

Infection Nursing Care Plan

Patient Information

Name:

Age:

Medical Record Number:

Date of Admission:

Primary Diagnosis:

Assessment

1. Signs and Symptoms of Infection (e.g., fever, redness, swelling, discharge):

2. Vital Signs:

Temperature:

Pulse:

Respirations:

Blood Pressure:

3. Laboratory Test Results (if applicable):

Nursing Diagnosis

Diagnosis related to infection (e.g., Risk for Infection, Impaired Skin Integrity):

Goals and Outcomes

Short-Term Goal (e.g., Patient will exhibit reduced signs of infection within 48 hours):

Long-Term Goal (e.g., Patient will be free from infection at the time of discharge):

Interventions

1. Administer prescribed antibiotics as ordered.

Specifics:

2. Perform wound care as per protocol.

Specifics:

3. Educate patient on hygiene practices.

Specifics:

4. Monitor vital signs and report any significant changes.

Specifics:

Evaluation

Response to Interventions (e.g., reduction in fever, healing of wound):

Progress towards Goals:

Reassessment and Modification of Plan

Adjustments to Care Plan (if needed):

Nurse's Signature

Name:

Date: