

## Nursing Process: Plan of Care for your Patient

| DATA                                                                                                                                                                       | NURSING DIAGNOSIS                                                                        | GOAL                                                  | NURSING INTERVENTIONS                                                                                                                                                                                       | RATIONALES                                                                                                                                                                                                                                                                                                                                                                                                                              | EVALUATION                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------|-------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------|
| <p><u>Subjective Data:</u></p> <p>None</p> <p><u>Objective Data:</u></p> <p>Stage 2 Sacral<br/>Left heel<br/>Blanchable<br/>erythema on<br/>Right posterior<br/>thigh.</p> | Risk for impaired tissue integrity related to bed bound as evidenced by muscle weakness. | Patient skin will remain intact throughout the shift. | <p>-Asses skin every two hours</p> <p>-reposition every two hours.</p> <p>-Provide education to the patient and caregivers about the prevention plan and ways to minimize the risk of pressure injury."</p> | <p>"Skin assessment provides information related to the patient's current status and detects impending or actual alterations in skin integrity." (Lynn, 2019, p.428)</p> <p>"Repositioning reduces the duration and magnitude of pressure over vulnerable areas of the body and provide comfort, hygiene, dignity and functional ability". (Lynn, 2019, p.427)</p> <p>"Explanation encourages patient understanding and cooperation</p> | met (patient's skin remained intact throughout the shift) |

# Restorative Nursing Care Plan Template

**JG Myers**



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