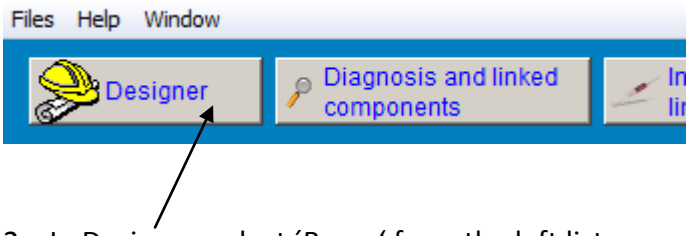
Getting Strarted

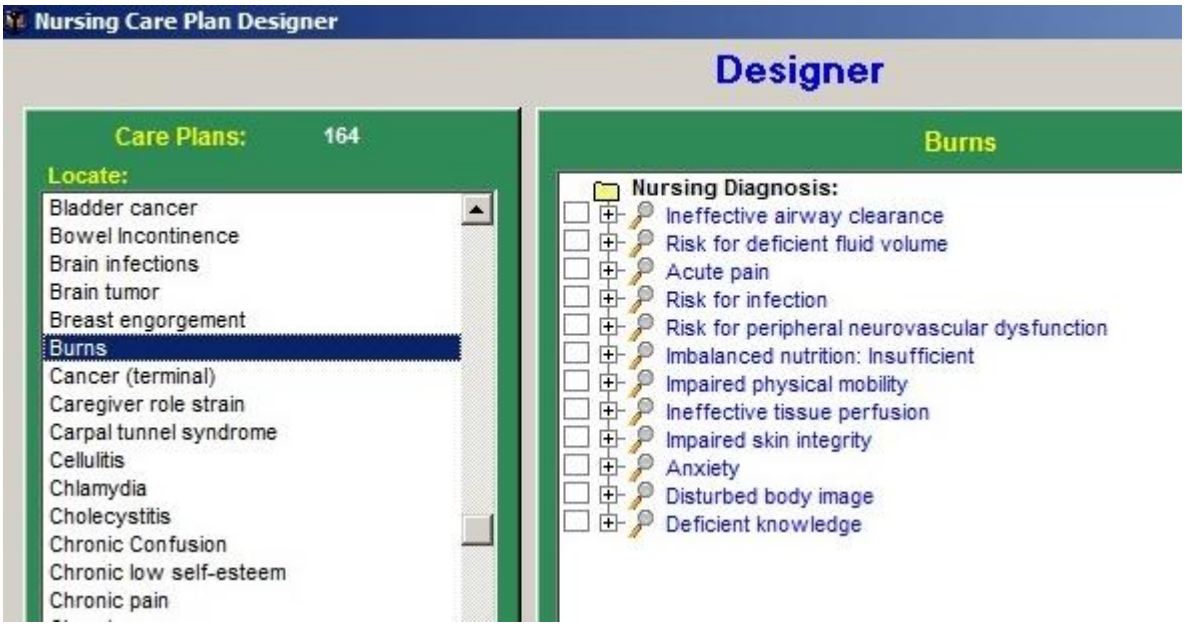
using the Nursing Care Plans Templates

Using available Nursing Care Plan Templates. These templates are delivered as is and there is nothing which prevents you to use and modify these templates. Almost no patient fits exactly into a template and adjustment is mandatory. We will show you by example how to do this.
We will use the Nursing Care Plan template : BURNS for this example. The patient has been transferred to ICU with severe 3 degree burn trauma. He is put into induced coma.
We will now create nursing care plan for this patient using the BURNS template.

