

S — Safety and protection

26 statements · Recommended tool: CP-SAFE Safety & Falls Score · Validated scales: Morse Fall Scale

S1 Likely to fall

Group: Safety and protection | Type: Risk problem

Definition: Weakness, medicine, poor balance, or hazards raise the chance of a fall.

Risk factors: Weakness; poor balance; sedating medicines; confusion; wet floors; poor sight; past falls

Warning signs: Unsteady walking; dizziness; holding on to walls; fall history; rushing to the toilet

Scenario. An older woman who fell last year walks to the bathroom alone at night after taking a sleeping tablet.

S: "I always get up at night to use the bathroom and I'm a bit wobbly."

O: Fell last year; walks unsteadily; takes a sleeping tablet; high fall-risk score; wears loose slippers.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Likely to fall related to weakness and poor balance (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess fall risk. | Assessing fall risk identifies which factors, such as past falls and medicine, apply to this patient so prevention can be targeted. | | Keep the bed low with the call bell in reach. | A low bed reduces injury if she falls or steps out, and a call bell in reach lets her ask for help instead of walking alone. | | Non-slip shoes. | Non-slip shoes give better grip and support than loose slippers, lowering the risk of slipping or tripping. | | Clear the path. | A clear path removes objects and spills she could trip on when walking to the bathroom at night. | | Assist walking. | Help from staff while walking gives support when she feels wobbly, especially after a sleeping tablet. | | Review medicines. | Some medicines, including sleeping tablets, cause drowsiness and unsteadiness, so reviewing them may allow a safer choice or dose. | ****Expected outcomes**** - No falls during the stay. - Calls for help before getting up. - Wears non-slip footwear. - States 3 fall prevention steps by discharge. ****Linking the data to the diagnosis**** The older woman fell last year, walks unsteadily, takes a sleeping tablet, wears loose slippers and has a high fall-risk score. She says she always gets up at night to use the bathroom and is a bit wobbly. No fall is described now, so the problem has not occurred and the diagnosis rests on risk factors, which makes likely to fall correct. The plan aims for no falls during the stay, calling for help before getting up, non-slip footwear worn, and the patient stating 3 fall prevention steps by discharge.

CarePath diagnosis: Likely to fall related to weakness and poor balance (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Assess fall risk.	Assessing fall risk identifies which factors, such as past falls and medicine, apply to this patient so prevention can be targeted.
Keep the bed low with the call bell in reach.	A low bed reduces injury if she falls or steps out, and a call bell in reach lets her ask for help instead of walking alone.
Non-slip shoes.	Non-slip shoes give better grip and support than loose slippers, lowering the risk of slipping or tripping.
Clear the path.	A clear path removes objects and spills she could trip on when walking to the bathroom at night.
Assist walking.	Help from staff while walking gives support when she feels wobbly, especially after a sleeping tablet.
Review medicines.	Some medicines, including sleeping tablets, cause drowsiness and unsteadiness, so reviewing them may allow a safer choice or dose.

Expected outcomes: No falls during the stay. · Calls for help before getting up. · Wears non-slip footwear. · States 3 fall prevention steps by discharge.

Linking the data: The older woman fell last year, walks unsteadily, takes a sleeping tablet, wears loose slippers and has a high fall-risk score. She says she always gets up at night to use the bathroom and is a bit wobbly. No fall is described now, so the problem has not occurred and the diagnosis rests on risk factors, which makes likely to fall correct. The plan aims for no falls during the stay, calling for help before getting up, non-slip footwear worn, and the patient stating 3 fall prevention steps by discharge.

S2 Likely to catch an infection

Group: Safety and protection | Type: Risk problem

Definition: Wounds, lines, weak defenses, or exposure raise the chance of infection.

Risk factors: Open wound; invasive lines; low immunity; diabetes; poor hygiene; surgery

Warning signs: Fever; redness; warmth; pus; raised white cell count; new confusion

Scenario. A patient with a central line and chemotherapy has a high risk of infection.

S: "I have a catheter line in my chest."

O: Central line in place; low white cell count (1.2); on chemotherapy; temperature 37.2 C; line site clean.

Tools: CP-SAFE, CP-INFECT · Morse Fall Scale, qSOFA / sepsis screen **CarePath diagnosis:** Likely to catch an infection related to a central line, chemotherapy, and a low white cell count (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---|---| | Wash hands. | Hand washing removes germs from the hands, the most common way infection is carried to a patient with weak defenses. | | Use clean technique for dressings and lines. | Clean technique for dressings and lines stops germs from entering the bloodstream through the central line. | | Monitor temperature. | Fever may be the earliest sign of infection in someone with a low white cell count, so regular checks catch it early. | | Teach hygiene. | Teaching hygiene, such as handwashing and keeping the line site dry, lets the patient reduce germs between nursing visits. | | Report early signs. | Early reporting of signs such as fever, redness or chills allows quick treatment before infection spreads in a patient with low immunity. | **Expected outcomes** - No fever, redness, or pus at the line site. - Blood tests show no infection. - Hands cleaned before every contact. - Patient reports early signs. **Linking the data to the diagnosis** The patient has a central line, is on chemotherapy, and has a low white cell count of 1.2. Their temperature is 37.2 C and the line site is clean, so there is no fever, redness or pus. Infection has not occurred, so this is a risk diagnosis resting on the line and weak defenses, not an actual infection. The patient says they have a catheter line in the chest. The plan aims for no fever, redness or pus at the line site, blood tests showing no infection, hands cleaned before every contact, and the patient reporting early signs.

CarePath diagnosis: Likely to catch an infection related to a central line, chemotherapy, and a low white cell count (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Wash hands.	Hand washing removes germs from the hands, the most common way infection is carried to a patient with weak defenses.
Use clean technique for dressings and lines.	Clean technique for dressings and lines stops germs from entering the bloodstream through the central line.
Monitor temperature.	Fever may be the earliest sign of infection in someone with a low white cell count, so regular checks catch it early.
Teach hygiene.	Teaching hygiene, such as handwashing and keeping the line site dry, lets the patient reduce germs between nursing visits.
Report early signs.	Early reporting of signs such as fever, redness or chills allows quick treatment before infection spreads in a patient with low immunity.

Expected outcomes: No fever, redness, or pus at the line site. · Blood tests show no infection. · Hands cleaned before every contact. · Patient reports early signs.

Linking the data: The patient has a central line, is on chemotherapy, and has a low white cell count of 1.2. Their temperature is 37.2 C and the line site is clean, so there is no fever, redness or pus. Infection has not occurred, so this is a risk diagnosis resting on the line and weak defenses, not an actual infection. The patient says they have a catheter line in the chest. The plan aims for no fever, redness or pus at the line site, blood tests showing no infection, hands cleaned before every contact, and the patient reporting early signs.

S3 Likely to get hurt

Group: Safety and protection | Type: Risk problem

Definition: The person's condition or surroundings raise the chance of accidental harm.

Risk factors: Confusion; weakness; hazards; poor sight; unsafe equipment

Warning signs: Near misses; bumps; unsafe movements; cluttered space

Scenario. A confused patient climbs over the bed rails.

S: "I need to get out and go home."

O: Confused; climbs over bed rails; unsteady; bed alarm sounding.

Tools: CP-SAFE, CP-OLDER · Morse Fall Scale, 4AT / CAM, Mini-Cog ****CarePath diagnosis:**** Likely to get hurt related to confusion and weakness (risk factors); no signs of the problem are present yet.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Remove hazards. | Removing hazards such as clutter and unsafe objects lowers the chance of tripping or bumping. | | Supervise. | A confused, unsteady patient cannot judge danger, so close supervision lets staff step in before injury. | | Meet needs early. | Needs such as toileting, thirst and pain can drive restlessness, so meeting them early lessens the urge to leave the bed. | | Use safe equipment. | Safe equipment, such as a low bed and a working bed alarm, reduces the height of any fall and alerts staff quickly. | | Reassure and reorient. | Calm reassurance and reminders of place and time lower fear and confusion, which reduces attempts to leave. | ****Expected outcomes**** - No injuries. - Stays in bed or sits safely with supervision. - Needs anticipated. - Confusion treated and patient calmer. ****Linking the data to the diagnosis**** The confused patient says they need to get out and go home, climbs over the bed rails, is unsteady, and the bed alarm is sounding. No injury has happened yet, so the diagnosis is a risk one resting on confusion and weakness, not an actual injury. It is related to likely to fall, but here the danger includes climbing and other unsafe movements. The plan aims for no injuries, the patient staying in bed or sitting safely with supervision, needs anticipated, and confusion treated so the patient is calmer.

CarePath diagnosis: Likely to get hurt related to confusion and weakness (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Remove hazards.	Removing hazards such as clutter and unsafe objects lowers the chance of tripping or bumping.
Supervise.	A confused, unsteady patient cannot judge danger, so close supervision lets staff step in before injury.
Meet needs early.	Needs such as toileting, thirst and pain can drive restlessness, so meeting them early lessens the urge to leave the bed.
Use safe equipment.	Safe equipment, such as a low bed and a working bed alarm, reduces the height of any fall and alerts staff quickly.
Reassure and reorient.	Calm reassurance and reminders of place and time lower fear and confusion, which reduces attempts to leave.

Expected outcomes: No injuries. · Stays in bed or sits safely with supervision. · Needs anticipated. · Confusion treated and patient calmer.

Linking the data: The confused patient says they need to get out and go home, climbs over the bed rails, is unsteady, and the bed alarm is sounding. No injury has happened yet, so the diagnosis is a risk one resting on confusion and weakness, not an actual injury. It is related to likely to fall, but here the danger includes climbing and other unsafe movements. The plan aims for no injuries, the patient staying in bed or sitting safely with supervision, needs anticipated, and confusion treated so the patient is calmer.

S4 Broken or damaged skin

Group: Safety and protection | Type: Actual problem

Definition: Skin is cut, torn, blistered, or broken down.

Possible causes: Cuts; surgery; pressure; moisture; friction; burns

Signs and symptoms: Open area; redness; blisters; drainage; pain at the skin

Scenario. A bedbound man has a torn area of skin on his elbow after sliding up the bed.

S: "It hurts where the skin came off."

O: Skin tear 3 cm on the elbow; bedbound; slid up the bed; clean edges; minimal drainage.

