**Issue 2:** Mary is at very high risk of developing pressured areas. Sister has a Waterlow Pressure Ulcer Risk Scale score of 20+. She is immobile and has dry and tissue paper skin.

Goal 1: Prevent the development of pressure areas on the patient.

Actions:

Action 1:

Make use of a turning schedule that is relevant and applicable to the condition of the patient in conjuction with the implementation of pressure relieving position. (p). Systematically turning and repositioning the patient can help to relieve pressure from bony prominences (Ulcer management). Hourly position changes should be developed that includes the use of positioning aids such as foam wedges and wedge pillows. It is important to regularly inspect the skin in order to determine if the positioning frequency is to be modified. One should look to see if any skin discolouration is evident. (P). Nurses must assist and reposition the patient as Mary is unable to move herself and relieve the pressure.

Action 2:

Minimisation of pressure shear and friction. Mary is immobilised and therefore at high risk. Nurses should ensure that the correct positioning, transferring and handling techniques are being used, as shearing forces or friction can cause damage to the skin (ulcer management). Aids such as hoists and slide sheets should be used to eliminate dragging and friction. Care should be taken when transferring patients between the bed and a chair.

Goal 2:

To reduce the risk factors for pressure ulceration. The risk factors Mary has are: aging, chronic diseases, immobility, doubly incontinence and dry skin.

Action 1:

Nurses must ensure that Mary has a healthy nutritional intake in order to maintain a healthy status. Nutrition is a very important factor in the development of pressure ulcers. Very thin older people lack a protective layer of fat. There is an extremely high risk of developing pressure sores on areas such as the hip bones which are unprotected bony features. (P, pressured area). A balanced diet that contain the minimum required protein and caloric needs of Mary should be encouraged by the nurses. (P, ulcer management). Any assessment of nutritional status such as weight loss should be assessed and recorded frequently. Enough daily fluid intake is also encouraged as it can increase the skin hydration status.

Action 2:

Maintaining a stable skin pH reduces the risk of infection and helps discourage the colonisation of bacteria which helps to retain skin integrity therby reducing the risk factors. (P). In order to establish a baseline for case management and the evaluation of interventions as well as the identifications of skin damage, regular inspections are essential. (P). Cleansing the skin should be provided everyday to improve overall hygiene and stimulate circulation. Cream is to be applied onto skin to form a protective layer. In order to avoid maceration and denuding of the skin, exposure to urine or faces should be minimized. This can be achieved by on schedule toileting and changing of pads. (p).

**Outcome:**

From the maintenance of good skin integrity, the outcome of reducing the risk factors of developing pressure ulcers should be achieved. Further evaluation should be performed regularly as part of an ongoing process of monitoring and assessment. A systematic skin inspection of at risk patient should be conducted daily for signs of impaired skin integrity. Any signs should be reported and treated on first occurence time. A Waterlow assessment is to be completed every week or more frequently if there are any changes in condition. The Waterlow score is expected to become lower under the implementation of regular maintenance of skin integrity.

From the study for this case study, I have learned to provide patient-certre care is important.