Pressure Ulcer Nursing Care Plan

Patient Information

Full Name: Sarah Smith

Date of Birth: 09 / 09 / 1988

Gender: F

Patient ID: /

Contact Number: +00 000 0000

Email Address: sarahsmith@email.com

Potential use of medical devices that increase the risk of PI development:

- [ ] Respiratory devices
- [ ] Orthopedic devices
- [x] Urinary or fecal-collecting devices
- [ ] Repositioning devices
- [ ] Drains
- [ ] Tubes
- [ ] Intravenous catheters and lines
- [ ] Restraints
- [x] Stockings
- [x] Bandaging

Assessment	Intervention	Notes
Impaired Skin Integrity	• Inspecting the patient's skin routinely. • Focusing on common pressure points during skin assessment. • Assessing for the presence of medical devices that could cause pressure.	Pressure of bands holding catheter bag to right leg overnight causing skin breakdown. No other points of concern, left hip to be monitored as patient favours this side in sleep. Two points of skin integrity breakdown where top band and lower band secure bag. bands MUST be removed at night or while patient is sitting. Stage 2 for top pressure point, stage 1 for lower.

	• Assessing the skin for signs of possible tissue damage. • Determining the stage of the pressure injury. • Assessing nutritional status and initiating corrective measures, as indicated. • Encouraging adequate fluid intake. • Maintaining strict skincare and hygiene. • Changing position frequently in the chair and bed.	
Risk for Infection	• Assessment of signs and symptoms of systemic infection. Monitor temperature routinely. • Observation of the wound, noting the presence of drainage and inflammation. • Recording risk factors for the occurrence of infection. • Instruct the client or family members in techniques to prevent the spread of infection.	Risk for infection is high, Pressure injuries are close to a urine collecting device and on leg that is often exposed due to summer weather. Patient is immunosuppresed, currently reciving chemotherapy. all care members have been instructed on care and stages of pressure injury.
Risk for Impaired Peripheral Tissue Perfusion	• Assessing for the presence of peripheral vascular/arterial diseases. • Monitoring the client's blood glucose levels routinely. Assess for peripheral neuropathy.	N/A

	• Monitoring the client's vital signs. • Repositioning or turning the patient every 2 hours. • Utilization of special support surfaces for pressure reduction such as foam, air, or gel-filled mattress overlays.	

Indicate stage of pressure injury/s:

Stage	Location	Intervention
Stage 1 pressure injury: Nonblanchable erythema of intact skin *Discoloration of the skin that doesn't turn white when pressed*	Right leg, lower band	redness and swelling no skin broken. pressure cause removed and observation 2 hourly.
Stage 2 pressure injury: Partial-thickness skin loss with exposed dermis	Right Leg, upper band.	pressure cause removed, bangage and pressure relief ring applied.
Stage 3 pressure injury: Full-thickness skin loss		
Stage 4 pressure injury: Full-thickness skin and tissue loss		
Unstageable pressure injury: Obscured full-thickness skin and tissue loss		
Deep pressure injury: Persistent non-blanchable deep red, maroon, or purple discoloration		

Physician's Notes and Recommendations

Use of catheter straps adressed with all care staff as application is too tight, patient laying in the band side overnights has caused skin breakdown and pressure wound. Closse observation and wound care 2-4 hourly.

Physician's Signature: _____ **Date:** ____ / ____ / ___