

Adult/Geriatric Critical Thinking Worksheet

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Unit: S6

Pt. Initials: J.Y.

Date: 3/29/2022

1. Disease Process & Brief Pathophysiology

Wound Dehiscence: Dehiscence is a partial or total separation of previously approximated wound edges, due to a failure of proper wound healing. This scenario typically occurs 5 to 8 days following surgery when healing is still in the early stages. The causes of dehiscence are similar to the causes of poor wound healing and include ischemia, infection, increased abdominal pressure, diabetes, malnutrition, smoking, and obesity.

4. Diagnostic Tests pertinent or confirming of diagnosis

X-ray

Ultrasound

CT scan

2. Factors for the Development of the Disease/Acute Illness

Infection at the wound site

Poor perfusion/ ischemia

Pressure on sutures

New injury to the area

Weak tissue or muscle at the wound area

Incorrect suturing at time of surgery

Use of high dose/ long term corticosteroids

Diabetes

5. Lab Values that may be affected

WBC

RBC

HgB

Blood cultures

CBC

3. Signs and Symptoms

Bleeding

Pain

Swelling

Redness

Fever

Broken sutures

Open wound

6. Current Treatment

Antibiotics

Changing wound dressings

(-) pressure wound vac

Surgery

Open wound to air

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7. Focused Nursing Diagnosis:

Impaired skin integrity

8. Related to (r/t):

Mechanical interruption of skin/tissues

Altered circulation, effects of medication;
accumulation of drainage; altered metabolic state

9. As evidenced by (aeb):

Disruption of skin surface/layers and tissues

10. Desired patient outcome:

By the time of discharge patient's wound will be free of infection, will be completely healed, and free of any complications .

11. Nursing Interventions related to the Nursing Diagnosis in #7:

1 .Maintain patency of drainage tubes; apply collection bag over drains and incisions in presence of copious or caustic drainage.

Evidenced Based Practice:

Facilitates approximation of wound edges; reduces risk of infection and chemical injury to skin and tissues.

2. Monitor or maintain dressings: hydrogel, vacuum dressing.

Evidenced Based Practice:

May be used to hasten healing in large, draining wound/ fistula, to increase patient comfort, and to reduce frequency of dressing changes. Also allows drainage to be measured more accurately and analyzed for pH and electrolyte content as appropriate.

3. Inspect wound regularly, noting characteristics and integrity. Note patients at risk for delayed healing

12. Patient Teaching:

1. Teach pt to do good hand hygiene before coming into contact with tier wound to prevent infection.

2. Teach pt how to split abdominal incision area with a pillow or pad during coughing or movement to prevent pressure on wound

3. Teach patient to report redness, swelling, heat, or pain coming from incision site/ wound. Signs and symptoms of infection = what we want to prevent

13. Discharge Planning/Community Resources:

1. Contact wound care specialist to come teach pt about wound care at home.

2. Refer pt to a rehab or a health care facility to get help with around the clock wound care and meds.

3. follow up appointment with general surgeon/ Dr.

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Evidenced Based Practice:

Early recognition of delayed healing or developing complications may prevent a more serious situation. Wounds may heal more slowly in patients with comorbidity, or the elderly in whom reduced cardiac output decreases capillary blood flow.

