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Bowel pattern disrupted by illness or reduced activity Household diarrhea and water safety

Community 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: Loose stools and concern that drinking water may be unsafe.

Objective findings and required checks: Hydration and household exposure require assessment; vulnerable members are identified.

Physical examination and investigations: Assess hydration, food/water history, cluster patterns and stool testing when clinically indicated.

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

Clinical focus and pathophysiology

Household diarrhea and water safety: Contaminated water, food or hands can transmit enteric pathogens.

Medical / surgical management

Treat individual illness under the local pathway and coordinate safe-water, sanitation and outbreak referral advice.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Oral rehydration solution	Replace suitable oral losses	Prepare correctly with safe water
prescribed treatment	Treat a defined indication	Antibiotics are not routine for every diarrheal illness.

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 stool frequency, consistency, pain and usual bowel pattern. Assess: Assess abdominal findings, bowel records and signs of obstruction or dehydration.	Bowel pattern disrupted by illness or reduced activity. Possible factors: altered intake, motility or medicine effects. Validate against the patient's assessment.	Short-term: At the next patient-specific reassessment: Bowel-related discomfort decreases without new red-flag findings. Longer-term: Before the clinically approved transition or agreed follow-up: Describes an appropriate bowel routine and when to seek review.	1. Assess abdominal red flags before routine bowel measures. Rationale: Severe pain, distension or vomiting may indicate urgent pathology. 2. Support privacy, mobility and the prescribed food and fluid plan. Rationale: An individualized routine supports comfortable elimination. 3. Administer prescribed treatment and document stool response. Rationale: Response monitoring helps prevent undertreatment and adverse effects. 4. Treat individual illness under the local pathway and coordinate safe-water, sanitation and outbreak referral advice. Rationale: Contaminated water, food or hands can transmit enteric pathogens. 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 handwashing, safe water storage, food hygiene and correct use of authorized water-treatment methods.

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 dehydration, blood in stool, persistent vomiting, shock or illness in a vulnerable infant requires urgent 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

- Contaminated water, food or hands can transmit enteric pathogens.
- Priority concerns: Bowel pattern disrupted by illness or reduced activity.
- Severe dehydration, blood in stool, persistent vomiting, shock or illness in a vulnerable infant requires urgent review.
- Teach handwashing, safe water storage, food hygiene and correct use of authorized water-treatment methods.

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 Mental Health and Community Concepts, 2e - Open RN / WisTech Open, 2025
https://wtcs.pressbooks.pub/nursingmhcc/

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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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