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Insufficient fluid replacement for current losses Acute childhood diarrhea

Child Health Nursing | Focused diagnosis-based template

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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: 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.

Medical / surgical management

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

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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.

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Focused nursing-problem template

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: At the next patient-specific reassessment: 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

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

Health conditions A to Z: external further reading - NHS
https://www.nhs.uk/conditions/

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Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

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