Tools: CP-SAFE, CP-PAIN, CP-SKIN · Morse Fall Scale, NRS 0–10, FLACC, PAINAD, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Broken or damaged skin related to friction and shearing when sliding up the bed, as evidenced by a 3 cm skin tear on the elbow with minimal drainage. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess skin daily. | Daily skin checks detect changes in the wound or new areas of damage early, before they worsen. | | Clean and dress as ordered. | Cleaning removes germs and debris, and a dressing keeps the wound protected and moist, which supports healing and lowers infection risk. | | Protect from friction and moisture. | Friction and moisture damage fragile skin further, so protecting it prevents new tears and helps healing. | | Position carefully. | Careful positioning avoids the sliding and shearing that caused the tear and keeps pressure off the injured elbow. | | Report worsening. | Reporting worsening signs such as spreading redness, more drainage or pain allows early treatment of infection or delayed healing. | ****Expected outcomes**** - Wound clean with no infection signs. - Heals within 7-14 days. - No new tears. - Staff use safe lifting methods. ****Linking the data to the diagnosis**** The bedbound man says it hurts where the skin came off. The nurse found a 3 cm skin tear on the elbow with clean edges and minimal drainage after he slid up the bed. The skin is already broken, so this is an actual diagnosis, unlike likely to develop pressure sores, which applies while skin is still intact. The plan aims for a clean wound with no signs of infection, healing within 7 to 14 days, no new tears, and staff using safe lifting methods.

CarePath diagnosis: Broken or damaged skin related to friction and shearing when sliding up the bed, as evidenced by a 3 cm skin tear on the elbow with minimal drainage.

Intervention	Rationale
Assess skin daily.	Daily skin checks detect changes in the wound or new areas of damage early, before they worsen.
Clean and dress as ordered.	Cleaning removes germs and debris, and a dressing keeps the wound protected and moist, which supports healing and lowers infection risk.
Protect from friction and moisture.	Friction and moisture damage fragile skin further, so protecting it prevents new tears and helps healing.
Position carefully.	Careful positioning avoids the sliding and shearing that caused the tear and keeps pressure off the injured elbow.
Report worsening.	Reporting worsening signs such as spreading redness, more drainage or pain allows early treatment of infection or delayed healing.

Expected outcomes: Wound clean with no infection signs. · Heals within 7-14 days. · No new tears. · Staff use safe lifting methods.

Linking the data: The bedbound man says it hurts where the skin came off. The nurse found a 3 cm skin tear on the elbow with clean edges and minimal drainage after he slid up the bed. The skin is already broken, so this is an actual diagnosis, unlike likely to develop pressure sores, which applies while skin is still intact. The plan aims for a clean wound with no signs of infection, healing within 7 to 14 days, no new tears, and staff using safe lifting methods.

S5 Likely to develop pressure sores

Group: Safety and protection | Type: Risk problem

Definition: Staying in one position, moisture, or poor nutrition raise the chance of skin breakdown over bony areas.

Risk factors: Immobility; moisture; poor nutrition; older age; diabetes; thin skin

Warning signs: Red skin that does not fade; warm or hard spots over bony areas; pain at pressure points

Scenario. A thin, bedbound older patient with a poor appetite stays in the same position for long periods.

S: "I cannot move myself much."

O: Thin and bedbound; skin over the sacrum intact and turns white when pressed; moist skin; poor appetite; high pressure-injury risk score.

Tools: CP-SAFE, CP-SKIN · Morse Fall Scale, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Likely to develop pressure sores related to immobility, moisture and poor nutrition (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Turn every 2 hours or per plan. | Regular turning relieves pressure over bony areas, which restores blood flow to the skin and prevents tissue damage. | | Check skin. | Checking the skin finds early damage, such as redness that does not fade, while it can still be reversed. | | Use a pressure-relieving mattress. | A pressure-relieving mattress spreads body weight over a wider area, so less pressure falls on the sacrum and other bony points. | | Keep skin clean and dry. | Moisture softens skin and makes it easier to damage, so keeping it clean and dry protects it. | | Encourage nutrition. | Protein, calories and fluids are needed to maintain healthy skin and repair damage, so good nutrition lowers risk. | | Lift, do not drag. | Dragging causes friction and shear that damage skin, while lifting avoids rubbing across the sheet. | ****Expected outcomes**** - Skin stays intact. - Redness resolves within 3 days. - Position changed at least every 2 hours. - Food intake improves toward goal. ****Linking the data to the diagnosis**** The thin, bedbound older patient says they cannot move much, has moist skin, a poor appetite and a high pressure-injury risk score. The skin over the sacrum is intact and turns white when pressed, so no damage has occurred. Because the skin is not broken or damaged, this is a risk diagnosis and not an actual skin problem such as broken or damaged skin. The risk factors are immobility, moisture and poor nutrition. The plan aims for skin to stay intact, position changes at least every 2 hours, and food intake improving toward the goal.

CarePath diagnosis: Likely to develop pressure sores related to immobility, moisture and poor nutrition (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Turn every 2 hours or per plan.	Regular turning relieves pressure over bony areas, which restores blood flow to the skin and prevents tissue damage.
Check skin.	Checking the skin finds early damage, such as redness that does not fade, while it can still be reversed.
Use a pressure-relieving mattress.	A pressure-relieving mattress spreads body weight over a wider area, so less pressure falls on the sacrum and other bony points.
Keep skin clean and dry.	Moisture softens skin and makes it easier to damage, so keeping it clean and dry protects it.
Encourage nutrition.	Protein, calories and fluids are needed to maintain healthy skin and repair damage, so good nutrition lowers risk.
Lift, do not drag.	Dragging causes friction and shear that damage skin, while lifting avoids rubbing across the sheet.

Expected outcomes: Skin stays intact. · Redness resolves within 3 days. · Position changed at least every 2 hours. · Food intake improves toward goal.

Linking the data: The thin, bedbound older patient says they cannot move much, has moist skin, a poor appetite and a high pressure-injury risk score. The skin over the sacrum is intact and turns white when pressed, so no damage has occurred. Because the skin is not broken or damaged, this is a risk diagnosis and not an actual skin problem such as broken or damaged skin. The risk factors are immobility, moisture and poor nutrition. The plan aims for skin to stay intact, position changes at least every 2 hours, and food intake improving toward the goal.

S6 Likely to bleed easily

Group: Safety and protection | Type: Risk problem

Definition: Blood-thinning medicine, low platelets, or illness raise the chance of bleeding.

Risk factors: Blood thinners; low platelets; liver disease; trauma; surgery

Warning signs: Easy bruising; bleeding gums; nosebleeds; blood in urine or stool

Scenario. A patient has just started warfarin after a heart valve operation.

S: "The doctor said this medicine can make me bleed."

O: Started warfarin 3 days ago; INR 3.4 (target 2.0-3.0); platelets normal; no bruising or bleeding seen; walks with a stick.

Tools: CP-SAFE · Morse Fall Scale **CarePath diagnosis:** Likely to bleed easily related to blood thinners and an INR above target (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | | Check blood tests (INR) as ordered and report values above target. | INR shows how long blood takes to clot, so regular tests and reporting values above target let the doctor adjust the dose before bleeding occurs. | | Check with the prescriber before each warfarin dose while the INR is above target; give at the same time each day as ordered. | Warfarin is dosed by the INR, so a result above target needs the prescriber's decision before the next dose. Giving it at a fixed time keeps blood levels steady. | | Use a soft toothbrush and electric razor. | Soft brushing and electric razors cause less gum and skin injury, lowering the chance of bleeding. | | Avoid unneeded injections and protect from falls. | Injections and falls can cause bleeding or bruising, so limiting them lowers risk, especially as the patient walks with a stick. | | Apply firm pressure to any bleeding and report it. | Firm pressure helps a clot form to stop bleeding, and reporting it lets staff check whether the dose or INR needs review. **Expected outcomes** - No uncontrolled bleeding during the stay. - INR within the target range by the date set by the doctor. - Patient uses a soft toothbrush and reports bleeding early. **Linking the data to the diagnosis** The patient started warfarin 3 days ago after a heart valve operation, and says the doctor told them this medicine can make them bleed. The INR is 3.4 against a target of 2.0 to 3.0, platelets are normal, and no bruising or bleeding is seen. Since bleeding has not occurred, this is a risk diagnosis resting on blood thinners and an INR above target. The patient walks with a stick, so falls are also a concern. The plan aims for no uncontrolled bleeding, INR within target by the date the doctor sets, and the patient using a soft toothbrush and reporting bleeding early.

CarePath diagnosis: Likely to bleed easily related to blood thinners and an INR above target (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check blood tests (INR) as ordered and report values above target.	INR shows how long blood takes to clot, so regular tests and reporting values above target let the doctor adjust the dose before bleeding occurs.
Check with the prescriber before each warfarin dose while the INR is above target; give at the same time each day as ordered.	Warfarin is dosed by the INR, so a result above target needs the prescriber's decision before the next dose. Giving it at a fixed time keeps blood levels steady.
Use a soft toothbrush and electric razor.	Soft brushing and electric razors cause less gum and skin injury, lowering the chance of bleeding.
Avoid unneeded injections and protect from falls.	Injections and falls can cause bleeding or bruising, so limiting them lowers risk, especially as the patient walks with a stick.
Apply firm pressure to any bleeding and report it.	Firm pressure helps a clot form to stop bleeding, and reporting it lets staff check whether the dose or INR needs review.

Expected outcomes: No uncontrolled bleeding during the stay. · INR within the target range by the date set by the doctor. · Patient uses a soft toothbrush and reports bleeding early.

Linking the data: The patient started warfarin 3 days ago after a heart valve operation, and says the doctor told them this medicine can make them bleed. The INR is 3.4 against a target of 2.0 to 3.0, platelets are normal, and no bruising or bleeding is seen. Since bleeding has not occurred, this is a risk diagnosis resting on blood thinners and an INR above target. The patient walks with a stick, so falls are also a concern. The plan aims for no uncontrolled bleeding, INR within target by the date the doctor sets, and the patient using a soft toothbrush and reporting bleeding early.

S7 Body temperature too high or too low ▲ URGENT

Group: Safety and protection | Type: Actual problem

Definition: Body temperature is outside the safe range because of illness, surroundings, or medicine.

Possible causes: Infection; heat; cold exposure; burns; medicines; brain injury

Signs and symptoms: Very high or very low temperature; shivering or sweating; hot or cold skin; confusion

Scenario. A child has a temperature of 40 degrees and is flushed and restless.

S: "I feel really hot."

O: Temperature 40 C; flushed; heart rate 150/min in a child; restless; poor drinking.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Body temperature too high or too low related to suspected infection, as evidenced by a temperature of 40 C, flushed skin, a heart rate of 150/min, and restlessness. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check temperature. | Regular temperature checks show how high the fever is and whether treatment is working. | | Add or remove layers. | Removing extra layers helps heat leave the body when temperature is high, while adding layers helps retain heat if it is too low. | | Give fluids. | Fever and fast breathing increase fluid loss, so fluids prevent dehydration and help the child cool. | | Give fever medicine as ordered. | Fever medicine acts on the brain's temperature control to lower the temperature and increase comfort. | | Use cooling measures only as ordered. | Over-cooling can cause shivering, which raises body heat again, so cooling is used only as ordered and alongside fever medicine. | | Report abnormal results. | A very abnormal result may mean serious illness, so the doctor must hear quickly to find the cause and treat it. | ****Expected outcomes**** - Within 2 hours: temperature below 38 C, child calmer and drinking fluids, no convulsions. ****Linking the data to the diagnosis**** The child says they feel really hot. The nurse found a temperature of 40 C, flushing, a heart rate of 150/ min, restlessness and poor drinking. The temperature is well above the safe range, so the problem has already occurred and this is an actual diagnosis, with infection as the likely cause. The plan aims within 2 hours for a temperature below 38 C, a calmer child who is drinking fluids, and no convulsions. Because a child with this temperature, fast heart rate and poor drinking can become seriously unwell, abnormal results are reported promptly.

