

Nursing Care PLAN for Burn:

Assessment	Nursing Diagnosis	Goal/Expected Outcome	Intervention/Planning	Implementation	Rationale	Evaluation
<p>Subjective Data:</p> <ul style="list-style-type: none"> - Patient reports severe pain and redness at the burn site. <p>Objective Data:</p> <ul style="list-style-type: none"> - Burned area is red, swollen, and blistered; patient rates pain as 8/10. 	<p>Impaired Skin Integrity related to burn injury as evidenced by redness, swelling, and blistering.</p>	<p>Short-Term:</p> <ul style="list-style-type: none"> - Within 1 day, reduce pain and inflammation. <p>Long-Term:</p> <ul style="list-style-type: none"> - Wound heals with minimal scarring and controlled infection. 	<p>Clean the wound with antiseptic solutions and apply antimicrobial dressings; administer pain medication as prescribed.</p>	<p>Follow aseptic techniques during dressing changes; monitor pain every 30 minutes; document wound progress.</p>	<p>Proper wound care reduces bacterial colonization and promotes healing.</p>	<p>Pain decreases; wound appearance improves; signs of infection reduce.</p>
<p>Subjective Data:</p> <ul style="list-style-type: none"> - Patient reports feeling weak and fatigued. <p>Objective Data:</p> <ul style="list-style-type: none"> - Vital signs indicate low blood pressure; patient appears 	<p>Deficient Fluid Volume related to fluid loss from burn injury as evidenced by hypotension and weight loss.</p>	<p>Short-Term:</p> <ul style="list-style-type: none"> - Within 1 hour, stabilize blood pressure and improve hydration. <p>Long-Term:</p> <ul style="list-style-type: none"> - Patient maintains adequate fluid volume and 	<p>Initiate IV fluid therapy and administer blood products if needed; monitor urine output and vital signs.</p>	<p>Begin fluid resuscitation immediately; reassess vital signs every 15 minutes; document fluid balance.</p>	<p>Fluid replacement is essential to restore volume and prevent shock.</p>	<p>Vital signs stabilize; urine output increases; patient reports improved energy.</p>

pale; weight loss noted.		improved overall stability.				
Subjective Data: - Patient and family express uncertainty about managing home wound care. Objective Data: - Inconsistent care practices noted; family asks for detailed instructions.	Deficient Knowledge regarding proper burn care as evidenced by family uncertainty and inconsistent home care.	Short-Term: - Within 24 hours, family will verbalize key wound care techniques. Long-Term: - Family adheres to the prescribed care plan and follows up regularly.	Develop an education plan with clear, written instructions and visual aids on burn care management.	Conduct individual teaching sessions; provide printed materials; schedule follow-up reviews.	Education empowers families to manage wound care effectively and reduces anxiety.	Family demonstrates understanding; home care practices become consistent; follow-up confirms adherence.