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Vulnerability to a fall or accidental injury Dehydration in an older adult

Nursing Foundation | 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: Thirst, dizziness on standing and drinking less than usual.

Objective findings and required checks: Dry mouth, reduced urine and postural symptoms; requires supervised assessment.

Physical examination and investigations: Review intake/output, weight, lying/standing observations when safe, renal function and electrolytes.

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

Clinical focus and pathophysiology

Dehydration in an older adult: Reduced intake and age-related vulnerability can lower circulating volume and disturb electrolytes.

Medical / surgical management

Assess circulation and swallowing; provide oral or prescribed intravenous replacement with frequent review.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed crystalloid	Replace fluid when oral intake is insufficient or unsafe	Monitor circulation, lung findings, urine and electrolyte trends
oral rehydration solution	Replace suitable oral losses	Prepare correctly and follow the individualized plan.

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 falls, dizziness, vision and usual walking aids. Assess: Assess gait, medicines, cognition and environmental risks.	Vulnerability to a fall or accidental injury. Possible factors: unsteady mobility, dizziness or environmental hazards. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: Transfers and essential activity occur without a fall during the care period. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates safe use of assistance and identifies home hazards.	1. Individualize fall precautions and keep necessary items and the call bell accessible. Rationale: Accessible support reduces unsafe unassisted movement. 2. Supervise transfers according to assessed need and check footwear and aids. Rationale: Correct assistance and equipment improve stability. 3. Review reversible contributors with the team, including postural symptoms and medicines. Rationale: Addressing causes improves safety beyond environmental measures. 4. Assess circulation and swallowing; provide oral or prescribed intravenous replacement with frequent review. Rationale: Reduced intake and age-related vulnerability can lower circulating volume and disturb electrolytes. 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

Plan accessible drinks if permitted, assistance with intake and early review for recurrent symptoms.

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

Urgent review for confusion, fainting, very low urine output or shock.

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

- Reduced intake and age-related vulnerability can lower circulating volume and disturb electrolytes.
- Priority concerns: Vulnerability to a fall or accidental injury.
- Urgent review for confusion, fainting, very low urine output or shock.
- Plan accessible drinks if permitted, assistance with intake and early review for recurrent symptoms.

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/

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

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B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council

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

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