

W — Wounds and skin

7 statements · Recommended tool: CP-SKIN Skin & Wound Score · Validated scales: Braden Scale, TIME wound chart

W1 Wound not healing

Group: Wounds and skin | Type: Actual problem

Definition: A wound stays open or shows little progress over the expected time.

Possible causes: Poor blood flow; infection; diabetes; poor nutrition; pressure

Signs and symptoms: No change in size; pale base; dead tissue; foul smell

Scenario. A leg ulcer stays open after six weeks.

S: "This ulcer won't heal."

O: Leg ulcer for 6 weeks; 4 cm; pale base; slough; foul odor.

Tools: CP-SKIN · Braden Scale, TIME wound chart ****CarePath diagnosis:**** Wound not healing related to poor blood flow, as evidenced by no change in size and pale base. ****Interventions and rationale**** | Intervention | Rationale | |---|---| | Assess the wound. | Measuring size, depth, tissue type, drainage and odor shows whether the wound is improving and what is blocking healing. | | Treat the cause. | Healing needs blood flow and a controlled cause, so treating poor circulation, infection or pressure addresses why it is not healing. | | Dress as ordered. | The right dressing keeps the wound moist and clean, protects it and manages drainage and odor, supporting tissue repair. | | Support nutrition. | Protein, calories and vitamins are needed to build new tissue, so good nutrition supports closure. | | Refer to a wound specialist. | A wound specialist can offer advanced treatments and a plan for a wound that has not responded for weeks. | ****Expected outcomes**** - Within 2-4 weeks: wound size reduced by 20-30%, no infection, care plan followed. ****Linking the data to the diagnosis**** The patient says, 'This ulcer won't heal.' The leg ulcer has been open for 6 weeks, measures 4 cm, has a pale base, slough and a foul odor. Healing should show progress by now, and there is none, so the problem is actual. The statement rests on poor blood flow, with no change in size and a pale base. The plan aims, within 2 to 4 weeks, for the wound to shrink by 20 to 30 percent, stay free of infection and follow the agreed care plan.

CarePath diagnosis: Wound not healing related to poor blood flow, as evidenced by no change in size and pale base.

Intervention	Rationale
Assess the wound.	Measuring size, depth, tissue type, drainage and odor shows whether the wound is improving and what is blocking healing.
Treat the cause.	Healing needs blood flow and a controlled cause, so treating poor circulation, infection or pressure addresses why it is not healing.
Dress as ordered.	The right dressing keeps the wound moist and clean, protects it and manages drainage and odor, supporting tissue repair.
Support nutrition.	Protein, calories and vitamins are needed to build new tissue, so good nutrition supports closure.
Refer to a wound specialist.	A wound specialist can offer advanced treatments and a plan for a wound that has not responded for weeks.

Expected outcomes: Within 2-4 weeks: wound size reduced by 20-30%, no infection, care plan followed.

Linking the data: The patient says, 'This ulcer won't heal.' The leg ulcer has been open for 6 weeks, measures 4 cm, has a pale base, slough and a foul odor. Healing should show progress by now, and there is none, so the problem is actual. The statement rests on poor blood flow, with no change in size and a pale base. The plan aims, within 2 to 4 weeks, for the wound to shrink by 20 to 30 percent, stay free of infection and follow the agreed care plan.

W2 Heavy wound drainage

Group: Wounds and skin | Type: Actual problem

Definition: A wound leaks large amounts of fluid and needs frequent dressing care.

Possible causes: Infection; large wound; swelling; fistula

Signs and symptoms: Soaked dressings; odor; damaged skin around the wound

Scenario. A surgical wound soaks its dressings every few hours.

S: "The dressing is soaked again."

O: Large wound; drainage soaks the dressing every 3 hours; surrounding skin red.

Tools: CP-SKIN · Braden Scale, TIME wound chart **CarePath diagnosis:** Heavy wound drainage related to infection, as evidenced by soaked dressings and odor. **Interventions and rationale** | Intervention | Rationale | | Use absorbent dressings. | Absorbent dressings hold large amounts of fluid away from the wound and skin, which keeps the area cleaner and reduces odor. | | Protect surrounding skin. | Constant moisture softens skin and causes breakdown, so a barrier or protective product keeps the red skin around the wound from worsening. | | Measure drainage. | Measuring or estimating drainage shows whether it is rising or falling, which guides dressing choice and shows whether treatment works. | | Report increases. | A rise in drainage may mean infection or other complications, so telling the team quickly allows early treatment. **Expected outcomes** - Drainage reduced. - Dressing changed on schedule. - Skin around the wound intact. **Linking the data to the diagnosis** The patient says, 'The dressing is soaked again.' The wound is large, the dressing is soaked every 3 hours and the surrounding skin is red. The excess drainage is already occurring, so an actual statement fits, and the evidence is soaked dressings and odor. It is chosen over a general wound statement because the main task is managing fluid and protecting skin. The plan aims for drainage to reduce, dressings to be changed on schedule and the skin around the wound to stay intact.

