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Sl. no	Assessment	Diagnosis	Interventions	Rationale	Expected outcomes
1.	**Subjective data:** - **Objective data:** Presence of extensive burn injury	Acute pain related to burn injury	• Assess the severity of pain • Administer IV analgesia as needed to manage pain. • Administer medication for pain 30 min before interventions. • Administer anti anxiety medications as needed to manage anxiety and agitation. • Evaluate effectiveness of medication. • Provide emotional support. • Reposition patient carefully using lifting sheet as necessary to avoid further trauma to skin. • Plan adequate rest periods to facilitate coping. • Administer medication before interventions. • Teach relaxation techniques, guided imagery, distraction to augment other pain relief measures. Plan diversional activities to distract patient from present situation. • Be aware that patient's pain may be replaced by itchiness. • Keep skin lubricated with water-based moisturizes to prevent drying. • Caution patient to avoid injury to new, fragile skin.	• Pain level provides baseline for evaluating effectiveness of pain relief measures. • Hypoxia can cause similar signs and must be ruled out before analgesic medication is administered. • Intravenous administration is necessary because of altered tissue perfusion from burn injury. • Emotional support is essential to reduce fear and anxiety resulting from burn injury. Fear and anxiety increase the perception of pain.	• States pain level is decreased • Absence of nonverbal cues of pain
2.	**Subjective data:**	Impaired gas exchange related	• Provide humidified oxygen. • Assess breath sounds, and respiratory rate, rhythm, depth, and symmetry. Monitor patient for signs of	• Humidified oxygen provides moisture to injured tissues;	Absence of dyspnea

	Objective data: Increased respiratory rate	to carbon monoxide poisoning, smoke inhalation, and upper airway obstruction **Goal:** Maintenance of adequate tissue oxygenation	hypoxia. • Observe for the following: Erythema or blistering of lips or buccal mucosa Singed nostrils Burns of face, neck, or chest Increasing hoarseness Soot in sputum or tracheal tissue in respiratory secretions • Monitor arterial blood gas values, pulse oximetry readings, and carboxyhemoglobin levels. • Report labored respirations, decreased depth of respirations, or signs of hypoxia to physician immediately. • Prepare to assist with intubation and escharotomies. • Monitor mechanically ventilated patient closely.	supplemental oxygen increases alveolar oxygenation. • These factors provide baseline data for further assessment and evidence of increasing respiratory compromise. • These signs indicate possible inhalation injury and risk of respiratory dysfunction. • Increasing PCO2 and decreasing PO2 and O2 saturation may indicate need for mechanical ventilation. • Immediate intervention is indicated for respiratory difficulty. • Intubation allows mechanical ventilation. Escharotomy enables chest excursion in circumferential chest burns. • Monitoring allows early detection of decreasing respiratory status or complications of mechanical ventilation.	• Respiratory rate between 12 and 20 breaths/min • Lungs clear on auscultation • Arterial oxygen saturation >96% by pulse oximetry • Arterial blood gas levels within normal Limits

