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| **Assessment: Client Data** *(What subjective and objective data from your client assessment indicates that the NANDA Label is a problem?)* | Nursing Diagnosis Statement(NANDA Approved) | | |
| ***Subjective Data:*** *(What did the client say about the issue?)* | ***NANDA Label:***  Impaired Tissue Integrity  *Definition: Damage to the mucous membrane, cornea, integumentary system, muscular fascia, muscle, tendon, bone, cartilage, joint capsule, and/or ligament* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.] do you have about the issue?)* | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * edema * physical trauma or injury * decreased nutritional intake * poor hygiene * decreased mobility * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are* ***the signs and/or symptoms*** *that prove the NANDA Label is a problem.)* | | |
| **Planning: Client Outcome** |  | | |
| ***Outcome*** *(Only one behavior/response. Needs to be specific, observable, measurable, achievable, realistic and timed for THIS client.)* | | ***Time*** *(When you expect the response to occur. If there is an agency policy for reassessment, such as with pain, utilize that time frame in your outcome to add it to your workflow.)* | |
| **The client will:**   * Experience area of injury decrease in size by 25% * Inspect skin for erythema, drainage or injuries * Describe 3 measures to protect and heal tissue * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * By the end of hospital day \_\_\_\_\_ (***1, 2, 3****?)* * Every 4/ 8/ 12/ 24/ hrs. *(circle one)* * by discharge / transfer *(circle one)* * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **PLANNING:** **Interventions** *(Select interventions that help the client achieve the outcome. Do not choose all assess and monitor interventions. The majority of your interventions should reflect nursing action (actually doing something). Rationales for actions are in italics. Rationales for actions must be included.)* | **IMPLEMENTATION:** *(****Document how you implemented the intervention and the client’s response*** *If you were unable to implement the intervention, state that, and why.)* |
| * Choose dressings that provide a moist healing environment, keep peri-wound skin dry, and control exudate and eliminate dead space. *To provide an environment to increase healing to injury and protect surrounding skin from further injury (Potter, Perry, Stockert, & Hall, 2017).* |  |
| * Instruct the client in understanding how dressings changes, maintaining a clean environment, nutrition, moisture, and movement maintain tissue integrity. *Teaching the client how to protect and heal from injury (Potter, et al., 2017).* |  |
| * Teach the client how to perform skin assessment*. To prevent new or further injury to client tissues (Potter, et al., 2017).* |  |
| * Reposition client every 2 hours and use pressure-reducing devices. *To prevent new or further injury to client tissues (Potter, et al., 2017).* |  |
| * Encourage fluid intake and nutritionally balanced meals. *To provide the nutrients needed to maintain and repair tissues (Potter, et al., 2017).* |  |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
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