Creating an effective care plan

By Jeri Lundgren, BSN, RN, PHN, CWS, CWCN

The development of a care plan related to skin integrity can be challenging for any clinician. It takes a strong understanding of skin integrity risk factors and knowledge of how to modify, stabilize, and eliminate those risk factors. This article provides tips for the care-planning process.

Establish goals

A skin integrity care plan starts with a comprehensive risk assessment and skin inspection. (For more information, refer to **What is a comprehensive risk assessment?** in the May/June 2014 issue of *Wound Care Advisor*.)

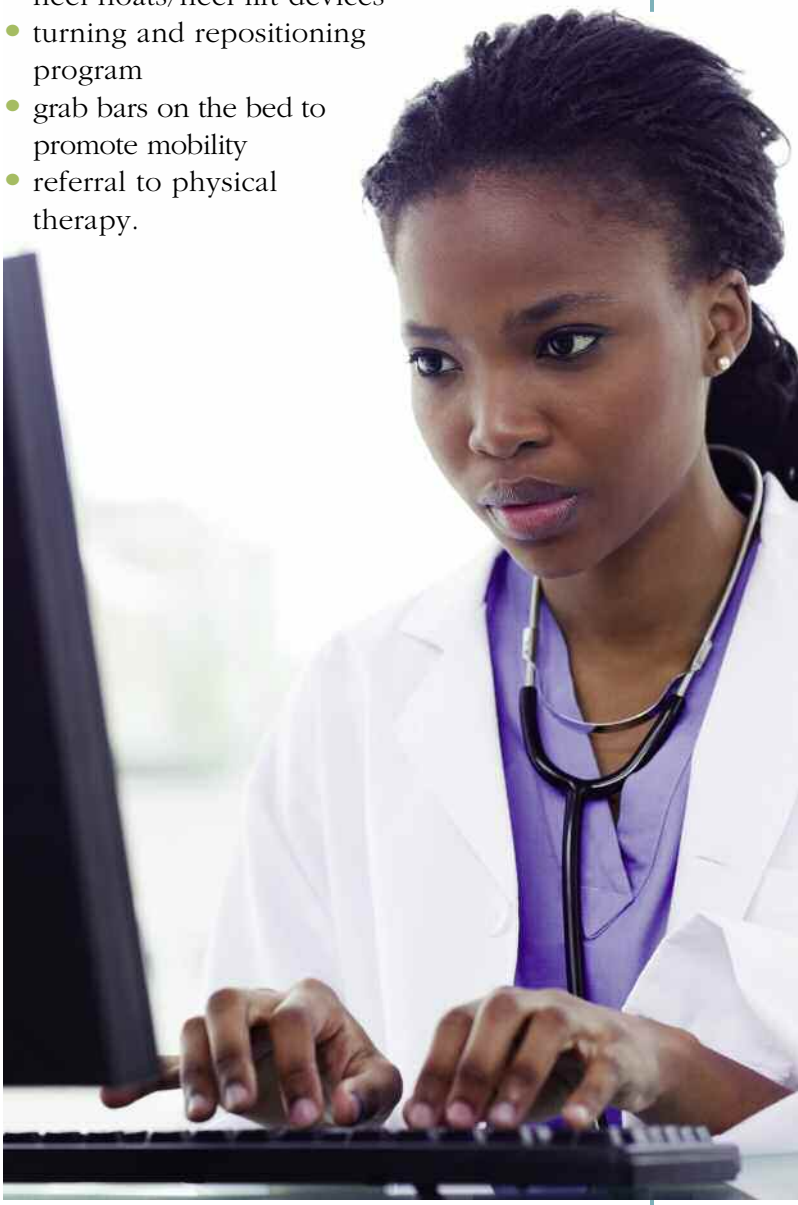
Once the risk assessment is complete, all identified risk factors or skin concerns should be brought forward to the plan of care. Now it's time to determine the goal. Ensure the goal is measurable; for example, "The skin will remain intact during the patient's stay" or "The pressure ulcer on the coccyx will show signs of healing, such as a decrease in dimension size and filling in of the wound base in 2 weeks."

You also want to ensure the goal is realistic. For example, you don't want to state that an arterial wound with no circulation will heal in 3 months. Instead, your goal may be that the arterial wound will remain stable.

Select interventions

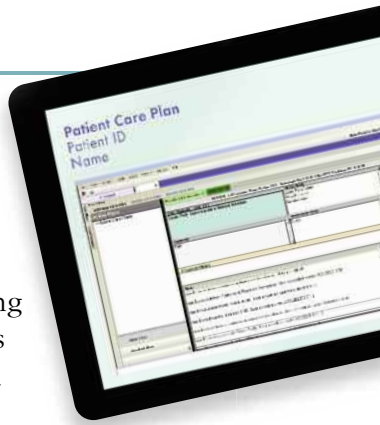
After you establish the goal, you're ready to develop the interventions. Correlating the interventions to the identified risk factors is key, but given the multitude of possible interventions, this can seem overwhelming. One solution is to develop a suggestion sheet of potential interventions for common risk factors. For example, for the risk factor of immobility, potential interventions might include:

- pressure redistribution surface for the bed and wheelchair
- heel floats/heel-lift devices
- turning and repositioning program
- grab bars on the bed to promote mobility
- referral to physical therapy.



It's important to understand the root cause of risk factors to help determine the appropriate intervention. For example, if the patient doesn't want to turn and reposition because of pain (a risk factor that's known to potentially reduce mobility), you would first need to provide pain relief.

Some risk factors, such as elimination problems secondary to urinary incontinence or nutrition deficit because of loss of taste, will require their own interventions. In this case, list the risk factor under skin integrity; then, under interventions, state "See elimination problem" or "See nutritional problem." This will eliminate the risk of having conflicting interventions listed under two care-plan problems.



Make care planning less intimidating

Overall, the care-planning process can become less intimidating if you use a comprehensive risk tool with a suggestion sheet of goals and interventions to consider. Also, it's imperative to ensure all interventions listed on the care plan that need to be implemented by the nursing assistant are clearly communicated and documented on the nursing assistant assignment sheet. ■

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