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Severe acute malnutrition support 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

18-month-old boy admitted for nutritional care. Care stage: At the first supervised assessment.

Medical history: Poor intake, growth faltering and recent infections prompted specialist nutritional admission. Feeding and fluid care follow the supervised malnutrition pathway. 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 poor appetite, weight loss and recent infections.

Objective findings and required checks: Marked growth concern; assess edema, glucose, temperature, hydration and danger signs.

Physical examination and investigations: Use the local specialist malnutrition pathway for anthropometry, metabolic assessment and infection evaluation.

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

Clinical focus and pathophysiology

Severe acute malnutrition support: Severe nutrient deficiency alters immunity and metabolism and makes routine fluid/feeding approaches potentially unsafe.

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Medical / surgical management

Provide specialist phased feeding, thermal support and carefully prescribed hydration; monitor refeeding and infection risks.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed therapeutic feeds	Provide phased nutritional rehabilitation	Use the specialist schedule and monitor tolerance
prescribed micronutrients or medicines	Treat defined deficits or complications	Avoid unsupervised supplementation or rapid changes.

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 poor appetite, weight loss and recent infections. Marked growth concern; assess edema, glucose, temperature, hydration and danger signs. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize nutritional intake below current needs; blood glucose instability requiring close monitoring; vulnerability to infection or worsening infection; 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

Provide specialist phased feeding, thermal support and carefully prescribed hydration; monitor refeeding and infection risks. 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 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. 4. Provide specialist phased feeding, thermal support and carefully prescribed hydration; monitor refeeding and infection risks. Rationale: Severe nutrient deficiency alters immunity and metabolism and makes routine fluid/feeding approaches potentially unsafe. 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 intake, usual treatment and symptoms of low or high glucose. Assess: Check glucose using the prescribed schedule and assess consciousness and hydration.	Blood glucose instability requiring close monitoring. Possible factors: altered insulin effect, intake, illness or treatment. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Glucose moves toward the individualized target without treatment-related hypoglycemia. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates monitoring and explains the personalized sick-day and emergency plan.	1. Verify glucose findings and reassess symptoms rather than treating a number alone. Rationale: Symptoms and trends guide safe interpretation. 2. Coordinate prescribed medication with nutrition and monitor the response. Rationale: Mismatch between treatment and intake can cause dangerous glucose changes. 3. Follow the local emergency pathway for severe hypoglycemia or suspected ketoacidosis. Rationale: These conditions can progress rapidly and require urgent team 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.
Ask: Ask about exposure, wound symptoms and recent invasive devices. Assess: Inspect relevant sites and monitor systemic findings and investigation trends.	Vulnerability to infection or worsening infection. Possible factors: disrupted barriers, exposure or reduced host defence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Aseptic care is maintained and any new signs of infection are escalated promptly. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates relevant hygiene and explains the infection-prevention plan.	1. Use hand hygiene and risk-based standard or transmission precautions. Rationale: Interrupting transmission protects the patient, staff and other patients. 2. Review invasive device need with the team and maintain indicated aseptic care. Rationale: Unnecessary devices and barrier breaks increase infection exposure. 3. Monitor for systemic deterioration and administer prescribed antimicrobials on schedule. Rationale: Early escalation and timely indicated treatment reduce avoidable harm.	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 the supervised feeding and follow-up plan, hygiene, growth monitoring and access to nutrition services. 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 the supervised feeding and follow-up plan, hygiene, growth monitoring and access to nutrition services.

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

Hypoglycemia, hypothermia, shock, reduced consciousness or feeding intolerance requires immediate 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

- Severe nutrient deficiency alters immunity and metabolism and makes routine fluid/feeding approaches potentially unsafe.

- Priority concerns: Nutritional intake below current needs; Blood glucose instability requiring close monitoring; Vulnerability to infection or worsening infection; Learning needs about the condition and care plan.

- Hypoglycemia, hypothermia, shock, reduced consciousness or feeding intolerance requires immediate pediatric review.

- Teach the supervised feeding and follow-up plan, hygiene, growth monitoring and access to nutrition services.

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

References

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