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Skin damage or vulnerability to pressure-related injury Wound dressing and healing

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: Local tenderness and uncertainty about changing the dressing.

Objective findings and required checks: Wound edges and exudate require documented assessment; no systemic instability in this scenario.

Physical examination and investigations: Assess wound dimensions, tissue, drainage, pain and infection signs; review glucose or cultures when indicated.

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

Clinical focus and pathophysiology

Wound dressing and healing: Healing depends on tissue perfusion, protection from contamination and adequate nutrition.

Medical / surgical management

Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed analgesic	Support comfortable wound care	Assess timing and effect
prescribed antimicrobial	Treat clinically diagnosed infection when indicated	Check allergy and response rather than routine use.

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. Use the prescribed dressing and aseptic technique, protect surrounding skin and address healing barriers. Rationale: Healing depends on tissue perfusion, protection from contamination and adequate nutrition. 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 dressing protection, hand hygiene, nutrition and the wound review schedule.

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

Spreading redness, increasing pain, wound separation, heavy bleeding or systemic illness needs urgent review.

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

- Healing depends on tissue perfusion, protection from contamination and adequate nutrition.
- Priority concerns: Skin damage or vulnerability to pressure-related injury.
- Spreading redness, increasing pain, wound separation, heavy bleeding or systemic illness needs urgent review.
- Teach dressing protection, hand hygiene, nutrition and the wound review schedule.

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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