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3.	**Subjective data:** - **Objective data:** dyspnoea	Ineffective airway clearance related to edema and effects of smoke inhalation **Goal:** Maintain patent airway and adequate airway clearance	• Maintain patent airway through proper patient positioning, removal of secretions, and artificial airway if needed. • Provide humidified oxygen. • Encourage patient to turn, cough, and deep breathe. Encourage patient to use incentive spirometry. Suction as needed.	• A patent airway is crucial to respiration. • Humidity liquefies secretions and facilitates expectoration. • These activities promote mobilization • and removal of secretions.	Patent airway • Respiratory secretions are minimal, colorless, and thin • Respiratory rate, pattern, and breath sounds normal
4.	**Subjective data:** **Objective data:** Decreased pulse rate	Fluid volume deficit related to increased capillary permeability and evaporative losses from the burn wound **Goal:** Restoration of optimal fluid and electrolyte balance and perfusion of vital organs.	• Observe vital signs (including central venous pressure or pulmonary artery pressure, if indicated) and urine output, and be alert for signs of hypovolemia or fluid overload. • Monitor urine output at least hourly and weigh patient daily. • Maintain IV lines and regulate fluids at appropriate rates, as prescribed. • Observe for symptoms of deficiency or excess of serum sodium, potassium, calcium, phosphorus, and bicarbonate. • Elevate head of patient's bed and elevate burned extremities. • Notify physician immediately of decreased urine output, blood pressure, central venous, pulmonary artery, or pulmonary artery wedge pressures, or increased pulse rate.	• Hypovolemia is a major risk immediately after the burn injury. Over resuscitation might cause fluid overload. • Output and weight provide information about renal perfusion, adequacy of fluid replacement, and fluid requirement and fluid status. • Adequate fluids are necessary to maintain fluid and electrolyte balance and perfusion of vital organs. • Rapid shifts in fluid and	• Serum electrolytes within normal limits • Urine output between 0.5 and 1.0 mL/kg/hr • Blood pressure higher than 90/60 mm Hg • Heart rate less than 120 beats/min • Exhibits clear

				electrolyte status are possible in the post burn period. • Elevation promotes venous return. • 6. Because of the rapid fluid shifts in burn shock, fluid deficit must be detected early so that distributive shock does not occur.	sensorium • Voids clear yellow urine with specific gravity within normal limits
5.	**Subjective data:** **Objective data:**	Hypothermia related to loss of skin microcirculation and open wounds **Goal:** Maintenance of adequate body temperature	1. Provide a warm environment through use of heat shield, space blanket, heat lights, or blankets. 2. Work quickly when wounds must be exposed. 3. Assess core body temperature frequently.	1. A stable environment minimizes evaporative heat loss. 2. Minimal exposure minimizes heat loss from wound. 3. Frequent temperature assessments help detect developing hypothermia.	• Body temperature remains 36.1to 38.3C (97to 101F) • Absence of chills or shivering
6.	**Subjective data:** **Objective data:**	Anxiety related to fear and the emotional impact of burn injury **Goal:** Minimization of patient's and	1. Assess patient's and family's understanding of burn injury, coping skills, and family dynamics. 2. Individualize responses to the patient's and family's coping level. 3. Explain all procedures to the patient and the family in clear, simple terms. 4. Maintain adequate pain relief.	1. Previous successful coping strategies can be fostered for use in the present crisis. Assessment allows planning of individualized interventions. 2. Reactions to burn injury are extremely variable. Interventions	• Patient and family verbalize understanding of emergent burn care • Able to

		family's anxiety	5. Consider administering prescribed antianxiety medications if the patient remains extremely anxious despite nonpharmacologic interventions.	must be appropriate to the patient's and family's present level of coping. 3. Increased understanding alleviates fear of the unknown. High levels of anxiety may interfere with understanding of complex explanations. 4. Pain increases anxiety. 5. Anxiety levels during the emergent phase may exceed the patient's coping abilities. Medication decreases physiologic and psychological anxiety responses.	answer simple questions
7.	**Subjective data:** **Objective data:**	Acute respiratory failure, distributive shock, acute renal failure, compartment syndrome, paralytic ileus, Curling's ulcer **Goal:** Absence of complications	**Acute Respiratory Failure** 1. Assess for increasing dyspnea, stridor, changes in respiratory patterns. 2. Monitor pulse oximetry, arterial blood gas values for decreasing PO2 and oxygen saturation, and increasing PCO2. 3. Monitor chest x-ray results. 4. Assess for restlessness, confusion, difficulty attending to questions, or decreasing level of consciousness. 5. Report deteriorating respiratory status immediately to	1. Such signs reflect deteriorating respiratory status. 2. Such signs reflect decreased oxygenation status. 3. X-ray may disclose pulmonary injury. 4. Such manifestations may indicate cerebral hypoxia. 5. Acute respiratory failure is life-threatening, and immediate intervention is required.	• Arterial blood gas values within acceptable limits: PO2 >80 mm Hg, PCO2 <50 mm Hg • Breathes spontaneously with adequate

