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Skin damage or vulnerability to pressure-related injury Pressure injury prevention

Nursing Foundation | Focused diagnosis-based template

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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.

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.

Medical / surgical management

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

Illustrative drug and treatment study

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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.

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Focused nursing-problem template

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: At the next patient-specific reassessment: 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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Apply this template

Complete with verified data: assessment cues; supported actual problem or risk; measurable outcome and review time; selected authorized interventions and rationale; observed response and next action.

Subjective / objective cues: _____

Patient-specific target and review time: _____

Evaluation evidence and next action: _____

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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.
- 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: What assessment evidence supports this problem, and what measurable result would demonstrate improvement?

References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

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https://www.indiannursingcouncil.org/gazette-notification

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