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Vulnerability to infection or worsening infection Intravenous infusion monitoring

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: 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.

Medical / surgical management

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

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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.

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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 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: At the next patient-specific reassessment: 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. 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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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 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: Vulnerability to infection or worsening infection.

- 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: 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

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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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