## Impaired skin integrity

<table>
<thead>
<tr>
<th>Nr.</th>
<th>Nursing Diagnosis</th>
<th>Date</th>
<th>Nursing Intervention/s and tasks</th>
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<tbody>
<tr>
<td></td>
<td>Impaired skin integrity</td>
<td></td>
<td><strong>Skin Surveillance</strong></td>
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<td></td>
<td>Related factors:</td>
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<td>Apply antibiotic ointment as ordered</td>
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<td></td>
<td>Alterations in turgor (changes in elasticity)</td>
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<td>Apply skin moisturizers to maintain suppleness and prevent cracking and fissures</td>
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<td></td>
<td>Altered circulation or reduced blood supply</td>
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<td>Assess Breast skin status</td>
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<td>Altered fluid status</td>
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<td>Assess skin color every 8 hours</td>
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<td></td>
<td>Altered metabolic state</td>
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<td>Avoid applying drying agents to skin</td>
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<td></td>
<td>Altered nutritional state (e.g., obesity, emaciation)</td>
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<td>Bathe infant using sterile water and mild soap.</td>
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<td>Altered pigmentation</td>
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<td>Change patient position regularly</td>
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<td></td>
<td>Altered sensation</td>
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<td>Change position every 2 hours</td>
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<td></td>
<td>Chemical substance</td>
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<td>Consider applying cool washcloths or covered ice</td>
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<td>Developmental factors</td>
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<td>Encourage ambulation</td>
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<td></td>
<td>Edema formation</td>
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<td>Inspect patient's skin every shift, document skin condition and report change</td>
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<td></td>
<td>External</td>
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<td>Inspect skin, noting areas of redness or pressure</td>
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<td></td>
<td>Extremes in age</td>
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<td>Instruct patient not to scratch</td>
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<td></td>
<td>Humidity</td>
<td></td>
<td>Keep head of bed elevated 30 to 45 degrees. Monitor facial edema</td>
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<td>Hyperthermia or hypothermia</td>
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<td>Keep patient's linens dry, clean and free from wrinkles or curmps</td>
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<td></td>
<td>Immunological deficit</td>
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<td>Keep skin area dry</td>
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<td></td>
<td>Mastitis</td>
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<td>Massage the area that stands out</td>
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<td>Mechanical factors (e.g., shearing forces, pressure, restrain)</td>
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<td>Monitor bloody drainage from surgical sites, suture and drains</td>
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<td></td>
<td>Mediations</td>
<td></td>
<td>Monitor patient's nutritional status every ____ hours and document</td>
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<tr>
<td></td>
<td>Physical immobilization</td>
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<td>Note and report any milky-appearing drainage.</td>
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<td></td>
<td>Radiation or chemotherapeutic agents</td>
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<td>Protect skin flaps and suture lines from tension or pressure</td>
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<td></td>
<td>Skeletal prominence</td>
<td></td>
<td>Provide foam, flotation, or alternate pressure mattress or bed</td>
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<td></td>
<td>Surgery</td>
<td></td>
<td>Provide wound care, as indicated</td>
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<tr>
<td></td>
<td>Swelling of breast</td>
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<td>Refer to physical therapy for regular exercise program</td>
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<td>Symptoms / Risk factors:</td>
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<td><strong>Incision Site Care</strong></td>
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<tr>
<td></td>
<td>bleeding</td>
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<td>Change dressing as prescribed</td>
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<td></td>
<td>decubitus ulcer formation</td>
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<td>Obs dressing (bleeding)</td>
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<td></td>
<td>Destruction of skin layers (dermis)</td>
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<td>Obs. signs of infection</td>
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<td></td>
<td>Display timely wound healing without complications.</td>
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<td><strong>Wound Care</strong></td>
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<td></td>
<td>Disruption of skin and tissue surface</td>
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<td>Administer antibiotics, as indicated.</td>
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<tr>
<td></td>
<td>Disruption of skin surface (epidermis)</td>
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<td>Administer oral, IV, and topical antibiotics, as indicated</td>
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<td></td>
<td>Invasion of body structures</td>
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<td>Check drains for placement, patency – strict sterile technique</td>
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<td></td>
<td>Open wounds</td>
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<td>Check dressing for drainage</td>
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<td></td>
<td>Temp &gt; 38.5</td>
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<td>Cleanse thoroughly around stoma and neck tubes</td>
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<td><strong>Outcome / Goal:</strong></td>
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<td>Cover dressing with plastic when using the bedpan</td>
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<td>Breast skin remains intact</td>
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<td>Debride necrotic and loose tissue</td>
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<td>Display timely wound healing without complications.</td>
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<td>Inspect dressings and wound</td>
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<td>Intact skin</td>
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<td>Maintain aseptic technique when changing dressings and caring for wound.</td>
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<td>Surgical wound clean</td>
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<td>Monitor all sites for signs of wound infection, such as unusual redness</td>
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<td>The integrity of the baby's skin can be maintained</td>
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<td>Monitor vital signs.</td>
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<td>Provide special care for eyes</td>
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<td>Reinforce necessity of not smoking.</td>
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<td>Shave/clip all hair from around burned areas</td>
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<td>Teach patient about cleaning the wound</td>
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<td>teach patient watching for signs of infection</td>
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<td>Teach wound care: Suprapubic, retropubic wounds and Perineal wounds</td>
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Plan created: 7.11.2016   by:__________________________

signature