Pressure Ulcer Nursing Care Plan

Patient Information			
Full Name:			
Date of Birth: / /			
Gender:			
Patient ID:			
Contact Number:			
Email Address:			

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

- Respiratory devices
- Orthopedic devices
- Urinary or fecal-collecting devices
- Repositioning devices
- Drains
- Tubes
- Intravenous catheters and lines
- Restraints
- □ Stockings
- 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. 	

	 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 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. 	

 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		
<i>Discoloration of the skin that doesn't turn white when pressed</i>		
Stage 2 pressure injury:		
Partial-thickness skin loss with exposed dermis		
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

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