Patients info label here

Impaired skin integrity

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

Plan created: 7.11.2016 by:_____

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