

Nursing Process: Plan of Care for your Patient

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

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Lingjun Ying



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