

**Nursing 102 Care of Adults
Clinical Preparation Week**

Integumentary: Pressure Injuries

**** Due Friday, February 7th by 0830 to Mrs. Wingate's "Clinical Prep Integ Dropbox". ****

1.) Then read the client profile and answer the questions below:

Client Information: Name: Robert Johnson

Age: 72

Gender: Male

Weight: 230 lbs

Height: 5'7"

Primary Diagnosis: Post-stroke hemiparesis (left-sided)

Secondary Diagnosis: Type 2 Diabetes Mellitus, Hypertension

Medical History: Obesity, peripheral neuropathy, chronic kidney disease (Stage 2)

Social History: Retired construction worker, widowed, lives alone, limited family support, receives home health visits twice weekly.

Clinical Presentation: Robert presents with a pressure injury on his sacral region identified during a routine home health visit. He has limited mobility due to left-sided weakness and primarily uses a wheelchair for mobility. He reports occasional incontinence and uses absorbent pads but has limited ability to reposition himself.

Wound Assessment:

- *Location: Sacral region, Stage 3 Pressure Injury (full-thickness tissue loss with visible adipose tissue)*
- *Size: 5 cm x 6.5 cm, depth 1.2 cm*
- *Exudate: Moderate amount, yellow and thick, pain: 6/10, worse with dressing changes*
- *Edges: Rolled edges noted, faint, musty odor*
- *Surrounding skin: Erythematous, warm to touch, no crepitus*

Braden Scale Assessment:

- 1.) Fill out a completed Braden Scale Assessment on Robert (Circle or highlight the values you select and total at bottom):

BRADEN SCALE – For Predicting Pressure Sore Risk

		SEVERE RISK: Total score ≤ 9		HIGH RISK: Total score 10-12		DATE OF ASSESS →				
		MODERATE RISK: Total score 13-14		MILD RISK: Total score 15-18						
RISK FACTOR	SCORE/DESCRIPTION						1	2	3	4
SENSORY PERCEPTION Ability to respond meaningfully to pressure-related discomfort	1. COMPLETELY LIMITED – Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished level of consciousness or sedation, OR limited ability to feel pain over most of body surface.	2. VERY LIMITED – Responds only to painful stimuli. Cannot communicate discomfort except by moaning or restlessness, OR has a sensory impairment which limits the ability to feel pain or discomfort over ½ of body.	3. SLIGHTLY LIMITED – Responds to verbal commands but cannot always communicate discomfort or need to be turned, OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.	4. NO IMPAIRMENT – Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.						
MOISTURE Degree to which skin is exposed to moisture	1. CONSTANTLY MOIST – Skin is kept moist almost constantly by perspiration, urine, etc. Dampness is detected every time patient is moved or turned.	2. OFTEN MOIST – Skin is often but not always moist. Linen must be changed at least once a shift.	3. OCCASIONALLY MOIST – Skin is occasionally moist, requiring an extra linen change approximately once a day.	4. RARELY MOIST – Skin is usually dry; linen only requires changing at routine intervals.						
ACTIVITY Degree of physical activity	1. BEDFAST – Confined to bed.	2. CHAIRFAST – Ability to walk severely limited or nonexistent. Cannot bear own weight and/or must be assisted into chair or wheelchair.	3. WALKS OCCASIONALLY – Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.	4. WALKS FREQUENTLY – Walks outside the room at least twice a day and inside room at least once every 2 hours during waking hours.						
MOBILITY Ability to change and control body position	1. COMPLETELY IMMOBILE – Does not make even slight changes in body or extremity position without assistance.	2. VERY LIMITED – Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.	3. SLIGHTLY LIMITED – Makes frequent though slight changes in body or extremity position independently.	4. NO LIMITATIONS – Makes major and frequent changes in position without assistance.						
NUTRITION Usual food intake pattern ¹ NPO: Nothing by mouth. ² IV: Intravenously. ³ TPN: Total parenteral nutrition.	1. VERY POOR – Never eats a complete meal. Rarely eats more than 1/3 of any food offered. Eats 2 servings or less of protein (meat or dairy products) per day. Takes fluids poorly. Does not take a liquid dietary supplement, OR is NPO ¹ and/or maintained on clear liquids or IV ² for more than 5 days.	2. PROBABLY INADEQUATE – Rarely eats a complete meal and generally eats only about ½ of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement OR receives less than optimum amount of liquid diet or tube feeding.	3. ADEQUATE – Eats over half of most meals. Eats a total of 4 servings of protein (meat, dairy products) each day. Occasionally refuses a meal, but will usually take a supplement if offered, OR is on a tube feeding or TPN ³ regimen, which probably meets most of nutritional needs.	4. EXCELLENT – Eats most of every meal. Never refuses a meal. Usually eats a total of 4 or more servings of meat and dairy products. Occasionally eats between meals. Does not require supplementation.						
FRICION AND SHEAR	1. PROBLEM – Requires moderate to maximum assistance in moving. Complete lifting without sliding against sheets is impossible. Frequently slides down in bed or chair, requiring frequent repositioning with maximum assistance. Spasticity, contractures, or agitation leads to almost constant friction.	2. POTENTIAL PROBLEM – Moves freely or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally slides down.	3. NO APPARENT PROBLEM – Moves in bed and in chair independently and has sufficient muscle strength to lift up completely during move. Maintains good position in bed or chair at all times.							
TOTAL SCORE	Total score of 12 or less represents HIGH RISK									

Total score: 14, moderate risk

2.) Identify 3 risk factors for skin breakdown Robert has?

Hemiparesis on left side, occasional incontinence, and diabetes/peripheral neuropathy.

3.) Write a nurse’s note on the skin assessment with an intervention you would implement as well as a re-assessment:

Time	Relevant Assessments Indicate pertinent assessment findings.	Time	Multidisciplinary Team Intervention What interventions were done in response to your abnormal assessments?	Time	Reassessment/Evaluation What was your patient’s response to the intervention?
0830	Sacral stage 3 pressure	0900	Turned q2hrs using foam	0900	Pain level 2/10, “I feel better on

	injury, moderate yellow exudate, pain 6/10, faint musty odor, erythema at surrounding skin and warm to touch.		wedges, foam sacral dressing applied, primofit applied, pain medication administered.		my side”, no incontinence.
1130	Sacral stage 3 pressure injury, moderate yellow exudate, faint musty odor, erythema at surrounding skin and warm to touch.	1145	Assisted into chair, waffle cushion, no more than 3 layers, repositioned q2hrs.	1200	Pain level 4/10. In chair for all of lunch. No incontinence.

- 4.) Identify 3 Pressure Injury Prevention Strategies you would implement for Robert knowing his Braden score:
- a. Foam sacral dressing.
 - b. Waffle cushion while in chair.
 - c. Strict q2hr turns using wedges.
 - d. No more than 3 layers under patient.