

Medications

1. Amlodipine 10 mg 1x a day
Pharm class: Calcium channel blocker. Antihypertensive.
Reason for taking: to control hypertension.
Nursing assessment: Assess BP because hypotension may occur.
2. Ferrous sulfate 324mg 2x a day. Pharm class: Hematinic. Antianemic nutritional supplement.
Reason client taking: to prevent iron deficiency based on recommended daily allowances.
Nursing assessment: Give iron tablets and capsuls with a full glass of juice or water.
3. Levothyroxine 88mg 1x a day. Pharm class: Synthetic thyroxine. Thyroid hormone replacement.
Reason client taking: To treat hypertension.
Nursing assessment: Expect to give drug IV if patient cant take tablets.
4. Losartan 100mg daily
Pharm Class: Angiotensin II receptor blocker.
Antihypertensive.
Reason client taking: To treat hypertension. Nursing consideration: Monitor BP and renal function studies as ordered to evaluate drug effectiveness.
5. Pantoprazole 40m daily - Pharm class: Proton pump inhibitor. Antilucer.
Reason client taking: to treat erosive esophagitis associated

Lab Values/Diagnostics

WBC - 47.81 - White blood cells are elevated to fight an infection/A reaction to a drug that increases white blood cell production (Capriotti & Frizzell, 2016).

Neutrophils – 42.96 - Pt’s neutrophils are high possibly due to physical or emotional stress and acute infection (Capriotti & Frizzell, 2016).

HGB –8.0 - Pt’s Hgb are low due to anemia (Capriotti & Frizzell, 2016).

HCT –26.2 - Pt’s Hct are low due to anemia (Capriotti & Frizzell, 2016).

Platelet – 634 – Pts platelets are high due to anemia. (Thrombocytosis) (Capriotti & Frizzell, 2016).

RBC – 2.96 - Pt’s RBC are low due to anemia (Capriotti & Frizzell, 2016).

Demographic Data**Date of Admission:10/27/21****Admission Diagnosis/Chief Complaint: weakness****Age:79****Gender: Female****Race/Ethnicity: White****Allergies: None****Code Status: Full****Height in cm: 157’2cm****Admission History**

79 y/o hypothyroidism, iron def anemia, and htn client came to the emergency department because of weakness and fatigue.

Medical History**Previous Medical History: Hypertension, Hyperlipidemia,****Prior Hospitalizations: N/A****Previous Surgical History: EGD/Colonoscopy, PR Lap, Cholecystectomy, PR LAP w/Cholangiography, w/o Bx****Social History: Never smoked or used smokeless tobacco. Does not use Alcohol.****Pathophysiology**

Disease process: Iron deficiency anemia occurs **when your body doesn't have enough iron to produce hemoglobin.** Hemoglobin is the part of red blood cells that gives blood its red color and enables the red blood cells to carry oxygenated blood throughout your body.

S/S of disease: Extreme fatigue, Weakness, Pale skin, Chest pain, fast heartbeat or shortness of breath, Headache, dizziness or lightheadedness, Cold hands and feet.

Method of Diagnosis: Iron-deficiency anemia is diagnosed by blood tests that should include **a complete blood count (CBC).** Additional tests may be ordered to evaluate the levels of serum ferritin, iron, total iron-binding capacity, and/or transferrin.

Treatment of disease: iron-deficiency anemia is treated with Iron supplements taken by mouth, Foods high in iron and foods that help your body absorb iron, Iron given through an intravenous (IV) infusion, and transfusions of red blood cells.

Active Orders

There are no current active orders on the patient at this time. Other than Monitoring labs; CBC, CMP

Physical Exam/Assessment

General: Pt appears alert and oriented x4 person, place, and day of week, groomed, and pain level is 0 out of 10.

Integument: Pt skin is warm, pink, and dry. Turgor normal, Pt has a Braden score of 21

HEENT:

- **Head and neck symmetrical, trachea midline no deviation, thyroid not palpable, no noted nodules. Bilateral carotid pulses palpable.**
- **Eyes bilateral sclera white, bilateral cornea foggy, conjunctive pink, no drainage.**
- **Nose septum midline turbinate's moist and pink.**
- **Mouth pharynx moist and pink, dentation good, and mucosa pink and moist with no lesions.**

Cardiovascular: Clear S1 and S2 heard without gallops or rubs. Peripheral pulses palpable. Capillary refill less than 3sec. No Edema noted.

Respiratory: Respirations are regular and even without laboring. Lungs sound are normal bilaterally no crackles rubs or wheezes. Some dyspnea on exertions.

Genitourinary: Urine is yellow and hazy in character. No pain with urination noted. No BM noted.

Diet at home is normal, current diet is regular, Abdomen is soft, and bowel sounds normal. No abdomen distention.

Musculoskeletal: Pt can perform ROM and ADL's independently slight weakness shown. Pt is unable to ambulate on her own without any assisting devices.

Neurological: Pt has positive MAEW and PERLA, strength was unequal with slight weakness on R side. Orientation normal with mental status ANO X4, speech understandable, sensory normal.

Most recent VS (include date/time and highlight if abnormal):

B/P: 110/57

TEMP: 36.6

PULSE: 77

RESPERATIONS: 18

O2: 96 ROOM AIR

Pain and pain scale used: 0 out of 10

<p align="center">Nursing Diagnosis 1</p> <p>Fatigue related to decreased hemoglobin as evidence by report of fatigue and lack of energy.</p>	<p align="center">Nursing Diagnosis 2</p> <p>Altered nutrition, less than body requirements, related to inadequate intake of essential nutrients.</p>	<p align="center">Nursing Diagnosis 3</p> <p>Risk for infection related to anemia as evidence by Increased WBC</p>
<p align="center">Rationale</p> <p>Pt is currently weak and tired a lot.</p>	<p align="center">Rationale</p> <p>Patient is currently tired and weak; she is on regular diet but is not eating a lot.</p>	<p align="center">Rationale</p> <p>Patients WBC are currently 47.81</p>
<p align="center">Interventions</p> <p>Intervention 1: Assist the client in developing a schedule for daily activity and rest. Stress the importance of frequent rest periods.</p> <p>Intervention 2: Educate energy-conservation techniques.</p>	<p align="center">Interventions</p> <p>Intervention 1: Diet. The nurse should encourage a healthy diet that is packed with essential nutrients.</p> <p>Intervention 2: Dietary teaching. Sessions should be individualized and involve the family members and include cultural aspects related to food preference and preparation.</p>	<p align="center">Interventions</p> <p>Intervention 1: Encourage intake of protein-rich and calorie-rich foods and encourage a balanced diet.</p> <p>Intervention 2: Encourage increased fluid intake unless contraindicated</p>
<p align="center">Evaluation of Interventions</p> <p>Asking the patient to rest would increase her energy for her daily activities. Goals met.</p>	<p align="center">Evaluation of Interventions</p> <p>Educating the patient on nutrition could increase her malnourishment. Goals met.</p>	<p align="center">Evaluation of Interventions</p> <p>Encouraging the patient to increase her fluid will prevent her from dehydration. Goals met.</p>

References (3) (APA):

Capriotti, T. (2016). *Davis Advantage for Pathophysiology: Introductory Concepts and Clinical Perspectives* (2nd ed.). F. A. Davis Company.

Jones & Bartlett Learning. (2020). *2021 Nurse's Drug Handbook* (20th ed.). Jones & Bartlett

Swearingen, P. L., & Wright, J. D. (2019). *All-in-one nursing care planning resource: medical-surgical, pediatric, maternity, and psychiatric-mental health*. St. Louis, MO: Elsevier.

