Pressure Ulcer Nursing Care Plan

Patient information	
Patient name: Smithy Johnson	Age: 75
Gender: Male	Date of birth: April 1, 1949

Medical history

Diabetes mellitus, type 2
Hypertension
Chronic kidney disease, stage 3
Limited mobility due to a stroke
History of a previous stage 2 pressure ulcer on the sacral area

Assessment

Subjective	Objective
The patient reports discomfort in the lower back region and occasionally notices redness after prolonged sitting. He expresses concerns about developing another ulcer, as he had one in the past. The patient also mentions difficulty in repositioning himself independently due to his reduced mobility.	Redness and partial skin loss over the sacral area (stage 2 pressure ulcer). Warmth in the affected area with signs of inflammation. Patient remains in a sitting or lying position for extended periods due to limited mobility. Skin is dry and flaky around the pressure points. Capillary refill time delayed in the affected area.

Nursing diagnosis

Impaired skin integrity related to prolonged pressure and immobility as evidenced by the presence of a stage 2 pressure ulcer.

Goals and outcomes	
Long-term	**Short-term**
The patient's pressure ulcer will completely heal within 4-6 weeks.	The patient will demonstrate proper repositioning techniques within 2 days.
The patient will prevent the development of new pressure ulcers through education and proper repositioning techniques.	Redness and inflammation in the ulcer area will decrease within 5 days with appropriate care.
	The patient will show improvement in skin integrity within 1 week.

Nursing interventions

Reposition the patient every 2 hours to alleviate pressure on the sacral area. Use pillows and foam pads to cushion pressure points and reduce friction. Apply a moisture-barrier cream after cleaning the ulcer area to prevent skin breakdown. Educate the patient and family on the importance of frequent position changes and proper skin care. Ensure the patient's nutritional intake is adequate, with a focus on protein and vitamins that support skin healing. Monitor the wound for signs of infection or deterioration, such as increased redness, swelling, or drainage. Collaborate with a physical therapist to promote mobility exercises that the patient can perform to improve circulation.

Rationale

Frequent repositioning prevents further pressure buildup, which can worsen the ulcer. Proper cushioning and moisture barriers help reduce friction and prevent further skin damage. Nutritional support is essential for wound healing, especially in elderly patients with underlying conditions like diabetes. Educating the patient and caregivers empowers them to participate actively in preventing further ulcers. Monitoring for infection ensures early intervention if complications arise.

Evaluation

The patient is repositioning with assistance every 2 hours. Redness and warmth around the ulcer have decreased within the first 5 days. The ulcer area shows early signs of healing with no further skin breakdown after 1 week.
The patient and family demonstrate an understanding of proper ulcer care and repositioning.

Additional notes

The patient will be reassessed every 2 days for changes in skin integrity. Continue monitoring for any signs of infection, especially considering the patient's history of diabetes. Involve the patient's family in long-term care planning, as mobility limitations will persist.

Nurse’s information

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