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Burns

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Ineffective airway clearance *Related factors:* Smoke inhalation Laryngeal swelling CO poisoning Upper airway obsturction Pulmonary edema Direct upper-airway injury by flame, steam, hot air, chemica Airway spasm *Symptoms / Risk factors:* Diminished breath sounds O2 sat < 90 % Cyanosis Restlessness *Outcome / Goal:* Improved breathsounds O2 sat. > 90%		**Respiratory Monitoring** Prepare for and transfer to critical care unit if indicated Obtain history of injury Asses preexisting respiratory conditions Asses O2 saturation and arterial blood gases Monitor changes in O2 saturation Monitor for increased restlessness, anxiety, and air hunger obs lung secretion and patients cough ability Monitor rate, rhythm, depth, and effort of respirations Monitor relationship of inspiration to expiration **Airway Management** Position the client to optimize respiration (head of bed elevated 45 degrees) Encourage effective coughing and deep breathing Perform chest physical therapy, as appropriate Administer humidified oxygen **Ventilation Assistance** Prepare for, or assist with, intubation or tracheostomy Maintain patent airway. Anticipate emergency intubation or tracheostomy (ready) Administer medications that promote airway patency and gas exchange Administer medications as ordered: Epinephrine,Coritcosteroids and Antihistam. Initiate postural drainage, chest physiotherapy, every ____ hour Monitor lab results Monitor trends in PEP (peak airway pressure)	
	Risk for deficient fluid volume *Related factors:* Increased metabolic rate Loss of fluid through abnormal routes Alteration of clotting process, hemorrhage *Symptoms / Risk factors:* Electrolyte imbalance Oliguria *Outcome / Goal:* Patient will maintain balanced fluid intake and output Normal vital signs		**Fluid Management** Monitor total fluid intake (and output) every 8 hours Monitor urine output, noting amount and color and time Monitor vital signs and central venous pressure Estimate wound drainage and insensible losses **Intravenous (IV) Therapy** Maintain and adjust IV fluid rate as ordered Administer calculated IV replacement of fluids Insert and maintain indwelling urinary catheter. Monitor laboratory studies, such as Hgb/Hct,electrolytes and urine (NA) Administer medications, as indicated Monitor for signs and symptoms of hypovolumia and shock **Shock Prevention**	
	Acute pain *Related factors:* Destruction of skin Edema formation Manipulation of injured tissues incision *Symptoms / Risk factors:* Tachycardia - High blodpressure - abnormal vital signs Antalgic positioning to avoid pain Facial mask EKG changes *Outcome / Goal:* Patient appears relaxed and comfortable		**Pain Management** Cover wounds as indicated soon as possible Elevate affected part using for instance pillow's Establish pain management plan with client, family, and healthcare providers Investigate changes in characteristics of pain. Note factors that aggravate and relieve pain Obs vital signs_____ Optimize the patient's comfort in bed Plan for aggressive pain management, as indicated Administer medication as prescribet Obs. pain (effectivnes of medication) Maintain comfortable environmental temperature	

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Burns

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for infection *Related factors:* Tissue destruction Lung obstruction and secretions Inadequate primary defenses. suppressed inflammatory response *Symptoms / Risk factors:* Temp > 37.5 *Outcome / Goal:* Norma body temperature Risk for infection reduced through treatment Surgical wound clean		**Infection Protection** Implement appropriate isolation techniques as indicated Monitor client's vital signs and signs ____ Use strict aseptic technique, IV, Tubes, drains and catheters Obtain specimens for culture and sensitivity, as indicated Promote meticulous hand washing by staff Monitor staff and visitors for presence of skin lesions Monitor and limit visitors, if necessary **Wound Care** Inspect dressings and wound Shave/clip all hair from around burned areas Provide special care for eyes Débride necrotic and loose tissue Administer oral, IV, and topical antibiotics, as indicated Monitor vital signs.	
	Risk for peripheral neurovascular dysfuncti *Related factors:* burns of extremities interruption of arterial or venous blood flow *Symptoms / Risk factors:* Necrosis of skin Neuropathia *Outcome / Goal:* peripheral pulses palpable Color of skin normal		**Circulatory Care: Arterial Insufficiency** Palpate peripheral pulses noting strength and equality Assess color, sensation, movement, capillary refill Elevate affected extremities, as appropriate Maintain fluid replacement per protocol Encourage and assist with early ambulation Monitor lab. Hgb/Hct ,	
	Imbalanced nutrition: Insufficient *Related factors:* Altered absorption of nutrients Hypermetabolic state *Symptoms / Risk factors:* Dehydration Capillary fragility Weakness of muscles required for swallowing or mastication Weight loss *Outcome / Goal:* Patient will maintain balanced intake and output		**Nutrition Therapy** Consult a dietitian Inspect oral mucosa and client's appetite Auscultate bowel sounds Administer enteral or parenteral feedings, as indicated Administer TPN feedings as ordered Initiate intermittent or tube feedings as indicated Monitor laboratory studies Resume or advance diet as indicated—clear liquids - high-protein, high-calorie Assess weight, age, body mass, strength, and activity and rest levels	
	Ineffective tissue perfusion *Related factors:* Interruption of flow, arterial Hypovolemia Tissue edema *Symptoms / Risk factors:* Blood pressure changes in extremities Altered blood pressure outside of acceptable parameters Altered sensations Abnormal arterial blood gases *Outcome / Goal:* Patient has reduced risk of complication from disease Report or demonstrate normal sensations and movement		**Circulatory Precautions** Check wound dressing and output from drain Monitor affected extremities for pulse,skin color and temprature Maintain adequate hydration to prevent increased blood viscosity Administer blod, plasma as indicated	

