Rachel Mordes
02/03/2026

Nursing 102 Care of Adults
Clinical Preparation Week

Integumentary: Pressure Injuries

** Due Friday February 6th by 0830 to Mrs. Wingate's "Clinical Prep Integ Dropbox". **

1) Complete the following lesson in ATI Engage Medical Surgical RN:
   - ✓ *Alterations in Tisue Integrity > "Pressure Injuries" and answer the questions within the lesson. (No need to print anything)*

2) 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*
- *Wound 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):

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BRADEN SCALE – For Predicting Pressure Sore Risk

SEVERE RISK: Total score ≤ 9 **HIGH RISK**: Total score 10-12
MODERATE RISK: Total score 13-14 **MILD RISK**: Total score 15-18

RISK FACTOR	SCORE/DESCRIPTION				DATE OF ASSESS ➡			
					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.		✓		
FRICTION 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 feebly 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**					1	2	

What was the Braden Score? 12

- Is that score low risk, medium risk or high risk? high risk

2) What is a **priority** patient problem for Robert? Impaired skin integrity

3) Identify 3 risk factors for skin breakdown Robert has?
   a. Chairfast / wheelchair / limited mobility
   b. Occasional incontinence (moist enviroment)
   c. Obesity: decreased mobility and poor nutrition

4) Using the information provided, write 1-2 **focused nursing notes** related to Robert's skin integrity.

(Pre-care): Skin assessment completed. Stage 3 pressure injury noted to sacral region measuring 5cm x 6.5cm with depth of 1.2cm. Moderate yellow, thick exudate present with faint musty odor. Rolled wound edges observed. Surrounding skin erythematous and warm to touch. Patient reports 6/10 pain.

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Time	**Relevant Assessments** Indicate pertinent assessment findings. ***Include pertinent wound characteristics (location, stage, size, drainage, pain) Include relevant risk factors that influence skin integrity***	Time	**Multidisciplinary Team Intervention** What interventions were done in response to your abnormal assessments? ***Describe at least one nursing intervention you would initiate Interventions should be appropriate for a Stage 3 pressure injury***	Time	**Reassessment/Evaluation** What was your patient's response to the intervention? ***Describe how the patient responded to the intervention Include findings such as pain level, wound tolerance, or effectiveness of the intervention Indicate whether further intervention or monitoring is needed***
16:00	Stage 3 pressure injury on sacral region, measuring 5cm x 6.5cm, 1.2cm depth, moderate thick yellow exudate, surrounding skin erythematous and warm.	16:20	Wound cleansed and appropriate dressing applied per protocol.	20:00	pt reported pain 3/10, dressing intact with no new drainage noted, surrounding skin remains erythematous. Continued wound care, monitoring required.
16:20	Risk factor impacting skin integrity include limited mobility, left-sided hemiparesis, type 2 diabetes, incontinence and unable to reposition independently.	16:30	Patient repositioned and pressure-reducing support measures recommended.	20:10	pt remains high risk for impaired skin integrity. Braden score of 12. Re-education on pressure-reducing support measures given.

6/10 pain ←

12 braden ←

5) Identify 3 Pressure Injury Prevention Strategies you would implement for Robert knowing his Braden score:

a. Turn pt q2hr, to off-load sacral pressure.

b. Maintain, dry, clean intact dressing with proper changes PRN.

c. Manage moisture and incontinence with frequent skin checks, absorbant products, and barrier creams.

D. Ensure 2 to 3≤ linen/clothing layers.

E. Educate and encourage proper nutrition/hydration.