CarePath diagnosis: Body temperature too high or too low related to suspected infection, as evidenced by a temperature of 40 C, flushed skin, a heart rate of 150/min, and restlessness.

Intervention	Rationale
Check temperature.	Regular temperature checks show how high the fever is and whether treatment is working.
Add or remove layers.	Removing extra layers helps heat leave the body when temperature is high, while adding layers helps retain heat if it is too low.
Give fluids.	Fever and fast breathing increase fluid loss, so fluids prevent dehydration and help the child cool.
Give fever medicine as ordered.	Fever medicine acts on the brain's temperature control to lower the temperature and increase comfort.
Use cooling measures only as ordered.	Over-cooling can cause shivering, which raises body heat again, so cooling is used only as ordered and alongside fever medicine.
Report abnormal results.	A very abnormal result may mean serious illness, so the doctor must hear quickly to find the cause and treat it.

Expected outcomes: Within 2 hours: temperature below 38 C, child calmer and drinking fluids, no convulsions.

Linking the data: The child says they feel really hot. The nurse found a temperature of 40 C, flushing, a heart rate of 150/ min, restlessness and poor drinking. The temperature is well above the safe range, so the problem has already occurred and this is an actual diagnosis, with infection as the likely cause. The plan aims within 2 hours for a temperature below 38 C, a calmer child who is drinking fluids, and no convulsions. Because a child with this temperature, fast heart rate and poor drinking can become seriously unwell, abnormal results are reported promptly.

S8 Likely to inhale food or fluid

Group: Safety and protection | Type: Risk problem

Definition: Weak swallowing or reduced alertness raise the chance of food or fluid entering the lungs.

Risk factors: Stroke; low consciousness; weak cough; tube feeding; dementia

Warning signs: Coughing at meals; wet voice; chest infection; fever

Scenario. An older woman with dementia eats very quickly and has a weak cough.

S: Daughter: "She eats very fast and does not chew well."

O: Dementia; weak cough; eats quickly, half propped in bed; swallow screen shows delayed swallow; temperature 36.9 C; chest clear.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Likely to inhale food or fluid related to dementia and weak cough (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Sit fully upright to eat. | Sitting fully upright lets food travel down by gravity and keeps the airway protected, lowering the chance of inhaling food. | | Supervise meals. | Watching meals allows the nurse to slow the pace, give prompts and respond at once to coughing or choking. | | Follow swallow advice. | Swallow advice from specialists, such as food texture and pace, matches the safest way to eat for her delayed swallow. | | Give mouth care. | Mouth care lowers the germs in the mouth, so if a little saliva or food is inhaled it is less likely to cause a lung infection. | | Check chest and temperature. | Checking the chest and temperature can reveal early signs of aspiration, such as crackles or fever, so treatment is not delayed. | ****Expected outcomes**** - No signs of aspiration. - Temperature normal. - Eats safely upright with supervision. - Swallow review completed. ****Linking the data to the diagnosis**** The older woman with dementia eats quickly, has a weak cough, and was half propped in bed while eating. Her daughter says she eats very fast and does not chew well, and a swallow screen showed a delayed swallow. Her temperature is 36.9 C and her chest is clear, so no food has been inhaled yet. This is a risk diagnosis resting on dementia and a weak cough, not an actual chest infection. The plan aims for no signs of aspiration, a normal temperature, safe eating upright with supervision, and completion of the swallow review.

CarePath diagnosis: Likely to inhale food or fluid related to dementia and weak cough (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Sit fully upright to eat.	Sitting fully upright lets food travel down by gravity and keeps the airway protected, lowering the chance of inhaling food.
Supervise meals.	Watching meals allows the nurse to slow the pace, give prompts and respond at once to coughing or choking.
Follow swallow advice.	Swallow advice from specialists, such as food texture and pace, matches the safest way to eat for her delayed swallow.
Give mouth care.	Mouth care lowers the germs in the mouth, so if a little saliva or food is inhaled it is less likely to cause a lung infection.
Check chest and temperature.	Checking the chest and temperature can reveal early signs of aspiration, such as crackles or fever, so treatment is not delayed.

Expected outcomes: No signs of aspiration. · Temperature normal. · Eats safely upright with supervision. · Swallow review completed.

Linking the data: The older woman with dementia eats quickly, has a weak cough, and was half propped in bed while eating. Her daughter says she eats very fast and does not chew well, and a swallow screen showed a delayed swallow. Her temperature is 36.9 C and her chest is clear, so no food has been inhaled yet. This is a risk diagnosis resting on dementia and a weak cough, not an actual chest infection. The plan aims for no signs of aspiration, a normal temperature, safe eating upright with supervision, and completion of the swallow review.

S9 Slow wound or surgical healing

Group: Safety and protection | Type: Risk problem

Definition: Poor nutrition, infection, or illness may slow healing.

Risk factors: Poor nutrition; diabetes; infection; smoking; steroids; older age

Warning signs: Wound edges apart; redness; drainage; fever; pain that worsens

Scenario. A diabetic smoker has a surgical wound on day 3 after surgery.

S: "I smoke, and my sugar is not always good."

O: Surgical wound day 3; edges together, no redness or drainage; smoker; diabetic; blood sugar 13 mmol/L; poor appetite.

Tools: CP-SAFE, CP-SKIN, CP-FLUID · Morse Fall Scale, Braden Scale, TIME wound chart, MUST, fluid chart, glucose **CarePath diagnosis:** Slow wound or surgical healing related to diabetes and smoking (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---| | Check the wound every shift. | Looking at the wound each shift finds early signs of trouble, such as redness, drainage or separated edges, so care can start sooner. | | Support nutrition. | Protein, vitamins and calories are needed to build new tissue, so good nutrition helps the wound heal, which matters when appetite is poor. | | Control blood sugar. | High blood sugar weakens defenses against infection and slows repair, so keeping it near target helps healing. | | Keep the dressing clean. | A clean, intact dressing protects the wound from germs and keeps conditions right for healing. | | Encourage stopping smoking. | Smoking narrows blood vessels and cuts oxygen to tissue, so stopping or cutting down improves healing. | | Report signs of infection. | Reporting infection signs promptly allows early treatment before the wound breaks down. | **Expected outcomes** - By day 10: wound edges closed with no pus or redness. - Blood sugar within the doctor's target. - Patient states a plan to cut down or stop smoking. **Linking the data to the diagnosis** On day 3 after surgery the wound edges are together with no redness or drainage, so healing is on track so far. The patient is diabetic, smokes, has a blood sugar of 13 mmol/L and a poor appetite, and says their sugar is not always good. Because the wound has not broken down or become infected, this is a risk diagnosis resting on diabetes and smoking. The plan aims by day 10 for closed wound edges with no pus or redness, blood sugar within the doctor's target, and a patient plan to cut down or stop smoking.

CarePath diagnosis: Slow wound or surgical healing related to diabetes and smoking (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check the wound every shift.	Looking at the wound each shift finds early signs of trouble, such as redness, drainage or separated edges, so care can start sooner.
Support nutrition.	Protein, vitamins and calories are needed to build new tissue, so good nutrition helps the wound heal, which matters when appetite is poor.
Control blood sugar.	High blood sugar weakens defenses against infection and slows repair, so keeping it near target helps healing.
Keep the dressing clean.	A clean, intact dressing protects the wound from germs and keeps conditions right for healing.
Encourage stopping smoking.	Smoking narrows blood vessels and cuts oxygen to tissue, so stopping or cutting down improves healing.
Report signs of infection.	Reporting infection signs promptly allows early treatment before the wound breaks down.

Expected outcomes: By day 10: wound edges closed with no pus or redness. · Blood sugar within the doctor's target. · Patient states a plan to cut down or stop smoking.

Linking the data: On day 3 after surgery the wound edges are together with no redness or drainage, so healing is on track so far. The patient is diabetic, smokes, has a blood sugar of 13 mmol/L and a poor appetite, and says their sugar is not always good. Because the wound has not broken down or become infected, this is a risk diagnosis resting on diabetes and smoking. The plan aims by day 10 for closed wound edges with no pus or redness, blood sugar within the doctor's target, and a patient plan to cut down or stop smoking.

S10 Reaction to medicine or allergen ⚠ URGENT

Group: Safety and protection | Type: Risk problem

Definition: The person may react to a medicine, food, latex, or other trigger.

Risk factors: Previous allergy; new medicine; latex; food; contrast dye

Warning signs: Rash; itching; swelling of face or lips; wheeze; low blood pressure

Scenario. A patient with a known penicillin allergy is prescribed an antibiotic.

S: "I'm allergic to penicillin, I hope that's on my chart."

O: Penicillin allergy recorded; new antibiotic prescribed; no rash; observations normal.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Reaction to medicine or allergen related to previous allergy and new medicine (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check allergies before every drug. | Checking allergy records before each drug prevents giving a medicine the patient is known to react to. | | Use an allergy band. | An allergy band alerts all staff to the allergy, even if the chart is missed or the patient cannot speak. | | Observe after new medicines. | Most reactions happen soon after a new medicine, so close watching spots rash, swelling or breathing change early. | | Stop the drug and call for help if symptoms appear. | Stopping the drug removes the trigger, and calling for help brings fast treatment for a reaction that can become life-threatening. | | Give emergency treatment as ordered. | Emergency treatments such as adrenaline act quickly against severe allergic reactions, so they are given as ordered without delay. | ****Expected outcomes**** - No allergic reaction. - Allergy band and chart alert in place. - Alternative drug used if needed. - Patient states allergy and reaction signs. ****Linking the data to the diagnosis**** The patient has a recorded penicillin allergy, has been prescribed a new antibiotic, and says they hope the allergy is on the chart. There is no rash and observations are normal, so no reaction has occurred and this is a risk diagnosis resting on the previous allergy and new medicine. If any sign appears, the drug is stopped and help is called first. The plan aims for no allergic reaction, an allergy band and chart alert in place, an alternative drug used if needed, and the patient stating the allergy and reaction signs.

CarePath diagnosis: Reaction to medicine or allergen related to previous allergy and new medicine (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check allergies before every drug.	Checking allergy records before each drug prevents giving a medicine the patient is known to react to.
Use an allergy band.	An allergy band alerts all staff to the allergy, even if the chart is missed or the patient cannot speak.
Observe after new medicines.	Most reactions happen soon after a new medicine, so close watching spots rash, swelling or breathing change early.
Stop the drug and call for help if symptoms appear.	Stopping the drug removes the trigger, and calling for help brings fast treatment for a reaction that can become life-threatening.
Give emergency treatment as ordered.	Emergency treatments such as adrenaline act quickly against severe allergic reactions, so they are given as ordered without delay.