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Burns

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Impaired skin integrity *Related factors:* Altered circulation or reduced blood supply Altered metabolic state Edema formation *Symptoms / Risk factors:* bleeding Destruction of skin layers (dermis) Open wounds Temp > 38.5 *Outcome / Goal:* Display timely wound healing without complications. surgcial wound clean		**Skin Surveillance** Encourage ambulation Inspect patient's skin every shift, document skin condition and report change Keep patient's linens dry, clean and free from wrinkles or curmps Monitor bloody drainage from surgical sites, suture and drains Monitor patient's nutitional status every _____ hours and document	
	Impaired physical mobility *Related factors:* Musculoskeletal, neuromuscular impairment Intolerance to activity/decreased strength and endurance Altered cellular metabolism Medications Prescribed movement restrictions *Symptoms / Risk factors:* Reluctance to attempt movement Limited ability to perform fine motor skills Limited ability to perform gross motor skills *Outcome / Goal:* Ability to move within prescribet limits (while in bed)		**Energy Management** Assess client's ability to perform normal tasks and ADL's Maintain proper body alignment with supports Monitor vital signs and response to activity, weakness,dyspena and fatigue Perform ROM exercises consistently Obs. pateints symptoms(comfort,vital sign and skin color) related to his activit Encourage activiy as tolerated, rest as needed Medicate for pain before activity or exercises	
	Anxiety *Related factors:* Environment Stress Threat of death Threat to or change in Health status *Symptoms / Risk factors:* Anxious Confusion Difficulty concentrating *Outcome / Goal:* Demonstrate problem-solving skills. Will experience a reduction in anxiety		**Anxiety reduction** Assess reasons for anxiety Provide accurate, concrete information about what is being done Reduce unnecessary externa stimuli Reinforce previous information client has been given Spend time talking with resident. Allow to express feelings. Administer medications as ordered and monitor for side effects, effectiveness.	
	Disturbed body image *Related factors:* Preceived body image changes Trauma or injury *Symptoms / Risk factors:* Actual change in structure and/or function Anxiety, depression, lack of eye contact Fear of rejection or of reaction by others *Outcome / Goal:* Patient is able to identify changes in self		**Body Image Enhancement** Assess feelings about self and body Assist patient to identify actions that will enhance appearance Avoid arguing with client Establish a therapeutic nurse-client relationship Encourage client to express his feelings Monitor whether patient can look at the changed body part Encourage family interaction with one another	

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Burns

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Deficient knowledge *Related factors:* Information misinterpretation Unfamiliarity with information resources *Symptoms / Risk factors:* Inaccurate follow through of instruction Multiple questions *Outcome / Goal:* Identify and use available resources appropriately Patient verbalize understanding of procedure		Teaching: Disease Process Acknowledge patient's knowledge about condition Discuss symptoms and interventions Discuss therapy/treatment options Emphasize need for long-term follow up and periodic reevaluation. Identify appropriate community resources Outline normally expected limitations, if any, on ADLs Stress importance of well-balanced diet and adequate fluid intake.	

Plan created: 3.11.2016 by:_____

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