1. Start CareScribble and click on ´Designer´

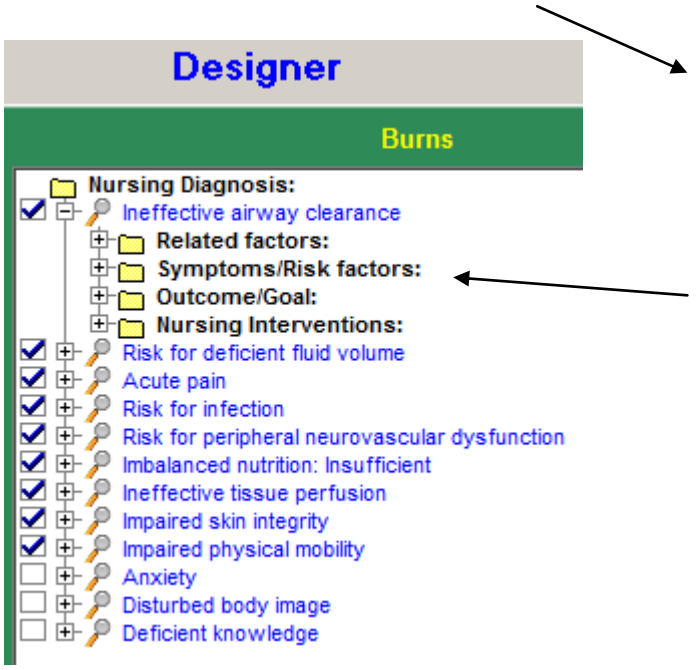


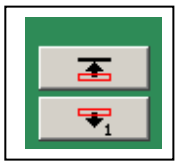
2. In Designer select ´Burns‘ from the left list .



3. After selection - the list(right) of Nursing Diagnosis for burns show up. Not all diagnosis would apply here in this (acute) phase. As the patient is in induced coma we will skip(not tagged)diagnosis *´Anxiety´ ´Disturbed body image´* and *´Deficient knowledge´* . When not tagged (skipped) it does not appear in the printout. They are for later use when patient is awake and recovering. You have of course the option to modify (add and remove) Nursing Diagnosis

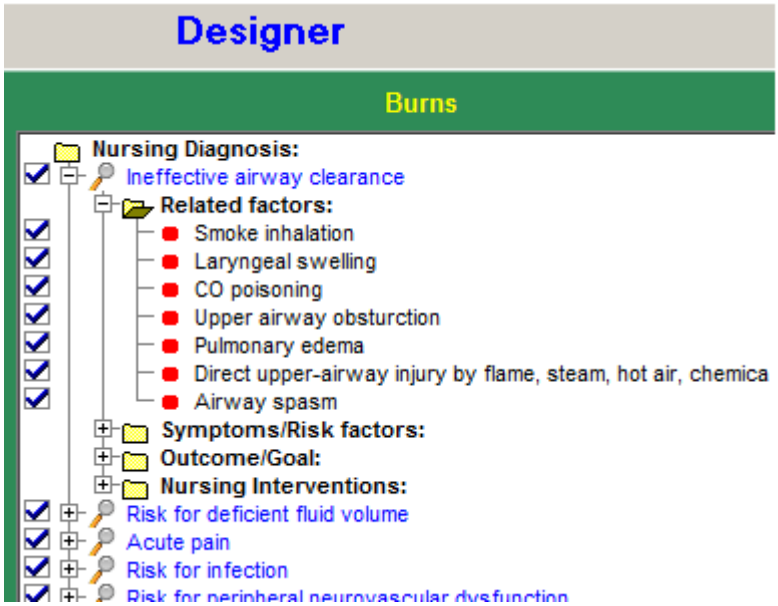
4. As shown her below the first 9 nursing diagnosis have been selected(tagged) and the last 3 diagnosis are not used (not tagged) in this phase (acute). We assume the order of diagnosis in the list is correct but if you prefer you could change the order. The most important and number one diagnosis is ´*Ineffective airway clearance*‘ and number two is ´*Risk for deficient fluid volume*‘ and so on. To change the order use the ***"Move Up / Move Down"*** feature (buttons) to ***prioritize*** diagnosis in list. This feature applies also for other data in list.



