COMMON NURSING DIAGNOSES

With Full Examples You Can Use

NANDA-I Format • 15 Complete Diagnoses • 5 Clinical Areas • Goals + Interventions + Rationale

HOW TO READ THE NANDA FORMAT

Diagnostic Label The standardized problem name (NANDA-I)	**Related To (RT)** The etiology / cause of the problem	**As Evidenced By (AEB)** Defining characteristics / signs & symptoms	**Goals** Measurable, time-bound patient outcomes	**Interventions + Rationale** Nursing actions and the evidence behind them

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RESPIRATORY

#01 Impaired Gas Exchange

NANDA-I: 00030

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Alveolar-capillary membrane changes, ventilation-perfusion imbalance (e.g., pneumonia, COPD, PE)	SpO2 < 94%, PaO2 < 80 mmHg, confusion, cyanosis, abnormal ABGs, dyspnea at rest

EXPECTED OUTCOMES / GOALS:

- Patient maintains SpO2 >= 94% on prescribed O2 within 4 hours
- ABG values return to within normal limits within 24 hours
- Patient reports decreased dyspnea on a 0-10 scale

NURSING INTERVENTIONS:	RATIONALE:
1. Monitor SpO2 continuously; assess RR, depth, and rhythm q2-4h	*Continuous monitoring detects early deterioration before it becomes critical*
2. Position patient in high-Fowler's or tripod position to maximize lung expansion	*Upright positioning uses gravity to lower diaphragm and increase lung volume*
3. Administer supplemental O2 as ordered; titrate to maintain SpO2 goal	*Supplemental O2 corrects hypoxemia; over-oxygenation avoided in COPD pts*
4. Encourage deep breathing and incentive spirometry q1-2h while awake	*Deep breathing opens atelectatic alveoli and improves V/Q matching*
5. Suction secretions as needed; monitor sputum color and amount	*Secretion removal clears airways, reducing obstruction and infection risk*

#02 Ineffective Airway Clearance

NANDA-I: 00031

RELATED TO (Etiology):

Excessive secretions, neuromuscular dysfunction, pain inhibiting cough, tracheobronchial infection

AS EVIDENCED BY (Defining Characteristics):

Ineffective cough, abnormal breath sounds (crackles, wheezes), dyspnea, cyanosis, changes in RR

EXPECTED OUTCOMES / GOALS:

- Patient demonstrates effective cough technique and clears secretions PRN
- Breath sounds clear to auscultation bilaterally within 24 hours
- RR remains 12-20 breaths/min with no accessory muscle use

NURSING INTERVENTIONS:	RATIONALE:
1. Auscultate lung sounds q4h and PRN; document and report changes	*Auscultation identifies secretion location and effectiveness of clearance*
2. Encourage fluid intake of 2-3 L/day unless contraindicated	*Adequate hydration thins secretions, making them easier to expectorate*
3. Teach and assist with controlled coughing techniques (huff coughing, splinting)	*Effective cough mobilizes secretions; splinting reduces post-op pain during cough*
4. Perform chest physiotherapy or postural drainage as ordered	*Gravity-assisted drainage moves secretions to central airways for clearance*
5. Administer bronchodilators and mucolytics as prescribed; evaluate effectiveness	*Bronchodilators open airways; mucolytics reduce sputum viscosity*

CARDIOVASCULAR

#03 Decreased Cardiac Output

NANDA-I: 00029

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Altered heart rate/rhythm, altered preload/afterload, impaired contractility (e.g., MI, HF, dysrhythmia)	BP < 90/60, HR < 60 or > 100, weak pulses, cold/clammy skin, decreased UO, fatigue, S3 heart sound

EXPECTED OUTCOMES / GOALS:

- BP maintains within patient's normal range; HR 60-100 bpm
- Urine output >= 0.5 mL/kg/hr indicating adequate perfusion
- Patient reports decreased fatigue; skin warm and dry with brisk cap refill

NURSING INTERVENTIONS:	RATIONALE:
1. Monitor BP, HR, rhythm, and hemodynamic parameters (CVP, MAP) continuously	*Continuous monitoring enables early detection of hemodynamic deterioration*
2. Assess for signs of poor perfusion: LOC changes, cool extremities, decreased UO	*Peripheral perfusion assessment reveals severity of output reduction*
3. Administer prescribed cardiac medications (inotropes, antidysrhythmics, diuretics)	*Medications optimize contractility, HR, preload, and afterload*
4. Maintain rest periods; limit activities that increase cardiac workload	*Rest decreases myocardial O2 demand, reducing cardiac workload*
5. Record strict I&O; every hour; weigh daily at same time on same scale	*Daily weights and I&O; detect fluid retention indicative of worsening HF*

