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Community anemia screening Comfort & daily function

Community Health Nursing | Comfort & daily function

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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

17-year-old girl attending a health session. Care stage: During supported recovery and essential daily activity.

Medical history: Fatigue prompted community screening. Diet, menstrual history and access to follow-up are reviewed privately and respectfully. 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 patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Clinical assessment

Subjective: Fatigue and uncertainty about an iron-rich diet.

Objective findings and required checks: Screening suggests anemia and requires appropriate confirmation and cause assessment.

Physical examination and investigations: Review hemoglobin assessment, diet, menstrual history with privacy and program referral criteria.

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

Clinical focus and pathophysiology

Community anemia screening: Low hemoglobin reduces oxygen transport; nutrition, blood loss and other causes must be considered.

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Medical / surgical management

Provide respectful nutrition counseling and coordinate confirmation, prescribed supplementation and follow-up.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed iron/folate	Treat or prevent deficiency under the applicable program	Verify age-specific regimen, side effects and safe storage
cause-specific treatment	Address the identified contributor	Avoid assuming all anemia is iron deficiency.

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 uncertainty about an iron-rich diet. Screening suggests anemia and requires appropriate confirmation and cause assessment. The patient or caregiver asks how to manage essential daily care without provoking symptoms or unsafe fatigue.

Nursing diagnosis

Prioritize nutritional intake below current needs; movement limited by weakness, discomfort or restriction; learning needs about the condition and care plan; difficulty sustaining the agreed treatment 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

During the next agreed care or activity session: 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

Provide respectful nutrition counseling and coordinate confirmation, prescribed supplementation and follow-up. Identify the safest achievable activity or comfort goal without overlooking the underlying illness. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met

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using observed evidence, document the review time and revise the plan. This 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: Identify the safest achievable activity or comfort goal without overlooking the underlying illness.

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: During the next agreed care or activity session: 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. Provide respectful nutrition counseling and coordinate confirmation, prescribed supplementation and follow-up. Rationale: Low hemoglobin reduces oxygen transport; nutrition, blood loss and other causes must be considered. 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 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: During the next agreed care or activity session: 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: 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: During the next agreed care or activity session: 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 accessible iron-containing foods, medicine instructions, menstrual concerns and follow-up testing. 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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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about missed treatment, side effects, cost and beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	Difficulty sustaining the agreed treatment plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	Short-term: During the next agreed care or activity session: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	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 accessible iron-containing foods, medicine instructions, menstrual concerns and follow-up 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, syncope, active bleeding or marked clinical deterioration needs urgent care.

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

- Low hemoglobin reduces oxygen transport; nutrition, blood loss and other causes must be considered.

- Priority concerns: Nutritional intake below current needs; Movement limited by weakness, discomfort or restriction; Learning needs about the condition and care plan; Difficulty sustaining the agreed treatment plan.

- Severe breathlessness, syncope, active bleeding or marked clinical deterioration needs urgent care.

- Teach accessible iron-containing foods, medicine instructions, menstrual concerns and follow-up testing.

Exam / viva: How can care preserve independence while staying within the patient's assessed limits?

References

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