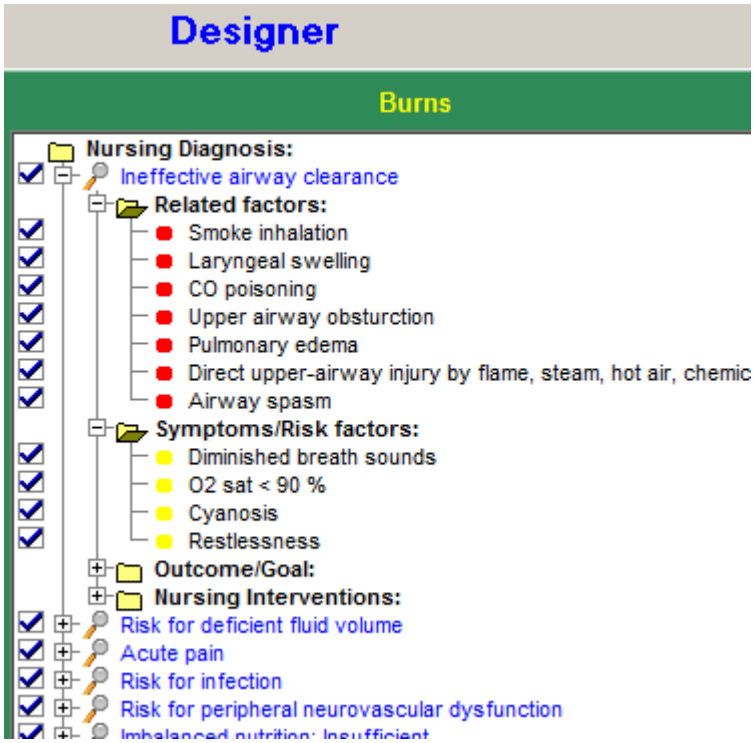


Next click on + for ´Ineffective airway clearance´. The associate data for this diagnosis show up. ´Related factors, Symptoms…. etc’

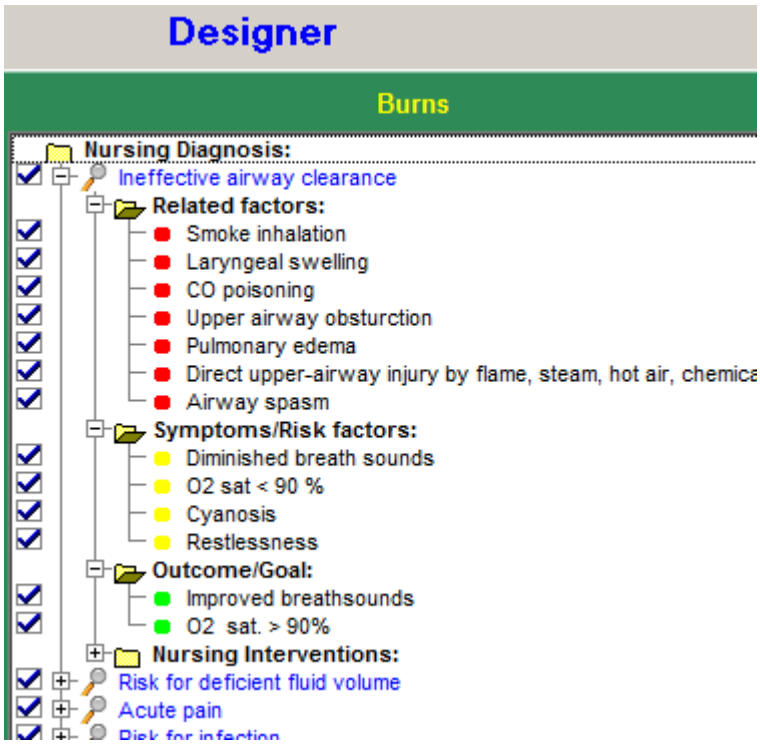
5. Click on + for ´Related factors´. The data here can also be selected/unselected and the order can also be modified as above in section 4.



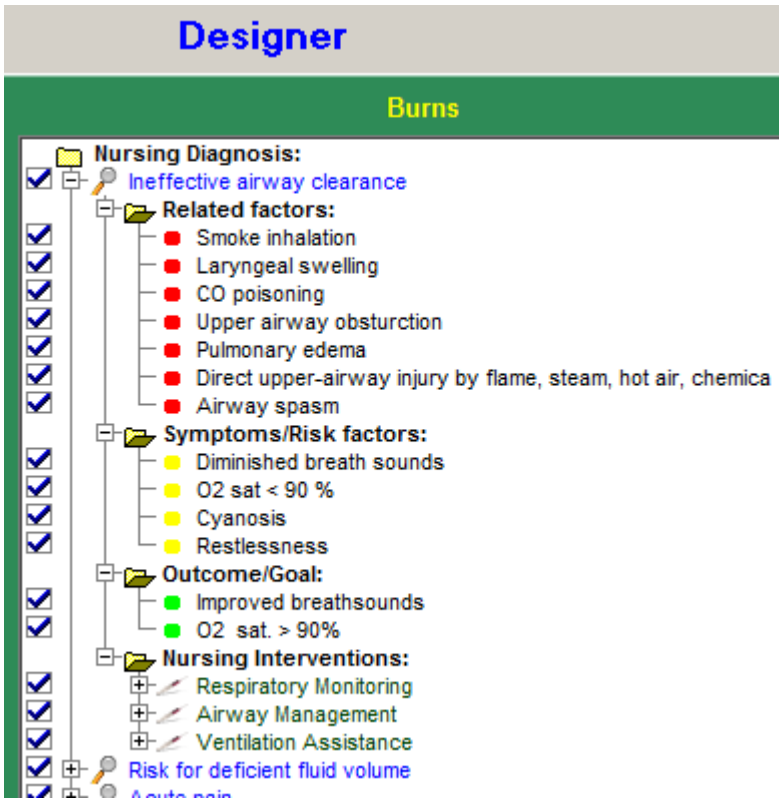
6. Click on + for ´Symptoms/Risk factors´ . The data here can also be selected/unselected and the order can also be modified as above in section 4.