			physician. 6. Prepare to assist with intubation or escharotomies as indicated. **Distributive Shock** 1. Assess for decreasing urine output, pulmonary artery and pulmonary artery wedge pressures, blood pressure, and cardiac output, or increasing pulse. 2. Assess for progressive edema as fluid shifts occur. 3. Adjust fluid resuscitation in collaboration with the physician in response to physiologic findings. **Acute Renal Failure** 1. Monitor urine output and blood urea nitrogen (BUN) and creatinine levels. 2. Report decreased urine output or increased BUN and creatinine values to physician. 3. Assess urine for hemoglobin or myoglobin. 4. Administer increased fluids as prescribed. **Compartment Syndrome**	6. Intubation allows mechanical ventilation. Escharotomies allow improved chest excursion with respirations. 1. Such signs and symptoms may indicate distributive shock and inadequate intravascular volume. 2. As fluid shifts into the interstitial spaces in burn shock, edema occurs and may compromise tissue perfusion. 3. Optimal fluid resuscitation prevents distributive shock and improves patient outcomes. 1. These values reflect renal function. 2. These laboratory values indicate possible renal failure. 3. Hemoglobin or myoglobin in the urine points to an increased risk of renal failure. 4. Fluids help to flush out hemoglobin and myoglobin from renal tubules, decreasing the potential for renal failure. 1. Assessment with Doppler	tidal volume • Chest x-ray findings normal • Absence of cerebral signs of hypoxia • Urine output between 0.5 and 1.0 mL/kg/hr • Blood pressure within patient's normal range (usually >90/60 mm Hg) • Heart rate within patient's normal range (usually <110/min) • Pressures and cardiac output remain within

			1. Assess peripheral pulses hourly with Doppler ultrasound device. 2. Assess warmth, capillary refill, sensation, and movement of extremity hourly. Compare affected with unaffected extremity. 3. Remove blood pressure cuff after each reading. 4. Elevate burned extremities. 5. Report loss of pulse or sensation or presence of pain to physician immediately. 6. Prepare to assist with escharotomies. **Paralytic Ileus** 1. Maintain nasogastric tube on low intermittent suction until bowel sounds resume. 2. Auscultate for bowel sounds, abdominal distention. **Curling's Ulcer** 1. Assess gastric aspirate for pH and blood.	device substitutes for auscultation and indicates characteristics of arterial blood flow. 2. These assessments indicate characteristics of peripheral perfusion. 3. Cuff may act as a tourniquet as extremities swell. 4. Elevation reduces edema formation. 5. These signs and symptoms may indicate inadequate tissue perfusion. 6. Escharotomies relieve the constriction caused by swelling under circumferential burns and improve tissue perfusion. 1. This measure relieves gastric and abdominal distention, also prevents vomiting. 2. As bowel sounds resume, feeding may be slowly initiated. Abdominal distention reflects inadequate decompression. 1. Acidic pH indicates need for antacids or histamine blockers. Blood indicates possible gastric	normal limits • Adequate urine output • BUN and creatinine values remain normal • Absence of paresthesias or symptoms of ischemia of nerves and muscles • Peripheral pulses detectable by Doppler • Absence of abdominal distention • Normal bowel sounds within 48 hours • Absence of abdominal distention •Normal bowel

			2. Assess stools for occult blood. 3. Administer histamine blockers and antacids as prescribed.	bleeding. 2. Blood in stools may indicate gastric or duodenal ulcer. 3. Such medications reduce gastric acidity and risk of ulceration.	sounds within 48 hours • Gastric aspirate and stools do not contain blood