

Responding/Taking Actions:

Nursing interventions for the top priority:

- Assess skin wound characteristics (size, color, drainage, odor, tissue type, etc.) at least one per shift & with every dressing change.
Rationale: Track healing progress, and identify early signs of infection or deterioration, and guides treatment effectiveness.
- Assess skin for level of Edema and pitting, and elevate legs with pillows, every 4 hours with vitals.
Rationale: To reduce swelling and increase circulation to extremities.
- Assess Ostomy, stoma and surrounding skin for color, appearance, edema, odor q 8 hours (0700, 1500, 2300), Provide ostomy care as needed.
Rationale: To track healing progress and identify early changes.
- Reposition patient every 2 hours while in bed and every 1 hour while in the chair.
Rationale: Frequent position changes relieve pressure on bony prominences, restores circulation and prevent further issues with ischemia or breakdown.
- Monitor vital signs and O2 saturation every 4 hours
Rationale: To determine change in patient status.
- Monitor hemoglobin, albumin and renal labs at least weekly or as ordered.
Rationale: Identifies anemia, and poor nutrition that can contribute to delayed wound healing; guides provider decisions for supplementation.
- Administer Midodrine 5mg TID as ordered (0700, 1200, 1700).
Rationale: To treat patient's low blood pressure.
- Administer Insulin depending on patients Glucose levels.
Rationale: To keep patient's glucose levels in a normal range.
- Administer Apixiban 2.5mg BID (0900, 2100)
Rationale: To control patients A-Fib.
- Educate Patient, and caregivers on importance of repositioning & pressure relief techniques.
Rationale: Promotes involvement in care and help prevent further skin breakdown after discharge.
- Educate Patient and caregivers on Importance on proper ostomy care.
Rationale: To make the transition to home ostomy care successful and track healing progress.

Reflecting/Evaluate Outcomes:

Evaluation of the top priority:

Vital Signs: T-98.3, P-97 irregular, R- 20, O2-99% on 1L for comfort, BP- 100/43
Patient presents with impaired skin integrity and fecal incontinence.
Unstageable Pressure ulcer on Coccyx
CKD & Anemia
Hard of Hearing with hearing aids
Skin dryness on lower extremities
Low air mattress in place
New ostomy placed

Limited Mobility
Incontinence
Chronic urinary catheter
Age 85 years old

Continue current plan of care.

(Doenges et al. , 2022)

Reference:

Doenges, M.E., Moorhouse, M.F., & Murr, A.C. (2022). Nurse's pocket guide: Diagnoses, prioritized interventions, and rationales (16th ed). F. A. Davis Company: Skyscape Medpresso, Inc.