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Pressure injury prevention Initial assessment

Nursing Foundation | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

76-year-old man with reduced mobility after illness. Care stage: At the first supervised assessment.

Medical history: Mobility declined during a recent illness. The patient previously walked with help; prolonged bed rest and moisture exposure now create pressure-related risk. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Heels feel sore and assistance is needed to turn.

Objective findings and required checks: Intact but vulnerable sacral and heel skin; moisture exposure and prolonged bed rest.

Physical examination and investigations: Assess skin, mobility, nutrition and pressure risk; document any non-blanching discoloration.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Pressure injury prevention: Sustained pressure and shear impair tissue perfusion, particularly over bony areas.

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Medical / surgical management

Individualize turning, heel offloading, support surfaces, moisture care and nutrition referral.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Barrier preparation	Protect skin from moisture when indicated	Check product suitability and skin response
prescribed analgesic	Enable comfortable repositioning	Reassess pain and adverse effects.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Heels feel sore and assistance is needed to turn. Intact but vulnerable sacral and heel skin; moisture exposure and prolonged bed rest. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize skin damage or vulnerability to pressure-related injury; movement limited by weakness, discomfort or restriction; daily self-care needs exceed current ability; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Individualize turning, heel offloading, support surfaces, moisture care and nutrition referral. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about discomfort, usual mobility and ability to reposition. Assess: Inspect skin, pressure points, wound characteristics and moisture exposure.	Skin damage or vulnerability to pressure-related injury. Possible factors: pressure, moisture, impaired sensation or tissue injury. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Skin is protected and existing damage shows no avoidable deterioration. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates the individualized skin-protection plan.	1. Assess skin and pressure risk using the local tool and clinical judgment. Rationale: Risk identification guides targeted prevention. 2. Individualize repositioning, heel offloading and pressure redistribution. Rationale: Reducing sustained pressure and shear protects tissue perfusion. 3. Use appropriate wound care and moisture management; refer for nutrition or specialist advice when needed. Rationale: Healing requires local protection and support for underlying contributors. 4. Individualize turning, heel offloading, support surfaces, moisture care and nutrition referral. Rationale: Sustained pressure and shear impair tissue perfusion, particularly over bony areas. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about usual mobility, fatigue and help needed with activities. Assess: Assess strength, range, gait, balance and ordered movement restrictions.	Movement limited by weakness, discomfort or restriction. Possible factors: reduced strength, pain or prescribed movement limits. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Completes a jointly agreed movement task safely with appropriate assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the home exercise or mobility plan before discharge.	1. Assess assistance needs and confirm prescribed restrictions before mobilization. Rationale: Matching support to ability prevents injury. 2. Plan graded movement, position changes and rest with physiotherapy where indicated. Rationale: Progressive activity supports function while limiting exhaustion. 3. Monitor tolerance and stop for new concerning symptoms. Rationale: Symptoms may indicate unsafe exertion or deterioration.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what the learner already knows and wants to understand. Assess:	Learning needs about the condition and care plan. Possible factors: new	Short-term: After the first indicated intervention, at the documented review time:	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few	Record the baseline and reassessed finding, the time

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Use teach-back or demonstration to identify specific gaps.	information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Teach skin checks, supported position changes and when a wound needs review; do not massage reddened pressure points. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Teach skin checks, supported position changes and when a wound needs review; do not massage reddened pressure points.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Report non-blanching discoloration, blistering, rapidly worsening skin damage or systemic illness.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Sustained pressure and shear impair tissue perfusion, particularly over bony areas.

- Priority concerns: Skin damage or vulnerability to pressure-related injury; Movement limited by weakness, discomfort or restriction; Daily self-care needs exceed current ability; Learning needs about the condition and care plan.

- Report non-blanching discoloration, blistering, rapidly worsening skin damage or systemic illness.

- Teach skin checks, supported position changes and when a wound needs review; do not massage reddened pressure points.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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