Expected outcomes: No allergic reaction. · Allergy band and chart alert in place. · Alternative drug used if needed. · Patient states allergy and reaction signs.

Linking the data: The patient has a recorded penicillin allergy, has been prescribed a new antibiotic, and says they hope the allergy is on the chart. There is no rash and observations are normal, so no reaction has occurred and this is a risk diagnosis resting on the previous allergy and new medicine. If any sign appears, the drug is stopped and help is called first. The plan aims for no allergic reaction, an allergy band and chart alert in place, an alternative drug used if needed, and the patient stating the allergy and reaction signs.

S11 Likely to develop blood clots

Group: Safety and protection | Type: Risk problem

Definition: Limited movement, surgery, or illness raise the chance of clots in the veins.

Risk factors: Surgery; immobility; long travel; cancer; dehydration; previous clot

Warning signs: Swelling, pain, redness, or warmth in one leg; sudden chest pain; breathlessness

Scenario. A patient is bedbound two days after hip surgery.

S: "My legs feel fine, but I cannot move much."

O: Two days after hip surgery; mostly bedbound; both calves soft, not swollen, tender or warm; no chest pain; drinking little.

Tools: CP-SAFE, CP-PAIN · Morse Fall Scale, NRS 0–10, FLACC, PAINAD ****CarePath diagnosis:**** Likely to develop blood clots related to surgery, immobility and poor fluid intake (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give clot prevention as ordered. | Clot prevention medicine or devices reduce the blood's tendency to clot while the patient is still, as after surgery. | | Encourage early movement and fluids as allowed. | Movement and fluids keep blood flowing through the leg veins and prevent blood thickening, lowering clot risk. | | Check both legs each shift for swelling, pain, redness or warmth. | Comparing both legs shows early signs of a clot, such as swelling, pain, redness or warmth, which often affect one leg. | | If one leg is swollen, tender or warm: do not massage it or apply stockings; keep the patient resting and call the doctor urgently. | Massage could dislodge a clot and send it to the lungs, and stockings are not applied over a possible clot, so rest and urgent medical review are safest. | | Report chest pain or breathlessness at once as an emergency. | Chest pain or breathlessness may mean a clot has reached the lungs, which is life-threatening and needs emergency help. | ****Expected outcomes**** - No leg swelling, chest pain or breathlessness during the stay. - Clot prevention given on time. - Patient walks as allowed and drinks fluids. - Any leg change is reported within the shift. ****Linking the data to the diagnosis**** Two days after hip surgery the patient is mostly bedbound and drinking little, and says their legs feel fine but they cannot move much. Both calves are soft, not swollen, tender or warm, and there is no chest pain. No clot is seen, so this is a risk diagnosis resting on surgery, immobility and poor fluid intake. If a leg becomes swollen or chest pain appears, help is called urgently. The plan aims for no leg swelling, chest pain or breathlessness, clot prevention given on time, walking and drinking as allowed, and any leg change reported within the shift.

CarePath diagnosis: Likely to develop blood clots related to surgery, immobility and poor fluid intake (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Give clot prevention as ordered.	Clot prevention medicine or devices reduce the blood's tendency to clot while the patient is still, as after surgery.
Encourage early movement and fluids as allowed.	Movement and fluids keep blood flowing through the leg veins and prevent blood thickening, lowering clot risk.
Check both legs each shift for swelling, pain, redness or warmth.	Comparing both legs shows early signs of a clot, such as swelling, pain, redness or warmth, which often affect one leg.
If one leg is swollen, tender or warm: do not massage it or apply stockings; keep the patient resting and call the doctor urgently.	Massage could dislodge a clot and send it to the lungs, and stockings are not applied over a possible clot, so rest and urgent medical review are safest.
Report chest pain or breathlessness at once as an emergency.	Chest pain or breathlessness may mean a clot has reached the lungs, which is life-threatening and needs emergency help.

Expected outcomes: No leg swelling, chest pain or breathlessness during the stay. · Clot prevention given on time. · Patient walks as allowed and drinks fluids. · Any leg change is reported within the shift.

Linking the data: Two days after hip surgery the patient is mostly bedbound and drinking little, and says their legs feel fine but they cannot move much. Both calves are soft, not swollen, tender or warm, and there is no chest pain. No clot is seen, so this is a risk diagnosis resting on surgery, immobility and poor fluid intake. If a leg becomes swollen or chest pain appears, help is called urgently. The plan aims for no leg swelling, chest pain or breathlessness, clot prevention given on time, walking and drinking as allowed, and any leg change reported within the shift.

S12 Likely to bleed heavily after surgery ▲ URGENT

Group: Safety and protection | Type: Risk problem

Definition: The surgical site may bleed more than expected.

Risk factors: Major surgery; blood thinners; clotting problems; slipping stitches

Warning signs: Soaked dressings; bloody drain output; low blood pressure; fast pulse; pale skin

Scenario. A patient has just come back from major abdominal surgery and is on blood-thinning injections.

S: "I feel a bit sore."

O: Just back from surgery; drain 40 mL blood-stained fluid in the first hour; pulse 84/ min; blood pressure 122/76; on blood-thinning injections.

Tools: CP-SAFE, CP-SKIN, CP-FLUID · Morse Fall Scale, Braden Scale, TIME wound chart, MUST, fluid chart, glucose **CarePath diagnosis:** Likely to bleed heavily after surgery related to major surgery and blood thinners (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---|---| | Check dressings, drain output and vital signs at ordered times. | Regular checks of dressings, drain and vital signs show bleeding early, since a rising pulse and falling blood pressure often appear before blood is visible. | | Keep dressings intact and mark any leaking area. | Intact dressings protect the wound, and marking any leaking area lets staff see whether bleeding is growing. | | Report quickly rising drain output, bright blood, rising pulse, falling blood pressure or paleness at once. | Fast reports let the surgical team act before blood loss becomes dangerous, as heavy bleeding can lead to shock. | | Prepare for treatment as ordered if bleeding is suspected. | Being ready, with equipment and orders at hand, saves time if bleeding is suspected. **Expected outcomes** - Drain output stays low and non-bloody. - Pulse and blood pressure stay in the doctor's range. - Any bleeding is reported within minutes and treated promptly. **Linking the data to the diagnosis** The patient has just returned from major abdominal surgery and is on blood-thinning injections, and says they feel a bit sore. The drain shows 40 mL of blood-stained fluid in the first hour, pulse is 84/min and blood pressure is 122/76. Heavy bleeding has not occurred, so this is a risk diagnosis resting on surgery and blood thinners. If signs of bleeding appear, help is called first. The plan aims for low, non-bloody drain output, pulse and blood pressure in the doctor's range, and any bleeding reported within minutes and treated promptly.

CarePath diagnosis: Likely to bleed heavily after surgery related to major surgery and blood thinners (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check dressings, drain output and vital signs at ordered times.	Regular checks of dressings, drain and vital signs show bleeding early, since a rising pulse and falling blood pressure often appear before blood is visible.
Keep dressings intact and mark any leaking area.	Intact dressings protect the wound, and marking any leaking area lets staff see whether bleeding is growing.
Report quickly rising drain output, bright blood, rising pulse, falling blood pressure or paleness at once.	Fast reports let the surgical team act before blood loss becomes dangerous, as heavy bleeding can lead to shock.
Prepare for treatment as ordered if bleeding is suspected.	Being ready, with equipment and orders at hand, saves time if bleeding is suspected.

Expected outcomes: Drain output stays low and non-bloody. · Pulse and blood pressure stay in the doctor's range. · Any bleeding is reported within minutes and treated promptly.

Linking the data: The patient has just returned from major abdominal surgery and is on blood-thinning injections, and says they feel a bit sore. The drain shows 40 mL of blood-stained fluid in the first hour, pulse is 84/min and blood pressure is 122/76. Heavy bleeding has not occurred, so this is a risk diagnosis resting on surgery and blood thinners. If signs of bleeding appear, help is called first. The plan aims for low, non-bloody drain output, pulse and blood pressure in the doctor's range, and any bleeding reported within minutes and treated promptly.

S13 Wrong medicine or dose

Group: Safety and protection | Type: Risk problem

Definition: Errors in drug, dose, time, route, or patient may cause harm.

Risk factors: Busy ward; similar drug names; poor handwriting; weak checks; lack of knowledge

Warning signs: Near-miss reports; wrong patient or dose; unexpected drug reaction

Scenario. A nurse prepares evening medicines on a busy ward where two patients have similar names.

S: Patient: "My name is Mr. Khan, not Mr. Khalid."

O: Two patients with similar names on the ward; busy shift; two similar-looking drug names on the chart; wristband not yet checked.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Wrong medicine or dose related to similar names, similar drug names and a busy ward (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Check the patient's name band and ask the patient to state their name before every medicine. | Two identifiers, the wristband and the patient's own spoken name, catch mix-ups that one check alone can miss, which matters when two patients have similar names. | | Check drug, dose, time, route and allergies against the order. | Checking each element against the order, including allergies, stops errors in drug, dose, time or route before the medicine reaches the patient. | | Mark similar-name patients with an alert. | An alert on similar-name patients warns every staff member to take extra care, so the risk of confusing the two men is lowered. | | Avoid interruptions while preparing medicines. | Interruptions break concentration and are a major cause of slips in drug preparation, so a quiet, uninterrupted process keeps checks accurate on a busy ward. | | Report and record any error or near miss. | Reporting errors and near misses lets the team find weak points in the system and fix them before a patient is harmed. | ****Expected outcomes**** - No wrong-patient or wrong-dose event during the shift. - Two identifiers checked for every medicine. - Near misses reported. ****Linking the data to the diagnosis**** The scenario shows a nurse preparing evening medicines on a busy ward with two patients who have similar names. Mr. Khan has said, "My name is Mr. Khan, not Mr. Khalid," the chart holds two similar-looking drug names, and the wristband has not yet been checked. No wrong drug or dose has been given, so this is a risk statement, not an actual error, and it rests on risk factors only. The plan aims to keep the shift free of wrong-patient or wrong-dose events. The nurse checks two identifiers for every medicine and reports any near miss, as the expected outcomes require.

CarePath diagnosis: Wrong medicine or dose related to similar names, similar drug names and a busy ward (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Check the patient's name band and ask the patient to state their name before every medicine.	Two identifiers, the wristband and the patient's own spoken name, catch mix-ups that one check alone can miss, which matters when two patients have similar names.
Check drug, dose, time, route and allergies against the order.	Checking each element against the order, including allergies, stops errors in drug, dose, time or route before the medicine reaches the patient.
Mark similar-name patients with an alert.	An alert on similar-name patients warns every staff member to take extra care, so the risk of confusing the two men is lowered.
Avoid interruptions while preparing medicines.	Interruptions break concentration and are a major cause of slips in drug preparation, so a quiet, uninterrupted process keeps checks accurate on a busy ward.
Report and record any error or near miss.	Reporting errors and near misses lets the team find weak points in the system and fix them before a patient is harmed.