#04 Risk for Ineffective Peripheral Tissue Perfusion

NANDA-I: 00228

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Diabetes mellitus, hypertension, peripheral artery disease, prolonged immobility, DVT risk	Risk diagnosis — no defining characteristics; presence of risk factors is sufficient

EXPECTED OUTCOMES / GOALS:

- Patient maintains palpable peripheral pulses 2+ bilaterally throughout stay
- Cap refill < 2 seconds; skin warm, dry, and intact on lower extremities
- Patient verbalizes 3 signs of impaired circulation to report immediately

NURSING INTERVENTIONS:	RATIONALE:
1. Assess peripheral pulses, skin color, temperature, and sensation q4-8h	*Baseline assessment identifies early signs of circulatory compromise*
2. Apply sequential compression devices (SCDs) and encourage ankle pumps hourly	*SCDs and exercises promote venous return and prevent clot formation*
3. Ambulate patient as early as possible; avoid prolonged sitting with legs dependent	*Ambulation is the most effective mechanical DVT prevention strategy*
4. Administer prophylactic anticoagulation as ordered; monitor for bleeding	*Anticoagulants reduce thrombus formation risk in high-risk patients*
5. Educate patient to avoid crossing legs, tight clothing, and smoking	*Behaviors that impair venous return increase DVT and PAD risk*

PAIN & COMFORT

#05 Acute Pain

NANDA-I: 00132

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Physical injury, surgical incision, inflammation, ischemia, tissue damage	Self-reported pain > 0/10, guarding behavior, facial grimacing, tachycardia, diaphoresis, limited mobility

EXPECTED OUTCOMES / GOALS:

- Patient reports pain <= 3/10 on numeric scale within 1 hour of intervention
- Patient demonstrates use of non-pharmacological pain relief techniques
- Patient participates in ADLs and mobility without unacceptable pain

NURSING INTERVENTIONS:	RATIONALE:
1. Assess pain using validated scale (NRS, FLACC, BPS) q4h and PRN; document quality, location, duration	*Validated scales provide objective, consistent measurement for trending and communication*
2. Administer analgesics as prescribed; evaluate effectiveness 30-60 min after administration	*Timely analgesia prevents pain escalation; reassessment confirms therapeutic effect*
3. Teach and assist with non-pharmacological methods: positioning, ice/heat, guided imagery, distraction	*Non-pharm methods modulate pain pathways without medication side effects*
4. Encourage patient to report pain before it becomes severe (pain anticipation vs. PRN chasing)	*Proactive reporting prevents undertreated pain that inhibits recovery and mobility*
5. Reassess and document pain after each intervention; notify provider if uncontrolled	*Documentation ensures accountability and guides analgesic adjustment by the care team*

#06 Chronic Pain

NANDA-I: 00133

RELATED TO (Etiology):

Chronic inflammatory disease (arthritis, fibromyalgia), neuropathy, cancer, musculoskeletal disorders

AS EVIDENCED BY (Defining Characteristics):

Self-report of pain > 3 months, changes in sleep pattern, depression, reduced activity tolerance, altered mood

EXPECTED OUTCOMES / GOALS:

- Patient reports pain at a manageable level (individualized goal) to participate in daily activities
- Patient demonstrates 3 adaptive coping strategies for pain management
- Patient sleeps 6-8 hours with minimal pain interruption

NURSING INTERVENTIONS:	RATIONALE:
1. Establish therapeutic relationship; validate the reality of chronic pain experience	*Validation reduces suffering and builds trust essential to therapeutic adherence*
2. Collaborate with patient to set realistic, individualized pain management goals	*Patient-centered goals improve engagement and realistic expectation-setting*
3. Coordinate multimodal approach: pharmacological, PT, OT, psychology, complementary therapies	*Multimodal therapy addresses biopsychosocial dimensions of chronic pain*
4. Assess for depression and anxiety — screen using PHQ-9 or GAD-7 as appropriate	*Chronic pain and depression co-occur in up to 85% of patients; both require treatment*
5. Educate patient and family about chronic pain physiology and self-management strategies	*Pain neuroscience education reduces catastrophizing and improves self-efficacy*

