

NURSING DIAGNOSIS: RISK FOR INFECTION		Patient's Medical Diagnosis:
DEFINITION:	The state in which an individual is at increased risk of being invaded by pathogenic organisms.	
DEFINING CHARACTERISTICS:	Inadequate primary defenses (broken skin, traumatized tissue, decrease in ciliary action, stasis of body fluids, change in pH, secretions, altered peristalsis); inadequate secondary defenses (decreased hemoglobin, leukopenia, suppressed inflammatory response) and immunosuppression: inadequate acquired immunity; tissue destruction and increased environmental exposure; chronic disease; invasive procedures; malnutrition; pharmaceutical agents; trauma; rupture of amniotic membranes; insufficient knowledge to avoid exposure to pathogens.	
RELATED FACTORS:	Included in risk factors.	
STUDENT INSTRUCTIONS:	In the space below enter the subjective and objective data gathered during your patient assessment.	
ASSESSMENT	<i>Subjective Data Entry</i>	<i>Objective Data Entry</i>
	TIME OUT!	Student Instructions: To be sure your patient diagnostic statement written below is accurate, you need to review the defining characteristics and related factors associated with the nursing diagnosis and see how your patient data matches. Do you have an accurate match or is additional data required or does another nursing diagnosis need to be investigated?
DIAGNOSIS	PATIENT DIAGNOSTIC STATEMENT:	Nursing Diagnosis: _____ Related to: _____ AEB: _____

PLANNING	Desired Outcome And Patient Criteria: The Patient Will:	
	TIME OUT!	The desired outcome must meet criteria to be accurate. The outcome must be specific, realistic, measurable, and include a time frame for completion. Does the action verb describe the patient's behavior to be evaluated? Can the outcome be used in the evaluation step of the nursing process to measure the patient's response to the nursing interventions listed below?
	Interventions	Rationale For Selected Intervention and References
EVALUATION	TIME OUT!	Do your interventions assist in achieving the desired outcome? Do your interventions address further monitoring of the patient's response to your interventions and to the achievement of the desired outcome? Are qualifiers: when, how, amount, time, and frequency used? Is the focus of the action's verb on the nurse's actions and not on the patient? Do your rationales provide sufficient reason and directions?
	What was your patient's response to the interventions?	
	Was the desired outcome achieved? If no, what revisions to either the desired outcome or interventions would you make? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DOCUMENTATION	Documentation Focus: Now that you have completed the evaluation, the next step is to document your care and the patient's response. Use the areas below to enter your progress note information.	