Patients info label here

Risk for impaired skin integrity

Nr.	Nursing Diagnosis	Date	Nursing Intervention/s and tasks	Sign.
	Risk for impaired skin integrity *Related factors:* Edema Hyperglycemia Pheripheral sensory neuropaathy Physical immobilization Prolonged bedrest Result from allergic reaction surgical procedure Thin skin, fragile capillaries near the skin surface, Vascular insufficiency *Symptoms / Risk factors:* Alterations in nutritional state (e.g., obesity, emaciation) Alterations in skin turgor (changes in elasticity) Bleeding Excretions and/or secretions Skeletal prominence *Outcome / Goal:* Patient maintains intact skin No Urticaria or Edema Demonstrate behaviors or techniques to prevent skin breakdow		**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 Avoid friction against the infected area 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 your skin clean and moisture Massage the area that stands out Monitor bloody drainage from surgical sites, suture and drains Monitor patient's nutitional status every _____ hours and document Monitor direct and indirect bilirubin 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 **Pressure Management** Encourage frequent position changes in bed and chair Inspect skin, noting skeletal prominences Monitor presence of edema and altered circulation Provede egg-crate mattress Provide frequent skin care **Medication Administration** Administer medication as prescribed Assist patient in taking medication Medication: Epinephrine, Antihistamin and Steroids (if not already done) Monitor patient for the therapeutic effect of the medication **Foot Care** Assess feet and legs for skin temperature, sensation, soft tissue injuries, corn Assess feet dryness, hammer toe or bunion deformation, hair distribution, pulses Instruct patient in foot care guidelines Maintain skin integrity by protecting feet from breakdown.	

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