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Acute childhood diarrhea Initial assessment

Child 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.

Patient profile and history

2-year-old boy with caregiver present. Care stage: At the first supervised assessment.

Medical history: The child developed acute loose stools and vomiting after previously normal feeding. The caregiver reports reduced drinking and fewer wet nappies. 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: A caregiver is available for teaching and assisted care. The family requests plain-language instructions, a practical feeding/activity plan and follow-up. Assess development, immunization record and safeguarding individually.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Several loose stools and vomiting with reduced drinking.

Objective findings and required checks: Hydration status requires structured assessment; urine and alertness are monitored.

Physical examination and investigations: Assess dehydration, weight, stool history, intake/output and tests when severe or atypical.

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

Clinical focus and pathophysiology

Acute childhood diarrhea: Intestinal illness increases fluid and electrolyte loss and can cause rapid dehydration in children.

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Medical / surgical management

Use the pediatric rehydration plan, continue age-appropriate feeding when tolerated and monitor response.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Oral rehydration solution	Replace suitable enteric losses	Mix exactly as instructed and monitor intake
zinc when prescribed under the local child-health guideline	Support diarrhea management	Verify age-appropriate prescription and course.

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

Nursing process - ADPIE

Assessment

Several loose stools and vomiting with reduced drinking. Hydration status requires structured assessment; urine and alertness are monitored. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize insufficient fluid replacement for current losses; bowel pattern disrupted by illness or reduced activity; nutritional intake below current needs; 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

After the first indicated intervention, at the documented review time: 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

Use the pediatric rehydration plan, continue age-appropriate feeding when tolerated and monitor response. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. 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: 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 thirst, intake, vomiting, stools and dizziness. Assess: Monitor weight trend, intake/output, mucosa, circulation and relevant electrolytes.	Insufficient fluid replacement for current losses. Possible factors: intake below requirements or increased fluid loss. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Hydration and circulation improve within the agreed reassessment interval. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver explains the individualized fluid plan and warning signs.	1. Measure intake and losses using age-appropriate methods. Rationale: Accurate trends guide replacement and help prevent overcorrection. 2. Offer oral fluids only when swallowing, consciousness and the treatment plan permit; otherwise implement prescribed replacement. Rationale: The safest route depends on aspiration risk and clinical severity. 3. Reassess perfusion, weight and laboratory trends after prescribed replacement. Rationale: Both continued dehydration and fluid overload require prompt recognition. 4. Use the pediatric rehydration plan, continue age-appropriate feeding when tolerated and monitor response. Rationale: Intestinal illness increases fluid and electrolyte loss and can cause rapid dehydration in children. 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 stool frequency, consistency, pain and usual bowel pattern. Assess: Assess abdominal findings, bowel records and signs of obstruction or dehydration.	Bowel pattern disrupted by illness or reduced activity. Possible factors: altered intake, motility or medicine effects. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Bowel-related discomfort decreases without new red-flag findings. Longer-term: Before the clinically approved transition or agreed follow-up: Describes an appropriate bowel routine and when to seek review.	1. Assess abdominal red flags before routine bowel measures. Rationale: Severe pain, distension or vomiting may indicate urgent pathology. 2. Support privacy, mobility and the prescribed food and fluid plan. Rationale: An individualized routine supports comfortable elimination. 3. Administer prescribed treatment and document stool response. Rationale: Response monitoring helps prevent undertreatment and adverse effects.	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 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: After the first indicated intervention, at the 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.	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.	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: After the first indicated intervention, at the documented review time:	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.	Explains the most important immediate 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. Teach safe ORS preparation, hand hygiene, continued feeding and warning signs; avoid unapproved antidiarrheal drugs. 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

Teach safe ORS preparation, hand hygiene, continued feeding and warning signs; avoid unapproved antidiarrheal drugs.

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

Lethargy, inability to drink, blood in stool, persistent vomiting or shock requires urgent pediatric 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

- Intestinal illness increases fluid and electrolyte loss and can cause rapid dehydration in children.

- Priority concerns: Insufficient fluid replacement for current losses; Bowel pattern disrupted by illness or reduced activity; Nutritional intake below current needs; Learning needs about the condition and care plan.

- Lethargy, inability to drink, blood in stool, persistent vomiting or shock requires urgent pediatric review.

- Teach safe ORS preparation, hand hygiene, continued feeding and warning signs; avoid unapproved antidiarrheal drugs.

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

References

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