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Vulnerability to infection or worsening infection Wound dressing and healing

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: Local tenderness and uncertainty about changing the dressing.

Objective findings and required checks: Wound edges and exudate require documented assessment; no systemic instability in this scenario.

Physical examination and investigations: Assess wound dimensions, tissue, drainage, pain and infection signs; review glucose or cultures when indicated.

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

Clinical focus and pathophysiology

Wound dressing and healing: Healing depends on tissue perfusion, protection from contamination and adequate nutrition.

Medical / surgical management

Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed analgesic	Support comfortable wound care	Assess timing and effect
prescribed antimicrobial	Treat clinically diagnosed infection when indicated	Check allergy and response rather than routine use.

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. Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers. Rationale: Healing depends on tissue perfusion, protection from contamination and adequate nutrition. 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 dressing protection, hand hygiene, nutrition and the wound review schedule.

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

Spreading redness, increasing pain, wound separation, heavy bleeding or systemic illness needs 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

- Healing depends on tissue perfusion, protection from contamination and adequate nutrition.
- Priority concerns: Vulnerability to infection or worsening infection.
- Spreading redness, increasing pain, wound separation, heavy bleeding or systemic illness needs urgent review.
- Teach dressing protection, hand hygiene, nutrition and the wound review schedule.

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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