Expected outcomes: No wrong-patient or wrong-dose event during the shift. · Two identifiers checked for every medicine. · Near misses reported.

Linking the data: The scenario shows a nurse preparing evening medicines on a busy ward with two patients who have similar names. Mr. Khan has said, "My name is Mr. Khan, not Mr. Khalid," the chart holds two similar-looking drug names, and the wristband has not yet been checked. No wrong drug or dose has been given, so this is a risk statement, not an actual error, and it rests on risk factors only. The plan aims to keep the shift free of wrong-patient or wrong-dose events. The nurse checks two identifiers for every medicine and reports any near miss, as the expected outcomes require.

S14 Harm from restraints

Group: Safety and protection | Type: Risk problem

Definition: Physical or chemical restraints can cause injury, distress, and loss of dignity.

Risk factors: Confusion; agitation; devices; long use; poor monitoring

Warning signs: Skin marks; distress; struggling; poor circulation

Scenario. A confused, agitated patient is pulling at his lines and staff are considering restraints.

S: "Let me go home!"

O: Confused; pulling at lines; no restraint applied yet; pain not yet assessed; full bladder.

Tools: CP-SAFE, CP-PAIN, CP-OLDER · Morse Fall Scale, NRS 0–10, FLACC, PAINAD, 4AT / CAM, Mini-Cog

****CarePath diagnosis:**** Harm from restraints related to confusion and agitation (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use the least restrictive option. | Less restrictive options such as redirection or a sitter cause less distress, injury and loss of dignity than physical restraint, so they are tried first. | | Follow policy. | Policy sets out legal and safety requirements, such as orders, consent and monitoring, which protect the patient from misuse of restraint. | | Check restraints often. | Restraints can reduce circulation, mark the skin or cause distress, so frequent checks find problems early. | | Treat the cause of agitation. | Agitation often has a cause such as pain, a full bladder or confusion. Treating it can remove the need for restraint altogether. | | Remove as soon as possible. | The longer restraints stay on, the greater the risk of injury, weakness and distress, so they should come off as soon as it is safe. | | Document. | Accurate records show why restraint was needed, how it was monitored and when it ended, which protects both patient and staff. | ****Expected outcomes**** - Restraint removed as soon as safe. - No injury. - Underlying cause (pain, confusion, full bladder) treated. - Patient calmer. ****Linking the data to the diagnosis**** The patient is confused and agitated, calling "Let me go home!" and pulling at his lines. Staff are considering restraints, but none has been applied yet, so no harm from restraints has occurred. The diagnosis is therefore a risk statement based on confusion and agitation, not an actual one. The nurse also notes that pain has not been assessed and that his bladder is full, both possible causes of his restlessness. The plan aims to avoid or limit restraint, remove it as soon as safe, prevent injury and treat the cause so that the patient becomes calmer.

CarePath diagnosis: Harm from restraints related to confusion and agitation (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use the least restrictive option.	Less restrictive options such as redirection or a sitter cause less distress, injury and loss of dignity than physical restraint, so they are tried first.
Follow policy.	Policy sets out legal and safety requirements, such as orders, consent and monitoring, which protect the patient from misuse of restraint.
Check restraints often.	Restraints can reduce circulation, mark the skin or cause distress, so frequent checks find problems early.
Treat the cause of agitation.	Agitation often has a cause such as pain, a full bladder or confusion. Treating it can remove the need for restraint altogether.
Remove as soon as possible.	The longer restraints stay on, the greater the risk of injury, weakness and distress, so they should come off as soon as it is safe.
Document.	Accurate records show why restraint was needed, how it was monitored and when it ended, which protects both patient and staff.

Expected outcomes: Restraint removed as soon as safe. · No injury. · Underlying cause (pain, confusion, full bladder) treated. · Patient calmer.

Linking the data: The patient is confused and agitated, calling "Let me go home!" and pulling at his lines. Staff are considering restraints, but none has been applied yet, so no harm from restraints has occurred. The diagnosis is therefore a risk statement based on confusion and agitation, not an actual one. The nurse also notes that pain has not been assessed and that his bladder is full, both possible causes of his restlessness. The plan aims to avoid or limit restraint, remove it as soon as safe, prevent injury and treat the cause so that the patient becomes calmer.

S15 Likely to wander or get lost

Group: Safety and protection | Type: Risk problem

Definition: Confusion or memory loss may lead the person to leave a safe place.

Risk factors: Dementia; confusion; unlocked doors; unfamiliar place

Warning signs: Pacing; trying to leave; looking for an old home; disorientation

Scenario. A man with dementia tries to leave the ward saying he must go to work.

S: "I need to go to work. Where's my coat?"

O: Dementia; found at the ward exit; pacing; no ID band on one arm.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Likely to wander or get lost related to dementia and confusion (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use an ID band. | An ID band lets staff or the public identify the patient and return him to the ward quickly if he leaves unseen. | | Place near the nursing station. | Close to the nursing station, staff can see him often and notice early signs of trying to leave. | | Distract and redirect. | Gentle distraction and redirection calm a confused person without argument, and they respect his sense of purpose, such as going to work. | | Secure exits per policy. | Secured exits make it harder to leave unnoticed, and following policy keeps this safe and lawful. | | Involve family. | Family know his routines and history, and familiar people or items can comfort him and reduce the urge to leave. | | Report a missing patient quickly. | Quick reporting starts a search early, when the patient is likely to be close by and the risk of harm is lowest. ****Expected outcomes**** - Patient stays safe. - Wears ID band. - Redirected calmly. - No episode of leaving the ward unseen. ****Linking the data to the diagnosis**** A man with dementia was found at the ward exit, pacing, saying, "I need to go to work. Where's my coat?" and he has no ID band on one arm. He has not yet left the ward unseen or been lost, so this is a risk diagnosis resting on dementia and confusion, not an actual event. The nurse is concerned because he is already trying to leave. The plan aims to keep him safe by applying an ID band, redirecting him calmly and watching the exits, so that no episode of leaving the ward unseen occurs.

CarePath diagnosis: Likely to wander or get lost related to dementia and confusion (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use an ID band.	An ID band lets staff or the public identify the patient and return him to the ward quickly if he leaves unseen.
Place near the nursing station.	Close to the nursing station, staff can see him often and notice early signs of trying to leave.
Distract and redirect.	Gentle distraction and redirection calm a confused person without argument, and they respect his sense of purpose, such as going to work.
Secure exits per policy.	Secured exits make it harder to leave unnoticed, and following policy keeps this safe and lawful.
Involve family.	Family know his routines and history, and familiar people or items can comfort him and reduce the urge to leave.
Report a missing patient quickly.	Quick reporting starts a search early, when the patient is likely to be close by and the risk of harm is lowest.

Expected outcomes: Patient stays safe. · Wears ID band. · Redirected calmly. · No episode of leaving the ward unseen.

Linking the data: A man with dementia was found at the ward exit, pacing, saying, "I need to go to work. Where's my coat?" and he has no ID band on one arm. He has not yet left the ward unseen or been lost, so this is a risk diagnosis resting on dementia and confusion, not an actual event. The nurse is concerned because he is already trying to leave. The plan aims to keep him safe by applying an ID band, redirecting him calmly and watching the exits, so that no episode of leaving the ward unseen occurs.

S16 Burn or scald risk

Group: Safety and protection | Type: Risk problem

Definition: Hot water, heat packs, or equipment may burn skin, especially where feeling is reduced.

Risk factors: Hot drinks; hot water bottles; baths; reduced feeling; seizures

Warning signs: Red skin; blisters; pain; heat injury noticed late

Scenario. A diabetic with numb feet likes to warm his feet with a hot water bottle.

S: "My feet are always cold, so I use a hot water bottle."

O: Diabetic nerve damage; reduced feeling in both feet; uses a hot water bottle at night; skin intact.

Tools: CP-SAFE, CP-SKIN · Morse Fall Scale, Braden Scale, TIME wound chart **CarePath diagnosis:**

Burn or scald risk related to reduced feeling and hot water bottle use (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---|---| | Test water temperature. | Numb feet cannot sense dangerous heat, so the nurse tests the water with a reliable method before it touches the skin. | | Avoid heat packs on numb skin. | Heat packs on skin with reduced feeling can cause burns that the patient does not notice until the damage is deep. | | Supervise baths. | Supervision during baths ensures the water is a safe temperature and that any problem is noticed at once. | | Teach safe use. | Teaching the patient to test with an elbow or thermometer lets him protect himself at home, where the nurse is not present. | | Check skin. | Regular skin checks find redness or blisters early, which matters because nerve damage hides pain and delays notice of injury. | **Expected outcomes** - No new burns. - Feet stay free of redness, blisters, and burns. - Patient tests temperature with the elbow or a thermometer and avoids heat packs. **Linking the data to the diagnosis** The patient is a diabetic with nerve damage and reduced feeling in both feet who says, "My feet are always cold, so I use a hot water bottle." He uses it at night, and his skin is intact. No burn has happened, so the problem is a risk, based on reduced feeling and hot water bottle use, not an actual injury. The plan aims to prevent burns by testing temperature, avoiding heat on numb skin and teaching him to test with an elbow or thermometer, so that no new burns occur.

CarePath diagnosis: Burn or scald risk related to reduced feeling and hot water bottle use (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Test water temperature.	Numb feet cannot sense dangerous heat, so the nurse tests the water with a reliable method before it touches the skin.
Avoid heat packs on numb skin.	Heat packs on skin with reduced feeling can cause burns that the patient does not notice until the damage is deep.
Supervise baths.	Supervision during baths ensures the water is a safe temperature and that any problem is noticed at once.
Teach safe use.	Teaching the patient to test with an elbow or thermometer lets him protect himself at home, where the nurse is not present.
Check skin.	Regular skin checks find redness or blisters early, which matters because nerve damage hides pain and delays notice of injury.

Expected outcomes: No new burns. · Feet stay free of redness, blisters, and burns. · Patient tests temperature with the elbow or a thermometer and avoids heat packs.

Linking the data: The patient is a diabetic with nerve damage and reduced feeling in both feet who says, "My feet are always cold, so I use a hot water bottle." He uses it at night, and his skin is intact. No burn has happened, so the problem is a risk, based on reduced feeling and hot water bottle use, not an actual injury. The plan aims to prevent burns by testing temperature, avoiding heat on numb skin and teaching him to test with an elbow or thermometer, so that no new burns occur.

S17 Choking ⚠ URGENT

Group: Safety and protection | Type: Risk problem

Definition: Food or objects may block the airway.

