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Intravenous infusion monitoring Initial assessment

Nursing Foundation | 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

40-year-old man receiving a prescribed peripheral infusion. Care stage: At the first supervised assessment.

Medical history: A peripheral cannula was inserted for the current prescribed infusion. Local soreness is a new finding and requires assessment before further use. 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: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Soreness near the cannula and concern about the pump alarm.

Objective findings and required checks: Cannula site and infusion prescription require immediate review; no assumption of normal patency.

Physical examination and investigations: Assess site, limb, prescribed solution, rate, line connections and pump settings.

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

Clinical focus and pathophysiology

Intravenous infusion monitoring: Infiltration, phlebitis, infection or flow errors can injure tissue and alter treatment delivery.

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Medical / surgical management

Follow the local pathway for a painful or abnormal IV site; verify the prescription and escalate suspected complications.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed IV fluid	Meet an identified clinical requirement	Verify solution, rate, compatibility and fluid response
prescribed IV medicine	Deliver indicated treatment	Check dilution, compatibility, line and adverse reactions.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Soreness near the cannula and concern about the pump alarm. Cannula site and infusion prescription require immediate review; no assumption of normal patency. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize skin damage or vulnerability to pressure-related injury; vulnerability to infection or worsening infection; possible treatment-related harm requiring prompt assessment; 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

Follow the local pathway for a painful or abnormal IV site; verify the prescription and escalate suspected complications. 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 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 discomfort, usual mobility and ability to reposition. Assess: Inspect skin, pressure points, wound characteristics and moisture exposure.	Skin damage or vulnerability to pressure-related injury. Possible factors: pressure, moisture, impaired sensation or tissue injury. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Skin is protected and existing damage shows no avoidable deterioration. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates the individualized skin-protection plan.	1. Assess skin and pressure risk using the local tool and clinical judgment. Rationale: Risk identification guides targeted prevention. 2. Individualize repositioning, heel offloading and pressure redistribution. Rationale: Reducing sustained pressure and shear protects tissue perfusion. 3. Use appropriate wound care and moisture management; refer for nutrition or specialist advice when needed. Rationale: Healing requires local protection and support for underlying contributors. 4. Follow the local pathway for a painful or abnormal IV site; verify the prescription and escalate suspected complications. Rationale: Infiltration, phlebitis, infection or flow errors can injure tissue and alter treatment 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.

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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 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.
Ask: Ask about medicine names, timing, symptoms and non-prescribed products. Assess: Review observations, medication record and relevant drug-specific investigations.	Possible treatment-related harm requiring prompt assessment. Possible factors: adverse medication effects or an administration problem. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: The suspected adverse event is escalated and no further avoidable exposure occurs. Longer-term: Before the clinically approved transition or agreed follow-up: Explains the revised medication plan and warning symptoms before discharge.	1. Assess airway, breathing, circulation and the time course of symptoms. Rationale: Serious adverse reactions require immediate stabilization. 2. Escalate suspected toxicity and follow the authorized hold, monitoring or antidote instructions. Rationale: Treatment decisions depend on the drug and clinical severity. 3. Document and communicate the reaction and reconcile the medicine list. Rationale: Accurate records reduce repeat exposure and support pharmacovigilance.	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 reporting of pain, swelling, leakage and alarms; patients should request staff help rather than changing settings. 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 reporting of pain, swelling, leakage and alarms; patients should request staff help rather than changing settings.

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

Pain with swelling, blistering, spreading redness, breathing difficulty or systemic reaction requires prompt escalation.

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

- Infiltration, phlebitis, infection or flow errors can injure tissue and alter treatment delivery.

- Priority concerns: Skin damage or vulnerability to pressure-related injury; Vulnerability to infection or worsening infection; Possible treatment-related harm requiring prompt assessment; Learning needs about the condition and care plan.

- Pain with swelling, blistering, spreading redness, breathing difficulty or systemic reaction requires prompt escalation.

- Teach reporting of pain, swelling, leakage and alarms; patients should request staff help rather than changing settings.

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

References

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