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Childhood iron-deficiency anemia Comfort & daily function

Child 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.

Clinical assessment

Subjective: Fatigue, picky eating and reduced playfulness.

Objective findings and required checks: Pallor and laboratory-confirmed iron deficiency; growth and diet require review.

Physical examination and investigations: Review blood count, iron assessment, growth, diet and evaluation for blood loss or other causes.

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

Clinical focus and pathophysiology

Childhood iron-deficiency anemia: Insufficient iron limits hemoglobin production and oxygen delivery.

Medical / surgical management

Support prescribed iron replacement, suitable diet and follow-up to confirm response.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks

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Medicine / treatment	Purpose	Nursing checks
Prescribed pediatric iron	Replace iron stores	Verify weight-based prescription, administration advice and safe storage
no unsupervised dose changes	Prevent poisoning or undertreatment	Keep the product out of children's reach.

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: 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. Support prescribed iron replacement, suitable diet and follow-up to confirm response. Rationale: Insufficient iron limits hemoglobin production and oxygen delivery. 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 mobility, fatigue and help needed with	Movement limited by weakness, discomfort or restriction.	Short-term: During the next agreed care or activity session:	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching	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
activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	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.	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.	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: During the next agreed care or activity session: 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 identify specific	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching.	Short-term: During the next agreed care or activity session: Explains the most important immediate action in their own words. Longer-term:	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	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
gaps.	Validate against the patient's assessment.	Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach iron-containing foods, correct medicine measurement, expected effects and follow-up testing. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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-containing foods, correct medicine measurement, expected effects 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

Marked breathlessness, syncope, cardiac symptoms or suspected accidental iron ingestion requires 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

- Insufficient iron limits hemoglobin production and oxygen delivery.

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

- Marked breathlessness, syncope, cardiac symptoms or suspected accidental iron ingestion requires urgent care.

- Teach iron-containing foods, correct medicine measurement, expected effects and follow-up testing.

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

References

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

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https://www.indiannursingcouncil.org/gazette-notification

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