Risk factors: Poor chewing; rushing; dementia; large food pieces; talking while eating

Warning signs: Coughing; clutching the throat; unable to speak; blue face

Scenario. A patient with dementia eats large pieces of meat quickly while talking.

S: Carer: "He stuffs his food into his mouth."

O: Dementia; eats fast; takes large bites; talks while eating; has not choked so far; several teeth missing.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Choking related to rushing, large food pieces and poor chewing (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Cut food small and serve soft foods if needed. | Small, soft pieces are easier to chew and swallow, which matters because he has missing teeth and takes large bites. | | Sit upright and supervise every meal. | An upright position lets food travel down the throat safely, and supervision means help is immediate if he begins to choke. | | Remind to eat slowly without talking. | Slow eating with no talking lowers the chance that food enters the airway instead of the stomach. | | Know how to give back blows and abdominal thrusts per protocol. | Knowing the correct technique means help can start in seconds, since a blocked airway can cause brain damage within minutes. | | If choking: encourage coughing, give back blows and thrusts, and call emergency help at once. | A blocked airway is an emergency. Coughing may clear it, and back blows and thrusts are the standard steps, with emergency help called at once. | ****Expected outcomes**** - No choking episodes during the stay. - Food cut small and meals supervised at every meal. - Carers state how to respond to choking. - If choking occurs: airway cleared and help called at once. ****Linking the data to the diagnosis**** A patient with dementia eats large pieces of meat quickly while talking, and the carer says, "He stuffs his food into his mouth." He also has several teeth missing. He has not choked so far, so this is a risk diagnosis based on rushing, large bites and poor chewing, not an actual event. The plan aims for no choking episodes, with food cut small and every meal supervised. Because choking can block the airway, the nurse treats any episode as urgent: help is called first, and back blows and thrusts are given while waiting.

CarePath diagnosis: Choking related to rushing, large food pieces and poor chewing (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Cut food small and serve soft foods if needed.	Small, soft pieces are easier to chew and swallow, which matters because he has missing teeth and takes large bites.
Sit upright and supervise every meal.	An upright position lets food travel down the throat safely, and supervision means help is immediate if he begins to choke.
Remind to eat slowly without talking.	Slow eating with no talking lowers the chance that food enters the airway instead of the stomach.
Know how to give back blows and abdominal thrusts per protocol.	Knowing the correct technique means help can start in seconds, since a blocked airway can cause brain damage within minutes.
If choking: encourage coughing, give back blows and thrusts, and call emergency help at once.	A blocked airway is an emergency. Coughing may clear it, and back blows and thrusts are the standard steps, with emergency help called at once.

Expected outcomes: No choking episodes during the stay. · Food cut small and meals supervised at every meal. · Carers state how to respond to choking. · If choking occurs: airway cleared and help called at once.

Linking the data: A patient with dementia eats large pieces of meat quickly while talking, and the carer says, "He stuffs his food into his mouth." He also has several teeth missing. He has not choked so far, so this is a risk diagnosis based on rushing, large bites and poor chewing, not an actual event. The plan aims for no choking episodes, with food cut small and every meal supervised. Because choking can block the airway, the nurse treats any episode as urgent: help is called first, and back blows and thrusts are given while waiting.

S18 Poisoning risk ⚠️ URGENT

Group: Safety and protection | Type: Risk problem

Definition: Access to harmful substances or medicine overdose raises the chance of poisoning.

Risk factors: Unlocked medicines; chemicals; confusion; small children; overdose

Warning signs: Vomiting; drowsiness; strange behavior; open containers nearby

Scenario. A toddler lives in a home where adult tablets are kept in a handbag within reach.

S: Parent: "She climbs everything."

O: Toddler aged 2; tablets in an unlocked handbag on a low table; cleaning products under the sink without a lock; no child-safe lids.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Poisoning risk related to unlocked medicines and chemicals and a small child (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Teach parents to lock medicines and chemicals away, out of sight and reach. | Toddlers climb and explore, so locked storage out of sight and reach is the most reliable way to stop them touching harmful substances. | | Use child-safe lids and keep medicines in original labelled containers. | Child-safe lids add a barrier, and original labelled containers prevent mix-ups and give poison services the information they need. | | Give the poison-control number and put it near the phone. | A number near the phone means parents can get expert advice fast, when delay can make poisoning worse. | | Teach what to do if swallowing is suspected: call poison control or emergency services at once and bring the container. | Poisoning can be an emergency. Calling for help at once and bringing the container allows quick, correct treatment. | | Recheck the home plan at follow-up. | Rechecking the plan confirms that changes were made and kept, and gives a chance to correct gaps before harm occurs. | ****Expected outcomes**** - Within 1 week: medicines and chemicals locked away. - Parents state storage rules and the poison-control number. - No poisoning event. ****Linking the data to the diagnosis**** A two-year-old lives in a home where adult tablets sit in an unlocked handbag on a low table, cleaning products are under the sink without a lock, and there are no child-safe lids. The parent says, "She climbs everything." Nothing has been swallowed, so the problem is a risk, based on these hazards and her age, not an actual poisoning. Because poisoning can be life-threatening, teaching stresses calling poison control or emergency services first if swallowing is suspected. The plan aims for locked storage within 1 week and no poisoning event.

CarePath diagnosis: Poisoning risk related to unlocked medicines and chemicals and a small child (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Teach parents to lock medicines and chemicals away, out of sight and reach.	Toddlers climb and explore, so locked storage out of sight and reach is the most reliable way to stop them touching harmful substances.
Use child-safe lids and keep medicines in original labelled containers.	Child-safe lids add a barrier, and original labelled containers prevent mix-ups and give poison services the information they need.
Give the poison-control number and put it near the phone.	A number near the phone means parents can get expert advice fast, when delay can make poisoning worse.
Teach what to do if swallowing is suspected: call poison control or emergency services at once and bring the container.	Poisoning can be an emergency. Calling for help at once and bringing the container allows quick, correct treatment.
Recheck the home plan at follow-up.	Rechecking the plan confirms that changes were made and kept, and gives a chance to correct gaps before harm occurs.

Expected outcomes: Within 1 week: medicines and chemicals locked away. · Parents state storage rules and the poison-control number. · No poisoning event.

Linking the data: A two-year-old lives in a home where adult tablets sit in an unlocked handbag on a low table, cleaning products are under the sink without a lock, and there are no child-safe lids. The parent says, "She climbs everything." Nothing has been swallowed, so the problem is a risk, based on these hazards and her age, not an actual poisoning. Because poisoning can be life-threatening, teaching stresses calling poison control or emergency services first if swallowing is suspected. The plan aims for locked storage within 1 week and no poisoning event.

S19 Unsafe home

Group: Safety and protection | Type: Risk problem

Definition: Hazards such as clutter, poor lighting, or loose rugs raise the chance of injury.

Risk factors: Loose rugs; poor lighting; clutter; stairs; no handrails; poor heating

Warning signs: Falls at home; near misses; narrow paths; faulty equipment

Scenario. An older man lives upstairs with no stair rail and a dark hallway.

S: "I go up the stairs every day and the hall is dark."

O: No stair rail; clutter in the hallway; poor lighting; walks with a stick.

Tools: CP-SAFE · Morse Fall Scale ****CarePath diagnosis:**** Unsafe home related to no stair rail, hallway clutter, and poor lighting (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Do a home safety check. | A home check finds the specific hazards that could cause a fall, so changes are aimed at real risks and not guesses. | | Improve lighting. | Good lighting helps him see steps and obstacles, which matters on stairs in a dark hallway. | | Clear clutter and secure loose items. | Loose rugs catch feet and sticks and are a common cause of falls in older adults, so removing them lowers the risk. | | Install rails. | A stair rail gives support and balance on stairs, particularly for a man who walks with a stick. | | Refer for occupational therapy. | Occupational therapy can assess how he moves at home and recommend equipment and changes that suit him. | ****Expected outcomes**** - Home hazards fixed within 2 weeks. - No falls at home. - Patient states the safety changes made. ****Linking the data to the diagnosis**** An older man says, "I go up the stairs every day and the hall is dark." The home has no stair rail, clutter in the hallway and poor lighting, and he walks with a stick. He has not yet fallen or been injured, so this is a risk diagnosis based on hazards, not an actual injury. The plan aims to fix home hazards within 2 weeks. If lighting, clutter and the missing rail are corrected, falls are prevented, and the patient can state the safety changes that were made.

CarePath diagnosis: Unsafe home related to no stair rail, hallway clutter, and poor lighting (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Do a home safety check.	A home check finds the specific hazards that could cause a fall, so changes are aimed at real risks and not guesses.
Improve lighting.	Good lighting helps him see steps and obstacles, which matters on stairs in a dark hallway.
Clear clutter and secure loose items.	Loose rugs catch feet and sticks and are a common cause of falls in older adults, so removing them lowers the risk.
Install rails.	A stair rail gives support and balance on stairs, particularly for a man who walks with a stick.
Refer for occupational therapy.	Occupational therapy can assess how he moves at home and recommend equipment and changes that suit him.

Expected outcomes: Home hazards fixed within 2 weeks. · No falls at home. · Patient states the safety changes made.

Linking the data: An older man says, "I go up the stairs every day and the hall is dark." The home has no stair rail, clutter in the hallway and poor lighting, and he walks with a stick. He has not yet fallen or been injured, so this is a risk diagnosis based on hazards, not an actual injury. The plan aims to fix home hazards within 2 weeks. If lighting, clutter and the missing rail are corrected, falls are prevented, and the patient can state the safety changes that were made.

S20 Abuse or violence exposure

Group: Safety and protection | Type: Risk problem

Definition: The person may be exposed to harm from others or be recovering from it.

Risk factors: Violence at home; assault; unsafe relationships; neglect

Warning signs: Unexplained injuries; fear; withdrawn behavior; delays in seeking care; partner answers for the patient

Scenario. A woman attends the clinic for the third time in four months with minor injuries; her partner always stays in the room.

S: "I am just clumsy."

O: Third visit in 4 months; healed bruise on the wrist; partner answers for her; appears anxious; no new injury today.

Tools: CP-SAFE, CP-MIND · Morse Fall Scale, PHQ-9, GAD-7, C-SSRS ****CarePath diagnosis:**** Abuse or violence exposure related to repeated injuries and a controlling partner (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Ask privately and kindly. | Private, kind questions let a person speak freely without fear of the partner, and a non-judging approach makes disclosure more likely. | | Ensure safety. | Her immediate safety comes first, because the risk of further harm can rise if the partner suspects she has spoken. | | Document facts. | Factual, objective notes, including injuries, are accurate and may be needed later for care or legal purposes. | | Follow local law and policy. | Laws and policies on reporting and confidentiality protect both the patient and the nurse and must be followed. | | Offer support services. | Support services give practical help such as safe housing, advice and counselling, which she may not know about. | | Do not blame. | Blame can cause shame and silence, so avoiding it keeps trust and makes it likelier she will seek help. | ****Expected outcomes**** - Patient assessed privately at this visit. - Safety plan and support-service contacts offered. - Injuries and facts documented. - Mandatory reporting duties followed. ****Linking the data to the diagnosis**** A woman attends the clinic for the third time in four months, says, "I am just clumsy," and has a healed bruise on her wrist. Her partner stays in the room and answers for her, and she appears anxious. There is no new injury today and no abuse has been confirmed, so this is a risk diagnosis resting on repeated injuries and a controlling partner. The plan aims to assess her privately at this visit, document the facts, offer a safety plan and support contacts, and follow mandatory reporting duties, without blame.

