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Childhood pneumonia 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

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

Medical history: The caregiver reports that the child was feeding and playing normally before this respiratory illness. No established chronic lung disease is reported. 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: Caregiver reports cough, fever, poor feeding and faster breathing.

Objective findings and required checks: Increased respiratory effort and reduced intake; use age-appropriate observations and equipment.

Physical examination and investigations: Assess age-specific respiratory signs, SpO2, hydration and investigations ordered for severity.

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

Clinical focus and pathophysiology

Childhood pneumonia: Lower respiratory infection causes inflammation and can impair gas exchange and feeding.

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Medical / surgical management

Follow the pediatric pneumonia pathway, support breathing and safe hydration, and provide prescribed treatment.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed pediatric antibiotic	Treat indicated bacterial pneumonia	Verify weight-based prescription, allergy and response
prescribed oxygen	Support the individualized oxygenation target	Use correct pediatric equipment and monitoring.

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

Nursing process - ADPIE

Assessment

Caregiver reports cough, fever, poor feeding and faster breathing. Increased respiratory effort and reduced intake; use age-appropriate observations and equipment. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize breathing difficulty affecting oxygenation; raised temperature increasing discomfort and fluid needs; insufficient fluid replacement for current losses; 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

Follow the pediatric pneumonia pathway, support breathing and safe hydration, and provide prescribed treatment. 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 breathlessness, chest tightness and activity tolerance. Assess: Record respiratory rate, effort, SpO2 and mental state against the prescribed target.	Breathing difficulty affecting oxygenation. Possible factors: altered ventilation or gas exchange. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Breathing effort improves and oxygenation remains within the individualized target. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the respiratory action plan and demonstrates the prescribed device technique.	1. Reassess work of breathing and response to each intervention. Rationale: Trend changes identify deterioration earlier than a single reading. 2. Position to ease breathing, cluster care and allow rest. Rationale: This can reduce respiratory demand and distress. 3. Give oxygen and respiratory medicines only according to the clinical prescription or emergency protocol. Rationale: Individualized treatment supports oxygenation without unsafe blanket targets. 4. Follow the pediatric pneumonia pathway, support breathing and safe hydration, and provide prescribed treatment. Rationale: Lower respiratory infection causes inflammation and can impair gas exchange and feeding. 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 chills, headache, intake and illness onset. Assess: Record temperature site, trend, hydration and other observations.	Raised temperature increasing discomfort and fluid needs. Possible factors: an inflammatory or infectious process. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Temperature-related discomfort improves and clinical deterioration is detected promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Explains monitoring, hydration instructions and warning signs for review.	1. Trend temperature together with circulation, breathing and mental state. Rationale: Temperature alone does not describe illness severity. 2. Provide comfortable clothing and fluids when permitted; avoid extreme cooling. Rationale: Supportive care reduces discomfort without provoking unnecessary stress. 3. Administer prescribed treatment and obtain ordered specimens using correct technique. Rationale: Cause-directed management and reliable samples support recovery.	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 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.	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 what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: 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.	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: 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 feeding support, medicine measurement, smoke avoidance and signs requiring immediate reassessment. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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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Health education and continuing care

Teach feeding support, medicine measurement, smoke avoidance and signs requiring immediate reassessment.

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

Apnea, cyanosis, severe chest indrawing, inability to drink or reduced responsiveness requires urgent help.

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

- Lower respiratory infection causes inflammation and can impair gas exchange and feeding.

- Priority concerns: Breathing difficulty affecting oxygenation; Raised temperature increasing discomfort and fluid needs; Insufficient fluid replacement for current losses; Learning needs about the condition and care plan.

- Apnea, cyanosis, severe chest indrawing, inability to drink or reduced responsiveness requires urgent help.

- Teach feeding support, medicine measurement, smoke avoidance and signs requiring immediate reassessment.

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

References

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