

# Case Study Synopsis

## Case Study: Skin Integrity

### Suggested Uses: Fundamentals

Aaron Brown is a 23-year-old Caucasian male with paraplegia. He lives at home with his parents while attending college. He visits the Health Clinic on campus for a regularly scheduled skin assessment, where the nurse observes a reddened, round area on his sacrum that is 3 cm in diameter. Additional assessment confirms that Aaron has a stage 1 pressure ulcer.

The nurse identifies other areas at risk for pressure ulcer formation and finds underlying spongy tissue. The nurse adds the nursing diagnosis “Impaired skin integrity” to the plan of care, recognizing altered mobility as the etiology and establishing a related goal. Client teaching includes positioning at bedtime, use of a gel-filled seat pad, and application of a transparent film dressing.

A month later, Aaron is admitted to the hospital with vomiting and diarrhea. Aaron’s ulcer is open with purulent drainage. The nurse protects Aaron’s skin from the diarrhea, and considers whether posting a turning schedule in his room is a privacy violation. The wound is infected with MRSA, so the nurse selects needed PPE and equipment to assess for a sinus tract. The nurse irrigates the wound and applies a wet-to-dry dressing.

The nurse calculates the dose of a prescribed antibiotic in liquid suspension form and pours and administers the suspension. The nurse is aware of the risk for anaphylactic shock and recognizes that antihistamines can be used to treat mild allergic reactions. When Aaron develops symptoms of possible toxicity, the nurse requests that a peak and trough drug level be obtained.

When Aaron is discharged, the home health nurse responds to Aaron’s feelings of anger, plans interventions related to his developmental stage, and provides teaching related to wound healing.