CarePath diagnosis: Abuse or violence exposure related to repeated injuries and a controlling partner (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Ask privately and kindly.	Private, kind questions let a person speak freely without fear of the partner, and a non-judging approach makes disclosure more likely.
Ensure safety.	Her immediate safety comes first, because the risk of further harm can rise if the partner suspects she has spoken.
Document facts.	Factual, objective notes, including injuries, are accurate and may be needed later for care or legal purposes.
Follow local law and policy.	Laws and policies on reporting and confidentiality protect both the patient and the nurse and must be followed.
Offer support services.	Support services give practical help such as safe housing, advice and counselling, which she may not know about.
Do not blame.	Blame can cause shame and silence, so avoiding it keeps trust and makes it likelier she will seek help.

Expected outcomes: Patient assessed privately at this visit. · Safety plan and support-service contacts offered. · Injuries and facts documented. · Mandatory reporting duties followed.

Linking the data: A woman attends the clinic for the third time in four months, says, "I am just clumsy," and has a healed bruise on her wrist. Her partner stays in the room and answers for her, and she appears anxious. There is no new injury today and no abuse has been confirmed, so this is a risk diagnosis resting on repeated injuries and a controlling partner. The plan aims to assess her privately at this visit, document the facts, offer a safety plan and support contacts, and follow mandatory reporting duties, without blame.

S21 Likely to harm others

Group: Safety and protection | Type: Risk problem

Definition: Anger, confusion, or illness may lead to violence toward other people.

Risk factors: Anger; psychosis; intoxication; confusion; past violence

Warning signs: Threats; clenched fists; pacing; shouting; damaging objects

Scenario. A patient with a history of violence is becoming restless and irritable on the ward after an argument with a visitor.

S: "Leave me alone."

O: Pacing; raised voice; clenched jaw; past aggression when intoxicated; no threats or physical acts so far.

Tools: CP-SAFE · Morse Fall Scale **CarePath diagnosis:** Likely to harm others related to anger and past violence (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | | Stay calm. | A calm nurse sets the tone and lowers the patient's arousal, whereas an anxious or sharp manner can make anger worse. | | Keep a safe distance. | A safe distance gives the nurse room to move away and reduces the chance of being hit. | | Give space. | Space lets an angry person feel less cornered, which often reduces the urge to lash out. | | Use de-escalation. | Calm talk, listening and a low voice can settle anger without force and keep everyone safer. | | Call for help. | Extra staff add safety and presence, and calling early is better than waiting until violence has started. | | Follow policy. | Policy guides safe, lawful responses and protects the patient, staff and others on the ward. | | Treat the cause. | Pain, intoxication, fear or illness can drive aggression, so treating the cause lowers the chance of it returning. | **Expected outcomes** - No harm to staff or other patients. - Patient calms within 30-60 minutes. - Cause assessed and treated. **Linking the data to the diagnosis**
A patient with a history of violence is becoming restless after an argument with a visitor. He says, "Leave me alone," and is pacing, with a raised voice and clenched jaw. He has been aggressive in the past when intoxicated. No threats or physical acts have occurred, so this is a risk diagnosis based on anger and past violence, not actual harm. The plan aims to prevent harm to staff and other patients by staying calm, giving space and calling for help, so he settles within 30 to 60 minutes and the cause is found and treated.

CarePath diagnosis: Likely to harm others related to anger and past violence (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Stay calm.	A calm nurse sets the tone and lowers the patient's arousal, whereas an anxious or sharp manner can make anger worse.
Keep a safe distance.	A safe distance gives the nurse room to move away and reduces the chance of being hit.
Give space.	Space lets an angry person feel less cornered, which often reduces the urge to lash out.
Use de-escalation.	Calm talk, listening and a low voice can settle anger without force and keep everyone safer.
Call for help.	Extra staff add safety and presence, and calling early is better than waiting until violence has started.
Follow policy.	Policy guides safe, lawful responses and protects the patient, staff and others on the ward.
Treat the cause.	Pain, intoxication, fear or illness can drive aggression, so treating the cause lowers the chance of it returning.

Expected outcomes: No harm to staff or other patients. · Patient calms within 30-60 minutes. · Cause assessed and treated.

Linking the data: A patient with a history of violence is becoming restless after an argument with a visitor. He says, "Leave me alone," and is pacing, with a raised voice and clenched jaw. He has been aggressive in the past when intoxicated. No threats or physical acts have occurred, so this is a risk diagnosis based on anger and past violence, not actual harm. The plan aims to prevent harm to staff and other patients by staying calm, giving space and calling for help, so he settles within 30 to 60 minutes and the cause is found and treated.

S22 Staff exposure to needles or body fluids (workplace safety)

Group: Safety and protection | Type: Risk problem

Definition: Healthcare workers may be exposed to blood-borne infection through sharps or splashes.

Risk factors: Sharps injuries; splashes; poor technique; lack of protective equipment

Warning signs: Needle-stick injury; splashes; incomplete hand hygiene

Scenario. A nurse works in a busy clinic where the sharps bin is overfull and needles are sometimes recapped by hand.

S: Nurse: "We never have time to use the safety devices."

O: Overfull sharps bin; needles recapped by hand; safety devices not used; gloves out of stock.

Tools: CP-SAFE · Morse Fall Scale **CarePath diagnosis:** Staff exposure to needles or body fluids (workplace safety) related to poor technique and lack of protective equipment (risk factors); no signs of the problem are present yet. **Interventions and rationale** | Intervention | Rationale | |---|---| | Use safety devices. | Safety devices cover or retract the needle after use, which directly lowers the chance of a needle-stick injury. | | Keep a sharps bin at the point of use. | A bin within reach means sharps are discarded at once, so they are not carried or left lying around. | | Never recap. | Hand recapping is a common cause of needle-stick injuries, because the needle can slip into the fingers. | | Wear gloves and eye protection. | Gloves and eye protection create a barrier against blood and splashes, which can carry infections such as hepatitis B and HIV. | | Report exposure immediately. | Early reporting allows quick washing, risk assessment and post-exposure treatment, which work best when started soon. | **Expected outcomes** - No needle-stick or splash injury during the shift. - Sharps bin emptied and safety devices available. - Staff state the steps to take after an exposure (wash, report at once, post-exposure care). **Linking the data to the diagnosis** A nurse works in a busy clinic where the sharps bin is overfull, needles are sometimes recapped by hand, safety devices are not used and gloves are out of stock. She says, "We never have time to use the safety devices." No injury or splash has happened, so this is a risk diagnosis based on poor technique and lack of protective equipment, not an actual exposure. The plan aims for no needle-stick or splash injury during the shift, an emptied bin, available safety devices and staff who know what to do after an exposure.

CarePath diagnosis: Staff exposure to needles or body fluids (workplace safety) related to poor technique and lack of protective equipment (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use safety devices.	Safety devices cover or retract the needle after use, which directly lowers the chance of a needle-stick injury.
Keep a sharps bin at the point of use.	A bin within reach means sharps are discarded at once, so they are not carried or left lying around.
Never recap.	Hand recapping is a common cause of needle-stick injuries, because the needle can slip into the fingers.
Wear gloves and eye protection.	Gloves and eye protection create a barrier against blood and splashes, which can carry infections such as hepatitis B and HIV.
Report exposure immediately.	Early reporting allows quick washing, risk assessment and post-exposure treatment, which work best when started soon.

Expected outcomes: No needle-stick or splash injury during the shift. · Sharps bin emptied and safety devices available. · Staff state the steps to take after an exposure (wash, report at once, post-exposure care).

Linking the data: A nurse works in a busy clinic where the sharps bin is overfull, needles are sometimes recapped by hand, safety devices are not used and gloves are out of stock. She says, "We never have time to use the safety devices." No injury or splash has happened, so this is a risk diagnosis based on poor technique and lack of protective equipment, not an actual exposure. The plan aims for no needle-stick or splash injury during the shift, an emptied bin, available safety devices and staff who know what to do after an exposure.

S23 Nerve or limb damage from positioning

Group: Safety and protection | Type: Risk problem

Definition: Pressure or poor positioning may damage nerves or reduce blood flow to a limb.

Risk factors: Long unchanged positions; tight casts; anesthesia; reduced feeling; tight devices

Warning signs: Numbness; tingling; pale or cold limb; weak movement; pain

Scenario. A patient is being positioned for a four-hour operation with an arm resting off the edge of the table.

S: (Under anaesthesia; cannot speak.)

O: Surgery planned for 4 hours; arm on a narrow board; no padding at the elbow; anaesthetized; skin intact; pulses present.

Tools: CP-SAFE, CP-SKIN · Morse Fall Scale, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Nerve or limb damage from positioning related to a long unchanged position and anesthesia (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Pad and support limbs. | Padding and support spread pressure over a wider area, protecting nerves and blood vessels, particularly at the elbow, which is not padded in this case. | | Avoid pressure. | Prolonged pressure on a nerve or vessel can cause damage, and an anaesthetized patient cannot feel or signal it. | | Reposition. | Changing position when possible relieves pressure on nerves and soft tissue and restores blood flow during a long operation. | | Check pulses, warmth, and color. | Pulses, warmth and color show whether blood is reaching the limb, so a problem can be found early. | | Loosen tight items. | Tight straps, dressings or devices can squeeze nerves and reduce blood flow, so loosening them removes the cause of the damage. | | Report changes. | Early reporting lets the team correct positioning and treat a problem before damage becomes permanent. | ****Expected outcomes**** - Normal feeling and movement within 24 hours. - No permanent nerve damage. - Limbs positioned correctly. ****Linking the data to the diagnosis**** A patient is being positioned for a four-hour operation with an arm resting off the edge of the table on a narrow board, with no padding at the elbow. The patient is anaesthetized and cannot speak or report discomfort. Skin is intact and pulses are present, so no nerve or limb damage has occurred and the diagnosis is a risk statement based on a long unchanged position and anaesthesia. The plan aims to keep limbs well supported and checked so that normal feeling and movement return within 24 hours, with no permanent nerve damage.

