

## 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 Left heel Blanchable erythema on Right posterior 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)

# Nursing Restorative Care Plans

**L Darling-Hammond**



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