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Iron-deficiency anemia Initial assessment

Adult Health Nursing | Initial assessment

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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.

Clinical assessment

Subjective: Fatigue, exertional breathlessness and reduced exercise tolerance.

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

Physical examination and investigations: Review blood count, ferritin/iron assessment and evaluation of the cause, including blood loss when appropriate.

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

Clinical focus and pathophysiology

Iron-deficiency anemia: Insufficient iron limits hemoglobin production and oxygen transport.

Medical / surgical management

Support graded activity, prescribed iron replacement and investigation of the underlying cause.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks

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Medicine / treatment	Purpose	Nursing checks
Prescribed oral iron	Replenish iron stores	Explain gastrointestinal effects, interactions and safe storage
prescribed alternative replacement	Use when clinically indicated	Monitor according to the route and protocol.

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

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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: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

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 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: After the first indicated intervention, at the documented review time: 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. 4. Support graded activity, prescribed iron replacement and investigation of the underlying cause. Rationale: Insufficient iron limits hemoglobin production and oxygen transport. 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.
Ask: Ask about usual diet, recent intake, weight change and food	Nutritional intake below current needs. Possible factors:	Short-term: After the first indicated intervention, at the	1. Assess nutritional risk and confirm swallowing safety and any fasting order. Rationale: The appropriate	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
access. Assess: Assess growth or weight trends, intake record and relevant nutritional findings.	poor appetite, increased requirements or feeding difficulty. Validate against the patient's assessment.	documented review time: 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.	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.	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 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: After the first indicated intervention, at the documented review time: 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 what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale:	Record the baseline and reassessed finding, the time and whether this goal is met,

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
identify specific gaps.	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.	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. Teach iron-rich foods, medicine instructions, safe storage away from children and repeat testing. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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

Teach iron-rich foods, medicine instructions, safe storage away from children 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

Chest pain, syncope, severe breathlessness or active bleeding needs urgent assessment.

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

- Insufficient iron limits hemoglobin production and oxygen transport.

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

- Chest pain, syncope, severe breathlessness or active bleeding needs urgent assessment.

- Teach iron-rich foods, medicine instructions, safe storage away from children and repeat testing.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

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