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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?)*  Client stated that she had a hernia repair, ostomy reversal, and an appendectomy all at same time and at some time in the recovery period a fistula developed | ***NANDA Label:***  Risk for impaired skin integrity  *Definition: Susceptible to alteration in epidermis and/or dermis, which would compromise health* | | ***Priority According to Maslow:***  *(circle one)*  ***HIGH***  ***MEDIUM***  ***LOW*** |
| ***Objective Data: (****What information, [lab values, vital signs, etc.] do you have about the issue?)*  Was able to see fistula in LRQ of abdomen covered in transparent protective covering with a drain port emptying into drainage bag. | ***Related to:*** *(Etiology: Pick one. This is what you will develop the outcome to address.)*   * Anemia * Cardiovascular diseases * Decreased tissue oxygenation   X Punctures   * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| ***As Manifested by:*** *(These are the signs and/or symptoms that prove the NANDA Label is a problem.)*  Wound care team has been documenting progress of healing with notes and photos showing that early on the wound was stage 4 and large circumference and has progressed significantly to stage 3 and now much smaller circumference to where nearly imperceptible opening | | |
| **Planning: Client Outcome** |  | | |
| ***Outcome*** *(Only one behavior/response. Needs to be specific, observable, measureable, 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:**  X Report altered sensation or pain at risk areas as soon as noted  X Demonstrate understanding of personal risk factor for impaired skin integrity  X Verbalize a personal plan for preventing impaired skin integrity.   * \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | * By the end of hospital day \_\_\_\_\_ *(1, 2, 3?)*   X Every day / week / month *(circle one)*  X 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.).* ***Make sure to cite the source (Ackley book) and add the page number at the end of each rationale in the box(es) below.*** | **IMPLEMENTATION:** *(****Document how you implemented the intervention and the client’s response*** *If you were unable to implement the intervention, state that, and why.)* |
| Inspect and monitor skin condition at least once a day for color or texture changes, redness, localized heat, edema, or induration, pressure damage, dermatological conditions, or lesions and any incontinence-associated dermatitis. *Determine whether the client is experiencing loss of sensation or pain. Systematic inspection can identify impending problems early* (Ackley & Ladwig, 2023, p. 896) | Inspection of fistula and surrounding area is done several times a day with each drainage and bag emptying. Wound care team assesses the site three times a week. |
| Implement and communicate a client-specific prevent plan. *A plan of care clearly documents in clients EHR will assist in ensuring consistency in care and documentation*. (Ackley & Ladwig, 2023, p. 897) | Inspection of fistula and surrounding area is done several times a day with each drainage and bag emptying. Wound care team assesses the site three times a week. Patient is vigilant about calling for assistance when she feels it’s required to help with proper drainage. |
| At-risk clients should be frequently repositioned. *Frequency of repositioning will be influenced by variable concerning the individual’s independent mobility and the support surface in use. Frequency of reposition should be determined by the individual’s tissue tolerance and medical condition.* (Ackley & Ladwig, 2023, p. 897) | Patient is able to reposition themselves in bed and knows to ask for help when transition out of bed as it requires a Hoyer lift. |
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| **EVALUATION of OUTCOME: *(Documented in a Nurse’s Note)*** | |
| Patient verbalizes and demonstrates the need for care and inspection of her wounds. She is aware and | |
| states skin breakdown is of serious concern. She inspects herself regularly and asks for assistance when | |
| needed. She displays all of these on a daily basis meeting the outcome timeframe. | |