CarePath diagnosis: Nerve or limb damage from positioning related to a long unchanged position and anesthesia (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Pad and support limbs.	Padding and support spread pressure over a wider area, protecting nerves and blood vessels, particularly at the elbow, which is not padded in this case.
Avoid pressure.	Prolonged pressure on a nerve or vessel can cause damage, and an anaesthetized patient cannot feel or signal it.
Reposition.	Changing position when possible relieves pressure on nerves and soft tissue and restores blood flow during a long operation.
Check pulses, warmth, and color.	Pulses, warmth and color show whether blood is reaching the limb, so a problem can be found early.
Loosen tight items.	Tight straps, dressings or devices can squeeze nerves and reduce blood flow, so loosening them removes the cause of the damage.
Report changes.	Early reporting lets the team correct positioning and treat a problem before damage becomes permanent.

Expected outcomes: Normal feeling and movement within 24 hours. · No permanent nerve damage. · Limbs positioned correctly.

Linking the data: A patient is being positioned for a four-hour operation with an arm resting off the edge of the table on a narrow board, with no padding at the elbow. The patient is anaesthetized and cannot speak or report discomfort. Skin is intact and pulses are present, so no nerve or limb damage has occurred and the diagnosis is a risk statement based on a long unchanged position and anaesthesia. The plan aims to keep limbs well supported and checked so that normal feeling and movement return within 24 hours, with no permanent nerve damage.

S24 Likely to spread infection to others

Group: Safety and protection | Type: Risk problem

Definition: An infectious person may pass germs to other patients, staff, or family.

Risk factors: Infectious illness; poor hand hygiene; shared equipment; crowded rooms

Warning signs: Cough; diarrhea; rash; fever; others becoming ill

Scenario. A patient with new diarrhea shares a room and a bathroom with other patients.

S: "I have had loose stools since this morning."

O: 3 loose stools today; shares a bathroom; stool test pending; temperature 37.0 C; hand hygiene not yet taught.

Tools: CP-SAFE, CP-ELIM · Morse Fall Scale, Bristol Stool Chart, bladder scan ****CarePath diagnosis:****

Likely to spread infection to others related to possible infectious illness and a shared bathroom (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Use isolation as needed. | Isolation separates a possibly infectious patient from others, which is important when he shares a room and bathroom. | | Do hand hygiene. | Hand hygiene is the single most effective way to stop germs spreading between people and surfaces. | | Wear masks and gloves. | Masks and gloves protect staff and prevent them from carrying germs to other patients on their hands and clothes. | | Clean equipment. | Shared equipment and surfaces can carry germs from one person to another, so cleaning removes this route. | | Teach patient and visitors. | Patient and visitors who understand why hygiene matters are more likely to follow it, protecting each other. | ****Expected outcomes**** - No other patients develop symptoms. - Isolation maintained. - Staff and visitors perform hand hygiene. ****Linking the data to the diagnosis**** A patient says, "I have had loose stools since this morning," and has had 3 loose stools today. He shares a room and a bathroom with other patients, his stool test is pending, his temperature is 37.0 C and hand hygiene has not yet been taught. The cause is not confirmed and no one else is ill, so this is a risk diagnosis resting on possible infectious illness and a shared bathroom. The plan aims to keep other patients free of symptoms through isolation and hand hygiene by staff, visitors and the patient.

CarePath diagnosis: Likely to spread infection to others related to possible infectious illness and a shared bathroom (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Use isolation as needed.	Isolation separates a possibly infectious patient from others, which is important when he shares a room and bathroom.
Do hand hygiene.	Hand hygiene is the single most effective way to stop germs spreading between people and surfaces.
Wear masks and gloves.	Masks and gloves protect staff and prevent them from carrying germs to other patients on their hands and clothes.
Clean equipment.	Shared equipment and surfaces can carry germs from one person to another, so cleaning removes this route.
Teach patient and visitors.	Patient and visitors who understand why hygiene matters are more likely to follow it, protecting each other.

Expected outcomes: No other patients develop symptoms. · Isolation maintained. · Staff and visitors perform hand hygiene.

Linking the data: A patient says, "I have had loose stools since this morning," and has had 3 loose stools today. He shares a room and a bathroom with other patients, his stool test is pending, his temperature is 37.0 C and hand hygiene has not yet been taught. The cause is not confirmed and no one else is ill, so this is a risk diagnosis resting on possible infectious illness and a shared bathroom. The plan aims to keep other patients free of symptoms through isolation and hand hygiene by staff, visitors and the patient.

S25 Eye damage in unconscious patients

Group: Safety and protection | Type: Risk problem

Definition: Eyes that do not blink or close may dry out or be scratched.

Risk factors: Sedation; coma; facial nerve weakness; eyes stay open

Warning signs: Dry eyes; redness; discharge; eyes do not close fully

Scenario. A sedated ICU patient on a ventilator does not blink and his eyes stay partly open.

S: (Sedated; cannot communicate.)

O: Sedated; no blink reflex; eyes partly open; corneas clear and moist; no redness.

Tools: CP-SAFE, CP-SKIN · Morse Fall Scale, Braden Scale, TIME wound chart ****CarePath diagnosis:**** Eye damage in unconscious patients related to sedation and incomplete eye closure (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Clean eyes. | Cleaning removes dust, discharge and germs that can irritate or infect the eye of a patient who cannot blink or protect it. | | Use lubricant. | Without blinking, tears do not spread over the eye and it dries quickly, so lubricant keeps the cornea moist. | | Close eyes gently or cover as ordered. | Closing the eyes or covering them as ordered stops air drying the surface, which would otherwise damage the cornea. | | Protect from injury. | Eyes that are open or unprotected can be scratched by linen, tubing or hands, so protection prevents injury. | | Report changes. | Redness, discharge or cloudiness can be early signs of damage or infection, and early reporting allows quick treatment. | ****Expected outcomes**** - Eyes stay moist and uninjured. - No ulcer. - Eye care every 2-4 hours. ****Linking the data to the diagnosis**** A sedated ICU patient on a ventilator does not blink, and his eyes stay partly open. He cannot communicate. His corneas are clear and moist and there is no redness, so no eye damage has occurred and the diagnosis is a risk statement based on sedation and incomplete eye closure. The plan aims to keep his eyes moist and uninjured, with no ulcer. Regular eye care every 2 to 4 hours, with lubricant and protection, is meant to prevent the drying and scratching that his missing blink reflex would otherwise allow.

CarePath diagnosis: Eye damage in unconscious patients related to sedation and incomplete eye closure (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Clean eyes.	Cleaning removes dust, discharge and germs that can irritate or infect the eye of a patient who cannot blink or protect it.
Use lubricant.	Without blinking, tears do not spread over the eye and it dries quickly, so lubricant keeps the cornea moist.
Close eyes gently or cover as ordered.	Closing the eyes or covering them as ordered stops air drying the surface, which would otherwise damage the cornea.
Protect from injury.	Eyes that are open or unprotected can be scratched by linen, tubing or hands, so protection prevents injury.
Report changes.	Redness, discharge or cloudiness can be early signs of damage or infection, and early reporting allows quick treatment.

Expected outcomes: Eyes stay moist and uninjured. · No ulcer. · Eye care every 2-4 hours.

Linking the data: A sedated ICU patient on a ventilator does not blink, and his eyes stay partly open. He cannot communicate. His corneas are clear and moist and there is no redness, so no eye damage has occurred and the diagnosis is a risk statement based on sedation and incomplete eye closure. The plan aims to keep his eyes moist and uninjured, with no ulcer. Regular eye care every 2 to 4 hours, with lubricant and protection, is meant to prevent the drying and scratching that his missing blink reflex would otherwise allow.

S26 Injury during seizure ⚠ URGENT

Group: Safety and protection | Type: Risk problem

Definition: Falls, tongue bites, or a blocked airway may occur during a seizure.

Risk factors: Epilepsy; head injury; fever in children; missed medicine

Warning signs: Sudden jerks; loss of awareness; falling; tongue bite; confusion afterwards

Scenario. A patient with epilepsy has missed two doses of anti-seizure medicine.

S: "I forgot my tablets for two days."

O: Epilepsy; two doses missed; last seizure 3 months ago; no seizure now; bed rails and padding not yet in place.

Tools: CP-SAFE, CP-NEURO · Morse Fall Scale, GCS, pupils, NIHSS ****CarePath diagnosis:**** Injury during seizure related to epilepsy and missed medicine (risk factors); no signs of the problem are present yet. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Give anti-seizure medicine on time and as ordered. | Missed doses lower drug levels in the blood and make a seizure more likely, so regular timing keeps protection steady. | | Keep the bed low and padded; clear the area. | A low, padded bed and a clear area reduce injury from falling or striking hard objects during a seizure. | | Teach the patient and family seizure first aid. | People nearby who know first aid can act quickly and correctly, which lowers the risk of harm. | | During a seizure: protect the head, time it, put nothing in the mouth, turn to the side afterward. | Protecting the head prevents injury, timing shows when help is needed, objects in the mouth can cause harm, and side-lying keeps the airway clear. | | Call for help if a seizure lasts over 5 minutes or repeats. | A seizure over 5 minutes or repeated seizures can be life-threatening and need urgent medical treatment. | ****Expected outcomes**** - No injury during the stay. - Medicine given on time. - Family states seizure first aid. - If a seizure occurs: timed, airway kept clear and doctor told. ****Linking the data to the diagnosis**** A patient with epilepsy says, "I forgot my tablets for two days," so two doses were missed. His last seizure was 3 months ago, he is not seizing now, and bed rails and padding are not yet in place. No seizure or injury has occurred, so this is a risk diagnosis based on epilepsy and missed medicine. Because a seizure can block the airway or cause serious injury, the plan states that help is called first for a long or repeated seizure. It aims for no injury during the stay, medicine on time and a family who can give seizure first aid.

CarePath diagnosis: Injury during seizure related to epilepsy and missed medicine (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Give anti-seizure medicine on time and as ordered.	Missed doses lower drug levels in the blood and make a seizure more likely, so regular timing keeps protection steady.
Keep the bed low and padded; clear the area.	A low, padded bed and a clear area reduce injury from falling or striking hard objects during a seizure.
Teach the patient and family seizure first aid.	People nearby who know first aid can act quickly and correctly, which lowers the risk of harm.
During a seizure: protect the head, time it, put nothing in the mouth, turn to the side afterward.	Protecting the head prevents injury, timing shows when help is needed, objects in the mouth can cause harm, and side-lying keeps the airway clear.
Call for help if a seizure lasts over 5 minutes or repeats.	A seizure over 5 minutes or repeated seizures can be life-threatening and need urgent medical treatment.

Expected outcomes: No injury during the stay. · Medicine given on time. · Family states seizure first aid. · If a seizure occurs: timed, airway kept clear and doctor told.

Linking the data: A patient with epilepsy says, "I forgot my tablets for two days," so two doses were missed. His last seizure was 3 months ago, he is not seizing now, and bed rails and padding are not yet in place. No seizure or injury has occurred, so this is a risk diagnosis based on epilepsy and missed medicine. Because a seizure can block the airway or cause serious injury, the plan states that help is called first for a long or repeated seizure. It aims for no injury during the stay, medicine on time and a family who can give seizure first aid.