FLUID & ELECTROLYTES

#07 Deficient Fluid Volume (Hypovolemia)

NANDA-I: 00027

RELATED TO (Etiology):

Active fluid loss (vomiting, diarrhea, hemorrhage, diaphoresis), inadequate fluid intake, polyuria

AS EVIDENCED BY (Defining Characteristics):

Decreased BP, tachycardia, dry mucous membranes, poor skin turgor, decreased UO < 30 mL/hr, concentrated urine

EXPECTED OUTCOMES / GOALS:

- BP and HR return to baseline; skin turgor normal within 8 hours of fluid resuscitation
- Urine output maintains >= 30 mL/hr with specific gravity 1.010-1.025
- Patient verbalizes adequate oral fluid intake and signs of dehydration to report

NURSING INTERVENTIONS:	RATIONALE:
1. Monitor VS, skin turgor, mucous membranes, and UO hourly during acute phase	*Frequent assessment detects ongoing losses and response to fluid replacement*
2. Administer IV fluids as ordered (NS, LR, albumin); monitor response closely	*IV fluids rapidly restore intravascular volume and hemodynamic stability*
3. Record strict I&O; weigh daily — 1 kg change = approx. 1 liter fluid shift	*Accurate I&O; and weight tracking quantify fluid balance in real time*
4. Monitor labs: BMP, BUN/creatinine ratio, hematocrit, urine specific gravity	*Rising BUN/Cr ratio and hemoconcentration confirm hypovolemia; guide therapy*
5. Encourage oral fluids if patient is not NPO; offer preferences to improve compliance	*Oral rehydration is preferred when tolerated; patient preference improves intake*

#08 Excess Fluid Volume (Hypervolemia)

NANDA-I: 00026

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Compromised regulatory mechanism (HF, CKD, cirrhosis), excessive sodium/fluid intake, corticosteroid use	Edema 2-3+, weight gain > 2 kg in 24h, crackles, JVD, ascites, S3 heart sound, dyspnea

EXPECTED OUTCOMES / GOALS:

- Patient loses 0.5-1 kg/day via diuresis; edema reduces to trace or absent
- Lung sounds clear; SpO2 >= 94% on baseline O2 within 24-48 hours
- Patient demonstrates dietary sodium restriction and daily weight monitoring

NURSING INTERVENTIONS:	RATIONALE:
1. Weigh patient daily at same time, same scale, same clothing; report gain > 2 lbs	*Daily weight is the most sensitive indicator of fluid balance changes*
2. Monitor lung sounds, JVD, peripheral edema, and abdominal girth every shift	*Physical assessment reveals fluid redistribution to lungs and body cavities*
3. Administer diuretics as ordered; monitor K+ and creatinine before/after doses	*Diuretics promote renal excretion of excess sodium and water; electrolyte monitoring prevents hypokalemia*
4. Restrict sodium (2-3 g/day) and fluid intake as prescribed; educate patient	*Sodium restriction reduces fluid retention; education improves long-term self-management*
5. Elevate edematous extremities; assess skin integrity over edematous areas q8h	*Elevation promotes venous return; edematous skin is fragile and at high risk for breakdown*

NUTRITION

#09 Imbalanced Nutrition: Less Than Body Requirements

NANDA-I: 00002

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Inability to ingest food (NPO, dysphagia, nausea/vomiting), increased metabolic demands (sepsis, burns, cancer), malabsorption	Weight loss > 10-20% of ideal, serum albumin < 3.5 g/dL, inadequate food intake reported, muscle wasting

EXPECTED OUTCOMES / GOALS:

- Patient consumes >= 75% of prescribed caloric intake at each meal within 48 hours
- Weight stabilizes or increases 0.5-1 kg/week toward goal weight
- Albumin and prealbumin trending toward normal on follow-up labs

