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Anemia during pregnancy Transition & follow-up

Midwifery & O.G. Nursing | Transition & follow-up

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

27-year-old pregnant woman with confirmed iron deficiency. Care stage: During planning for the next care setting after the team confirms clinical readiness.

Medical history: Fictional obstetric history: G2P1 at 28 weeks with confirmed iron deficiency. Previous birth was uncomplicated; current fatigue affects daily activity. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The woman requests respectful explanation and involvement of her chosen support person with consent. Assess access to maternity follow-up, nutrition, transport and infant-care support.

Scenario: The next care setting needs a clear handover and the patient or caregiver wants to know when to seek urgent review.

Clinical assessment

Subjective: Fatigue and breathlessness on exertion.

Objective findings and required checks: Pallor with low hemoglobin and iron assessment supporting deficiency.

Physical examination and investigations: Review blood count, iron assessment, diet, blood loss and gestation-specific clinical risk.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Anemia during pregnancy: Pregnancy increases iron requirements; deficiency reduces hemoglobin production.

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Medical / surgical management

Coordinate prescribed replacement, nutrition support and follow-up to document response.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed iron/folate	Treat identified pregnancy-related deficiency	Monitor adherence, gastrointestinal effects and response
alternative replacement if ordered	Treat selected intolerance or severity	Follow the maternity specialist plan.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Fatigue and breathlessness on exertion. Pallor with low hemoglobin and iron assessment supporting deficiency. The next care setting needs a clear handover and the patient or caregiver wants to know when to seek urgent review.

Nursing diagnosis

Prioritize nutritional intake below current needs; reduced circulation to vulnerable tissues; movement limited by weakness, discomfort or restriction; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

Before any clinically approved transition: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Coordinate prescribed replacement, nutrition support and follow-up to document response. Check unresolved risks, medicine reconciliation, practical support and follow-up before transition. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This

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vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Check unresolved risks, medicine reconciliation, practical support and follow-up before transition.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about usual diet, recent intake, weight change and food access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings.	Nutritional intake below current needs. Possible factors: poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Tolerates the agreed nutrition plan without new complications. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the individualized meal or feeding plan and follow-up arrangements.	1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate feeding route depends on clinical safety. 2. Offer suitable small meals or prescribed feeds with dietitian input when indicated. Rationale: Individualized support improves intake and nutrient adequacy. 3. Monitor tolerance, weight or growth and metabolic findings where required. Rationale: Progress and complications guide adjustment of support. 4. Coordinate prescribed replacement, nutrition support and follow-up to document response. Rationale: Pregnancy increases iron requirements; deficiency reduces hemoglobin production. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about dizziness, chest discomfort, fatigue and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	Reduced circulation to vulnerable tissues. Possible factors: altered blood flow or cardiac function. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately. Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: Before any clinically approved transition: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: Before any clinically approved transition: Explains the most important immediate	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Explain affordable iron-containing foods, administration instructions and repeat testing. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Explain affordable iron-containing foods, administration instructions and repeat testing.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Severe breathlessness, chest pain, syncope or bleeding requires urgent maternity review.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Pregnancy increases iron requirements; deficiency reduces hemoglobin production.

- Priority concerns: Nutritional intake below current needs; Reduced circulation to vulnerable tissues; Movement limited by weakness, discomfort or restriction; Learning needs about the condition and care plan.

- Severe breathlessness, chest pain, syncope or bleeding requires urgent maternity review.

- Explain affordable iron-containing foods, administration instructions and repeat testing.

Exam / viva: Which unresolved problem would delay transition, and what information must reach the next care team?

References

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