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AIDS

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for infection *Related factors:* Inadequate primary defenses. Tissue destruction Broken skin *Symptoms / Risk factors:* Refers to actual diganosis *Outcome / Goal:* Risk for infection reduced through treatment Achieve timely wound healing		**Infection Control** Assess client knowledge Wash hands before and after all care contacts Monitor vital signs_____ Examine skin and oral mucous membranes for white patches or lesions Administer antibiotics per os or IV as indicated Monitor effects of medication _____	
	Risk for imbalanced fluid volume *Related factors:* Fluid loss. Nausa Hypermetabolic state, fever Vomiting *Symptoms / Risk factors:* decreased skin/tongue turgor low bloodpressure tachycardia Weakness *Outcome / Goal:* Maintain adequate fluid balance while hospitalized Maintain normal blood pressure, pulse, and body temperature Maintain urine output more than 1300 mL/day		**Fluid Management** Provide fluid po if prescribet Give anti-emetic drugs as prescribet Maintain intravenous infusion as prescribed Measure intake and output;weigh _____ Monitor and record patient's intake (IV) and output (urin) Monitor vital signs Assess skin turgor, mucous membranes, and thirst Monitor Lab tests such as electrolytes	
	Risk for imbalanced nutrition: Insufficient *Related factors:* Increased losses from evaporation Frequent loose bowel movements Vomiting Hypermetabolic state, fever *Symptoms / Risk factors:* Weight loss *Outcome / Goal:* Hydration maintained Adequate urinary output Normal vital sign		**Nutritional Monitoring** Assess ability to chew, taste, and swallow. Auscultate bowel sounds weight_____ **Nutrition Therapy** Assess current timing and content of meals. Consult a dietitian Promote client participation in dietary planning as possible Administer enteral or parenteral feedings, as indicated Inspect oral mucosa and client's appetite Keep client nothing-by-mouth (NPO) status, as indicated Encourage as much physical activity as possible Administer medications, as indicated, for example: Antiemetics Weight as indicated	
	Ineffective breathing pattern *Related factors:* Anxiety Musculoskeletal impairment Respiratory muscle fatigue Retained secretions—tracheobronchial obstruction *Symptoms / Risk factors:* Cough Cyanosis Dyspnea Use of accessory muscles to breathe *Outcome / Goal:* Maintain adequate ventilation		**Respiratory Monitoring** Auscultate breath sounds Asses preexisting respiratory conditions Asses O2 saturation and arterial blood gases Elevate head and encourage frequent position changes Monitor for increased restlessness, anxiety, and air hunger Monitor rate, rhythm, depth, and effort of respirations Obs. lab results of electrolytes (Na(136-146),K(3,6-4,9) Suction nares and oropharynx carefully as needed Assist with and instruct in use of incentive spirometer Administer medications, as indicated	

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AIDS

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for injury *Related factors:* Abnormal blood profile *Symptoms / Risk factors:* Tissue hypoxia *Outcome / Goal:* Display homeostasis		**Bleeding Precautions** Monitor vital signs and detect any signs of bleeding Maintain a safe environment Hematest body fluids—urine, stool, and vomitus—for occult blood Administer blood products, as indicated	
	Acute pain *Related factors:* Inflamed skin Persistent coughing Necrosis *Symptoms / Risk factors:* Crampy pain Abnormal Bowel sounds Expressive behavior (e.g., restlessness, moaning, crying) Verbal or coded report *Outcome / Goal:* Patient appears relaxed and comfortable Patient verbalizes relief of pain and spasm		**Pain Management** Asses cause of pain Encourage ambulation and independence as tolerated Encourage client to report pain Evaluate pain level frequently. Maintain comfortable environmental temperature Provide diversional activities, such as reading and watching Television Note factors that aggravate and relieve pain Obs vital signs_____ Optimize the patient's comfort in bed Administer medication as prescribet Obs. pain (effectivnes of medication)	
	Impaired skin integrity *Related factors:* Physical immobilization Immunological deficit *Symptoms / Risk factors:* Disruption of skin and tissue surface decubitus ulcer formation *Outcome / Goal:* Display timely wound healing without complications.		**Skin Surveillance** Provide foam, flotation, or alternate pressure mattress or bed Apply skin moisturizers to maintain suppleness and prevent cracking and fissures Change patient position regularly Inspect patient's skin every shift, document skin condition and report change Instruct patient not to scratch Monitor patient's nutitional status every _____ hours and document Apply antibiotic ointment as orderd Provide wound care, as indicated Refer to physical therapy for regular exercise program	
	Impaired oral mucous membrane *Related factors:* Immunosuppression Dehydration *Symptoms / Risk factors:* Oral lesions or ulcers Self report of difficulty eating or swallowing White patches/plaques, spongy patches, or white curdlike exu Oral pain/discomfort *Outcome / Goal:* Report or demonstrate a decrease in symptoms Display intact mucous membranes		**Oral Health Restoration** Inspect oral cavity and note changes in: Saliva, Tongue,Teeth an Gum, and Lil Provide oral care daily and after food intake Avoid alcohol-based mouthwashes. Show patient how to brush inside of mouth, palate, Tongue and Teeth Plan diet to avoid salty, spicy, abrasive, and acidic food Administer medications, as indicated Refer for dental consultation, if appropriate	
	Fatigue *Related factors:* Disease states Malnutrition Depression Sleep deprivation *Symptoms / Risk factors:* Decreased performance Increase in physical complaints Increase in rest requirements *Outcome / Goal:* Report improved sense of energy Perform ADLs, with assistance as necessary		**Energy Management** Assess client's ability to perform normal tasks and ADL's Demonstrate proper performance of activities of dayli living (ADL's) Discuss future plans regarding food and fluid, as indicated Encourage activiy as tolerated, rest as needed Monitor vital signs and response to activity, weakness,dyspena and fatigue Perform ROM exercises consistently Medicate for pain before activity or exercises	

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AIDS

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Disturbed thought processes *Related factors:* Psychological conflicts Alteration of drug metabolism or excretion Hypoxemia, CNS infection by HIV *Symptoms / Risk factors:* Distractibility Inaccurate interpretation of environment Memory deficit/problems *Outcome / Goal:* Maintain usual reality orientation and optimal cognitive f.		**Reality Orientation** Be aware of client's distorted thinking ability Maintain a pleasant environment with appropriate Encourage client to do as much as possible Assist with diagnostic studies, such as MRI, CT scan, **Cognitive Stimulation** **Cognitive Restructuring**	
	Death anxiety *Related factors:* Confronting reality of potentially terminal disease Concern about impact of death on others *Symptoms / Risk factors:* Denial of one's own mortality or impending death Deep sadness Fear of leaving family alone after death Total loss of control over any aspect of one's own death *Outcome / Goal:* Verbalize acceptance of reality of situation Patient will identify need for time with others and alone Patient will optain the level of spiritual support he ask Patient will experience dying with dignity and love		**Active Listening** Confirm your awarness of the patient´s fear. Help the patient to express his/ her fear by careful and thoughtful questioning Spend time with the patient While interacting with the patient, maintain calm and accepting manner **Family Involvement Promotion** Assess level of anxiety present in family Determine level of coping impairment. Discuss underlying reasons for client behaviors with family Encourage family members to seek information and resources for coping skills Evaluate current behaviors that may be interfering with the care of client. Investigate cultural norms and factors Refer the family to social services or counseling **Pain Management** Administer medication as prescribet Obs. pain (effectivnes of medication) Obs vital signs_____ **Spiritual Support** Assess cultural beliefs Assess history of formal religious affiliation and desire for religious contact Encourage participation in desired religious activities Explore ways that religious practices have affected client's life Refer patient to priest,minister,rabbi,or spiritual counselor	
	Social isolation *Related factors:* Alterations in mental status Altered state of wellness Alterations in physical appearance *Symptoms / Risk factors:* Absence of supportive significant other(s) (family, friends, Expresses feelings of aloneness imposed by others Sad, dull affect Preoccupation with own thoughts *Outcome / Goal:* Patient develops ways to be more involved with others Patient dvelops satisfying relationships		**Socialization Enhancement** Ascertain client's perception of situation Be alert to verbal and nonverbal cues including withdrawal,despair and aloneless Encourage enhanced involvement in already established relationships Explore strengths and weaknesses of current network of relationships Give positive feedback when patient reaches out to others Identify support systems available to client	

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Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Powerlessness *Related factors:* Illness related regimen Diagnosis confirmation incomplete grieving process *Symptoms / Risk factors:* Expression of doubt regarding role performance Passivity Reluctance to express true feelings Resentment, anger, guilt *Outcome / Goal:* Acknowledge feelings and healthy ways to deal with them		**Self-Responsibility Facilitation** Identify factors that contribute to client's feelings of powerlessness Assess degree of feelings of helplessness	
	Deficient knowledge: Discharge *Related factors:* Lack of exposure or unfamiliarity with resources information misinterpretation *Symptoms / Risk factors:* Questions *Outcome / Goal:* Verbalize understanding of condition, prognosis, and treatme		**Teaching: Disease Process** Acknowledge patient's knowledge about condition Assess knowledge of the disease and treatment Discuss symptoms and interventions Discuss therapy/treatment options Emphasize need for long-term follow up and periodic reevaluation. Encourage client to make necessary changes in lifestyle Stress importance of well-balanced diet and adequate fluid intake. Review modes of transmission of disease, Instruct client and caregivers concerning infection control Stress importance of adequate rest. Identify signs and symptoms requiring medical evaluation: fewer and night sweat **Discharge Planning** Ascertain that patient has follow-up care arranged at discharge Contact appropraite personnel with orders Involve the patient/family in the discharge process Dscharge planned _____	

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