NURSING INTERVENTIONS:	RATIONALE:
1. Conduct nutritional screening on admission using validated tool (MNA, MUST, NRS-2002)	*Early screening identifies at-risk patients for timely intervention*
2. Consult registered dietitian for individualized calorie/protein/micronutrient plan	*RD expertise ensures accurate macronutrient calculations based on clinical status*
3. Monitor weight 3x/week; track dietary intake at each meal (% consumed)	*Weight and intake tracking quantify nutritional status and response to intervention*
4. Provide preferred foods in small, frequent meals; address barriers (nausea, pain, taste changes)	*Small meals reduce gastric distension; patient preferences improve intake compliance*
5. Administer enteral or parenteral nutrition as ordered if oral intake inadequate	*Enteral/parenteral nutrition maintains nutritional status when oral route is insufficient*

MOBILITY & ACTIVITY

#10 Impaired Physical Mobility

NANDA-I: 00085

RELATED TO (Etiology):

Neuromuscular impairment, musculoskeletal disorders, pain, decreased strength/endurance, post-operative restrictions

AS EVIDENCED BY (Defining Characteristics):

Limited ROM, inability to move purposefully, decreased muscle strength (3/5 or less), reluctance to move, use of assistive device

EXPECTED OUTCOMES / GOALS:

- Patient performs AROM/PROM exercises to all extremities each shift
- Patient ambulates with or without assistance as ordered, increasing distance daily
- Patient maintains skin integrity with no pressure injury development

NURSING INTERVENTIONS:	RATIONALE:
1. Assess functional mobility level, muscle strength, and ROM on admission and each shift	*Baseline assessment guides safe activity progression and measures improvement*
2. Consult physical and occupational therapy for individualized rehabilitation plan	*PT/OT expertise optimizes mobility restoration and adaptive equipment selection*
3. Reposition q2h using turn schedule; use pressure-relieving mattress/surfaces	*Repositioning every 2 hours redistributes pressure and prevents tissue ischemia*
4. Assist with and progress mobility as tolerated: dangle, stand, transfer, ambulate	*Progressive mobilization prevents deconditioning, PE, and hospital-acquired complications*
5. Apply assistive devices (walker, splints, braces) correctly; ensure safe environment	*Correct device use prevents falls and promotes safe, independent mobility*

INFECTION & PROTECTION

#11 Risk for Infection

NANDA-I: 00004

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Invasive procedures/lines, surgical wounds, immunosuppression, compromised skin integrity, malnutrition	Risk diagnosis — define as: presence of central line, surgical incision, urinary catheter, or immune compromise

EXPECTED OUTCOMES / GOALS:

- Patient remains afebrile with WBC within normal limits throughout hospitalization
- Invasive lines, wounds, and catheters show no signs of infection at each assessment
- Patient demonstrates proper hand hygiene and infection prevention technique before discharge

NURSING INTERVENTIONS:	RATIONALE:
1. Practice strict hand hygiene per WHO 5 Moments; ensure all staff and visitors comply	*Hand hygiene is the single most effective measure to prevent healthcare-associated infections*
2. Use aseptic/sterile technique for all invasive procedures, dressing changes, and catheter care	*Aseptic technique prevents introduction of pathogens into sterile body sites*
3. Assess all invasive line sites daily for redness, warmth, swelling, drainage, and tenderness	*Early site assessment detects local infection before systemic spread occurs*
4. Remove urinary catheters and IV lines as soon as clinically indicated (daily necessity review)	*Every day a catheter/line remains in place increases infection risk exponentially*
5. Monitor temperature, WBC, CRP, procalcitonin; culture before initiating antibiotics	*Early culture-directed therapy prevents antibiotic resistance and reduces sepsis mortality*

#12 Hyperthermia

NANDA-I: 00007

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Infectious process, inflammatory response, dehydration, vigorous activity, medications (NMS, serotonin syndrome)	Temp > 38.0 C (100.4 F), tachycardia, tachypnea, flushed skin, warm to touch, diaphoresis, altered LOC

EXPECTED OUTCOMES / GOALS:

- Temperature returns to 36.1-37.2 C within 2 hours of antipyretic administration
- Patient remains hemodynamically stable: HR < 100 bpm, BP within normal limits
- Fluid balance maintained; signs of dehydration absent

