stool and urine for occult blood

1. Assess legs and feet every 4-6 hours
2. Monitor pulse oximetry