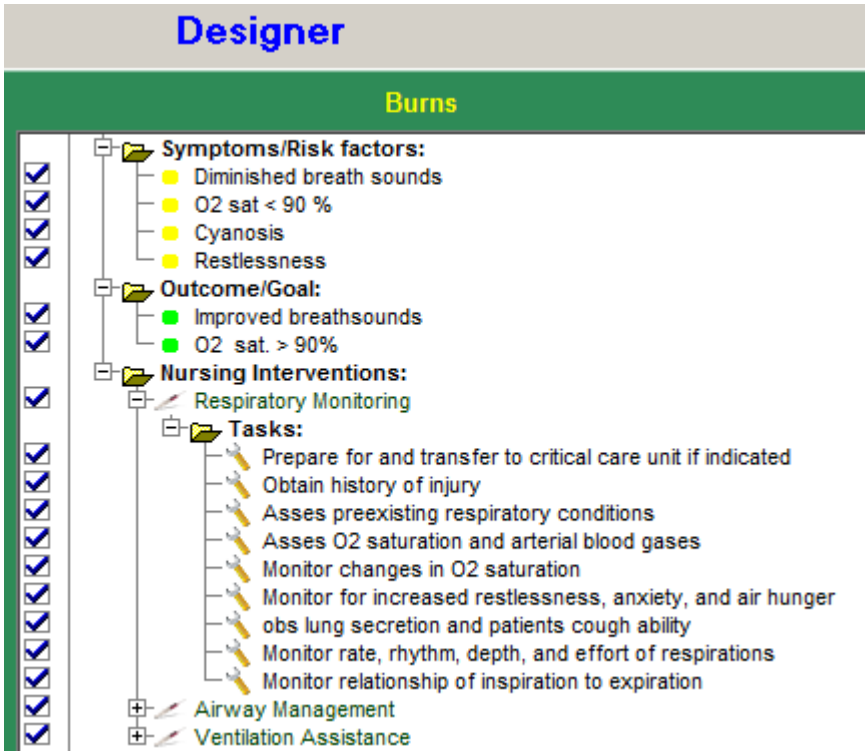
7. Click on + for ´Outcome/Goal´ . The data here can also be selected/unselected and the order can also be modified as above in section 4.