NURSING INTERVENTIONS:	RATIONALE:
1. Monitor temperature q1-2h during fever; use consistent method (oral, rectal, temporal)	*Frequent monitoring tracks fever trajectory and response to treatment*
2. Administer antipyretics (acetaminophen, ibuprofen) as ordered; evaluate effectiveness in 30-60 min	*Antipyretics act on hypothalamic thermostat to reduce set-point and lower temperature*
3. Apply cooling measures: remove excess blankets, cool damp cloth to forehead/axilla/groin	*External cooling dissipates body heat through conduction and evaporation*
4. Increase fluid intake (oral or IV) to compensate for insensible losses from diaphoresis	*Fever increases metabolic rate and fluid losses by 10-15% per degree of temperature rise*
5. Obtain blood cultures x2 prior to antibiotics; monitor CBC, CRP, culture results	*Cultures identify causative organism to guide targeted antibiotic therapy*

KNOWLEDGE & EDUCATION

#13 Deficient Knowledge

NANDA-I: 00126

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Lack of exposure to information, unfamiliarity with information resources, cognitive limitation, anxiety interfering with learning	Verbalization of problem, inaccurate follow-through of instructions, inappropriate or exaggerated behaviors (hysteria, hostility)

EXPECTED OUTCOMES / GOALS:

- Patient correctly demonstrates medication administration technique before discharge
- Patient verbalizes understanding of disease process, diet, and activity restrictions
- Patient identifies when and how to seek medical attention for warning signs

NURSING INTERVENTIONS:	RATIONALE:
1. Assess patient's current knowledge, readiness to learn, preferred learning style, and literacy level	*Tailored education based on assessment improves retention and adherence*
2. Provide education using teach-back method: have patient repeat information in their own words	*Teach-back confirms comprehension rather than just passive listening*
3. Use plain language, visual aids, and written materials at appropriate literacy level	*Plain language and visuals improve understanding in patients of all literacy levels*
4. Include family/caregivers in all education sessions; address questions and concerns	*Family inclusion improves home care and medication adherence post-discharge*
5. Document all teaching: topics covered, patient response, and plans for reinforcement	*Documentation ensures continuity of education across the care team*

PSYCHOLOGICAL & COPING

#14 Anxiety

NANDA-I: 00146

RELATED TO (Etiology):	AS EVIDENCED BY (Defining Characteristics):
Situational crisis (new diagnosis, hospitalization), threat to self-concept, unmet needs, unknown prognosis	Expressed apprehension, restlessness, increased HR and RR, trembling, poor concentration, insomnia, diaphoresis

EXPECTED OUTCOMES / GOALS:

- Patient reports anxiety level reduced to <= 3/10 within 1 hour of intervention
- Patient demonstrates at least 2 anxiety-reduction techniques independently
- Physiological indicators (HR, RR) return to baseline following relaxation techniques

NURSING INTERVENTIONS:	RATIONALE:
1. Establish therapeutic relationship; use calm, reassuring tone; maintain presence during acute episodes	*Therapeutic presence reduces isolation and activates the parasympathetic nervous system*
2. Acknowledge and validate patient's feelings without minimizing concerns	*Validation reduces emotional distress and builds trust for therapeutic intervention*
3. Teach and practice relaxation techniques: deep breathing, progressive muscle relaxation, guided imagery	*Relaxation techniques activate vagal tone, lowering HR, RR, and perceived anxiety*
4. Provide accurate information about diagnosis, procedures, and plan of care to reduce fear of unknown	*Accurate information reduces anxiety caused by uncertainty and misperception*
5. Collaborate with social work, chaplaincy, or psychiatry if anxiety is severe or complex	*Interdisciplinary support addresses social, spiritual, and psychiatric dimensions of anxiety*

#15 Risk for Falls

NANDA-I: 00155

RELATED TO (Etiology):

Age > 65, impaired balance/gait, orthostatic hypotension, altered LOC, polypharmacy, environmental hazards, history of prior falls

AS EVIDENCED BY (Defining Characteristics):

Risk diagnosis — Morse Fall Scale score >= 45 (high risk) or presence of multiple risk factors

EXPECTED OUTCOMES / GOALS:

- Patient remains free from falls and fall-related injury throughout hospitalization
- Patient and family verbalize fall prevention strategies before discharge
- Patient correctly uses call light and requests assistance with ambulation each shift

