Patients info label here

Risk for infection

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for infection *Related factors:* Broken skin Chronic illness Cystic fibrosis Defense system in lung low Defense system in lung low /imparied Development of atelectasis Extension of infection Inadequate primary defenses. Indwelling catheter (contamination) Lack of knowledge of nature of disease Lung obstruction and secretions Mastitis Nutritional deficiencies Possible Bowel perforation Possible perforation of diverticulitis Premature Reports of high-risk behaviors Sexual exposure Stasis of respiratory secretions suppressed inflammatory response Surgical wound Tissue destruction Wound drains *Symptoms / Risk factors:* Bladder irrigation Body temp. higer than_____ Broken skin Decreased hemoglobin and leukopenia Dysuria Enlarged lymph nodes Genital lesions Immobility Inadequate acquired immunity Instrumentation Insufficient knowledge to avoid exposure to pathogens IV- site contamination Malnutrition Nutritional deficiencies Rupture of amniotic membranes Temp > 37.5 Urethral disharge *Outcome / Goal:* States symptoms of infection of which to be aware Achieve timely wound healing Be free of signs of infection Demonstrates appropriate hygienic measures Immune Status OK Maintains white blood cell count Norma body temperature Risk for infection reduced through treatment Surgical wound clean		**Infection Control** Assess client knowledge Assess client knowledge of Secually Transmitted Infections Administer medication due as ordered by the physician Administering doctor-prescribed fever reducers Assess whether clothing or bed covers are too warm for the enviroment Assist with peritoneal aspiration, if indicated. Encourage fluid intake by offering fluids regularly Encourage increased oral intake based on individual needs Examine skin and oral mucous membranes for white patches or lesions Input and Output of Fluid Measurement Maintain strict aseptic technique in caring for abdominal drains, incisions Monitor effects of medication _____ Monitor lab. studies, as indicated_____ Monitor urine output. Monitor vital signs_____ Note skin color, temperature, and moisture. Observe drainage from wounds or drains. Obtain specimens as indicated Prepare for surgical intervention if planned Provide information about Chlamydia and Gonorrhea Provide information about Chlamydia,Gonorrhea ,Syphilis, Genital warts, herpes Teach about recurrence and/ or reinfection Teach about use of antiinfective agents as indicated:Azithromycin and Doxycyclir Teach the patient to complete the prexcibed treatments Wash hands before and after all care contacts **Infection Protection** Monitor client's vital signs and signs of possible hemorrhage and perforation Administer IV Antibiotics therapy as prescribet Assess skin for color, moisture, texture, and turgor Débride necrotic and loose tissue Follow precautions for airborne-, droplet-, and contact-transmission Implement appropriate isolation techniques as indicated Instruct parents and child in personal hygiene and practices Instruct patient to all the medication prescribed Obs rate and characteristics of respirations, sound, cough and sputum Observe and report signs of infection such as redness and increased tempera Observe for signs of infection:, fever (>38°C] , increased pain and leukocytosis Perform care of umbilical cord according to protocol Provide well-designed site care for all peripheral, cv, and arterial Use proper hand washing techniques before and after giving care to child Use proper hand washing techniques before and after giving care to client Use strict aseptic or clean technique to reinforce or change dressing Use strict aseptic technique, IV, Tubes, drains and catheters **Wound Care** Check drains for placement, patency -strict sterile technique Check dressing for drainage Débride necrotic and loose tissue Maintain aseptic technique when changing dressings and caring for wound. Monitor all sites for signs of wound infection, such as unusual redness Provide special care for eyes Monitor vital signs. Reinforce necessity of not smoking. Teach the patient / caregiver about wound care using aseptic technique	

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