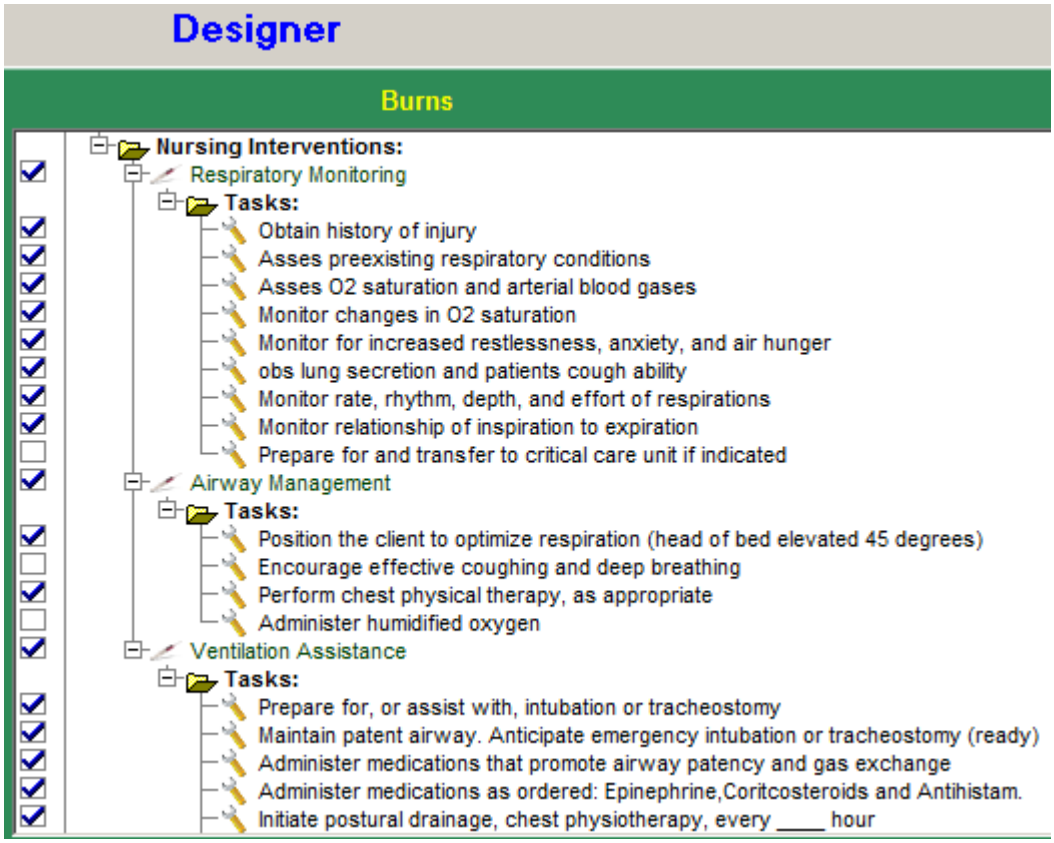
8. Click on + for ´Nursing Interventions´ . The data here can also be selected/unselected and the order can also be modified as above in section 4.



9. Click on + for ´Respiratory Monitoring´ . The data(Tasks) here can also be selected/unselected and the order can also be modified as above in section 4.

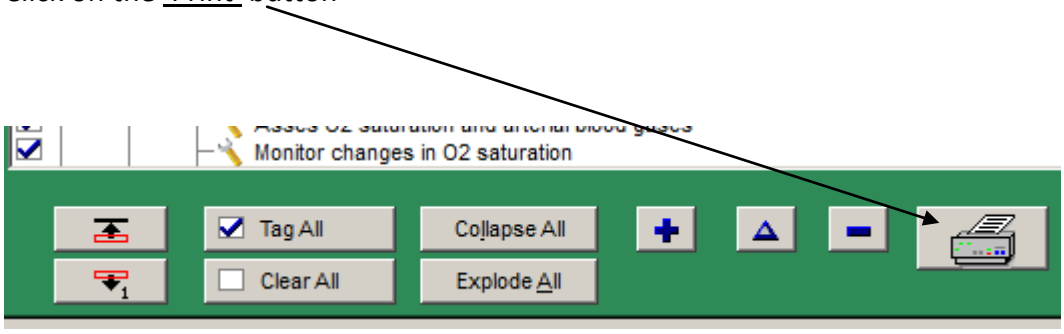


10. The same method applies for ‘Airway Management’ and ‘ Ventilation Assistance’



Now it’s all done for the first diagnosis and now you should go to next diagnosis and use and perform the same action - it’s perhaps slow process when doing this for the first time for all selected diagnosis associate data but when you get used to do this – it’s fast process.

11. When all diagnosis and associate data is done it is time to see the result.
Click on the ‘Print’ button



The result or printout is shown here below as an example but you can also save the plan as PDF and/or Word docs (for further editing using your own favorite PDF and/or Word editor).

Printout

Care Plan: **Burns**

Nr.	Nursing Diagnosis	Date	Intervention/s and tasks	Sign.
	Ineffective airway clearance ***Related factors:*** Smoke inhalation Laryngeal swelling CO poisoning Upper airway obstruction 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 breath sounds 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 Antihistamine. • 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	
	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.	

---------- Plan continues on next page ----------

Nr.	Nursing Diagnosis	Date	Intervention/s and tasks	Sign.
	Risk for peripheral neurovascular dysfunction ***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	
	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	

Plan created: 27.4.2016 by: _____

Signature