NURSING INTERVENTIONS:	RATIONALE:
1. Complete fall risk assessment on admission, each shift, and after any fall using validated scale (Morse, STRATIFY)	*Validated assessment tools objectively quantify risk and guide targeted interventions*
2. Implement universal fall precautions: bed in lowest position, brakes locked, call light in reach, non-skid footwear	*Environmental modifications reduce hazards that precipitate mechanical falls*
3. For high-risk patients: bed/chair alarm, hourly rounding, consider sitter if confusion present	*Alarms and rounding increase response time when patient attempts unsafe self-mobilization*
4. Review and address contributing medications (sedatives, antihypertensives, diuretics, opioids)	*Polypharmacy (especially sedatives and antihypertensives) is a major modifiable fall risk factor*
5. Educate patient and family on fall risk and personal strategies; display fall precaution signs	*Patient-engaged education improves adherence to asking for help when needed*

QUICK REFERENCE — NURSING DIAGNOSIS CHEAT SHEET

Use this page for fast review and care plan writing

#	Nursing Diagnosis	NANDA Code	Key Related To	Priority Interventions
1	**Impaired Gas Exchange**	00030	Alveolar-capillary membrane changes, ventilation-perfusion imbalance (...	Monitor SpO2 continuously; assess RR, depth, and rhythm q2-4h; Position patient in high-Fowler's or tripod pos...
2	**Ineffective Airway Clearance**	00031	Excessive secretions, neuromuscular dysfunction, pain inhibiting cough...	Auscultate lung sounds q4h and PRN; document and report changes; Encourage fluid intake of 2-3 L/day unless co...
3	**Decreased Cardiac Output**	00029	Altered heart rate/rhythm, altered preload/afterload, impaired contrac...	Monitor BP, HR, rhythm, and hemodynamic parameters (CVP, MAP) continuously; Assess for signs of poor perfusion...
4	**Risk for Ineffective Peripheral Tissue Perfusion**	00228	Diabetes mellitus, hypertension, peripheral artery disease, prolonged ...	Assess peripheral pulses, skin color, temperature, and sensation q4-8h; Apply sequential compression devices (...
5	**Acute Pain**	00132	Physical injury, surgical incision, inflammation, ischemia, tissue dam...	Assess pain using validated scale (NRS, FLACC, BPS) q4h and PRN; document quality, location, duration; Adminis...
6	**Chronic Pain**	00133	Chronic inflammatory disease (arthritis, fibromyalgia), neuropathy, ca...	Establish therapeutic relationship; validate the reality of chronic pain experience; Collaborate with patient ...
7	**Deficient Fluid Volume (Hypovolemia)**	00027	Active fluid loss (vomiting, diarrhea, hemorrhage, diaphoresis), inade...	Monitor VS, skin turgor, mucous membranes, and UO hourly during acute phase; Administer IV fluids as ordered (...
8	**Excess Fluid Volume (Hypervolemia)**	00026	Compromised regulatory mechanism (HF, CKD, cirrhosis), excessive sodiu...	Weigh patient daily at same time, same scale, same clothing; report gain > 2 lbs; Monitor lung sounds, JVD, pe...
9	**Imbalanced Nutrition: Less Than Body Requirements**	00002	Inability to ingest food (NPO, dysphagia, nausea/vomiting), increased ...	Conduct nutritional screening on admission using validated tool (MNA, MUST, NRS-2002); Consult registered diet...
10	**Impaired Physical Mobility**	00085	Neuromuscular impairment, musculoskeletal disorders, pain, decreased s...	Assess functional mobility level, muscle strength, and ROM on admission and each shift; Consult physical and o...
11	**Risk for Infection**	00004	Invasive procedures/lines, surgical wounds, immunosuppression, comprom...	Practice strict hand hygiene per WHO 5 Moments; ensure all staff and visitors comply; Use aseptic/sterile tech...
12	**Hyperthermia**	00007	Infectious process, inflammatory response, dehydration, vigorous activ...	Monitor temperature q1-2h during fever; use consistent method (oral, rectal, temporal); Administer antipyretic...

13	Deficient Knowledge	00126	Lack of exposure to information, unfamiliarity with information resour...	Assess patient's current knowledge, readiness to learn, preferred learning style, and literacy level; Provide ...
14	Anxiety	00146	Situational crisis (new diagnosis, hospitalization), threat to self-co...	Establish therapeutic relationship; use calm, reassuring tone; maintain presence during acute episodes; Acknow...
15	Risk for Falls	00155	Age > 65, impaired balance/gait, orthostatic hypotension, altered LOC,...	Complete fall risk assessment on admission, each shift, and after any fall using validated scale (Morse, STRAT...

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