CarePath diagnosis: Heavy wound drainage related to infection, as evidenced by soaked dressings and odor.

Intervention	Rationale
Use absorbent dressings.	Absorbent dressings hold large amounts of fluid away from the wound and skin, which keeps the area cleaner and reduces odor.
Protect surrounding skin.	Constant moisture softens skin and causes breakdown, so a barrier or protective product keeps the red skin around the wound from worsening.
Measure drainage.	Measuring or estimating drainage shows whether it is rising or falling, which guides dressing choice and shows whether treatment works.
Report increases.	A rise in drainage may mean infection or other complications, so telling the team quickly allows early treatment.

Expected outcomes: Drainage reduced. · Dressing changed on schedule. · Skin around the wound intact.

Linking the data: The patient says, 'The dressing is soaked again.' The wound is large, the dressing is soaked every 3 hours and the surrounding skin is red. The excess drainage is already occurring, so an actual statement fits, and the evidence is soaked dressings and odor. It is chosen over a general wound statement because the main task is managing fluid and protecting skin. The plan aims for drainage to reduce, dressings to be changed on schedule and the skin around the wound to stay intact.

W3 Pressure sore present

Group: Wounds and skin | Type: Actual problem

Definition: Skin and tissue over a bony area has broken down from pressure.

Possible causes: Prolonged pressure; moisture; friction; poor nutrition

Signs and symptoms: Open sore over a bony area; pain; discharge

Scenario. A bedbound patient has an open sore on the tailbone.

S: "My tailbone is open."

O: Open sore on the sacrum, 4 cm; bedbound; moist skin.

Tools: CP-SKIN · Braden Scale, TIME wound chart ****CarePath diagnosis:**** Pressure sore present related to prolonged pressure, as evidenced by a 4 cm open sore over the sacrum and moist skin.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Relieve pressure. | Pressure is what caused the damage, so taking it off the area allows blood to reach the tissue and healing to begin. | | Dress as ordered. | The ordered dressing protects the wound, keeps it moist and clean, and lowers the chance of infection. | | Turn regularly. | Changing position regularly stops pressure from building over the same bony area and protects other skin. | | Support nutrition. | Protein, calories, fluids and vitamins supply what the body needs to repair damaged tissue. Good intake also helps the skin resist further damage. | | Monitor. | Regular checks of size, color, drainage and pain show whether the wound is healing or getting worse. | ****Expected outcomes**** - Wound size reduces. - No infection. - Pressure relieved. - Nutrition improves. ****Linking the data to the diagnosis**** The patient says, 'My tailbone is open.' There is an open sore on the sacrum measuring 4 cm, and he is bedbound with moist skin. Skin has already broken down, so this is an actual problem and not a risk of pressure injury. It rests on prolonged pressure and an open sore over a bony area. The plan aims for the wound to reduce in size, stay free of infection, keep pressure relieved and improve nutrition.

CarePath diagnosis: Pressure sore present related to prolonged pressure, as evidenced by a 4 cm open sore over the sacrum and moist skin.

Intervention	Rationale
Relieve pressure.	Pressure is what caused the damage, so taking it off the area allows blood to reach the tissue and healing to begin.
Dress as ordered.	The ordered dressing protects the wound, keeps it moist and clean, and lowers the chance of infection.
Turn regularly.	Changing position regularly stops pressure from building over the same bony area and protects other skin.
Support nutrition.	Protein, calories, fluids and vitamins supply what the body needs to repair damaged tissue. Good intake also helps the skin resist further damage.
Monitor.	Regular checks of size, color, drainage and pain show whether the wound is healing or getting worse.

Expected outcomes: Wound size reduces. · No infection. · Pressure relieved. · Nutrition improves.

Linking the data: The patient says, 'My tailbone is open.' There is an open sore on the sacrum measuring 4 cm, and he is bedbound with moist skin. Skin has already broken down, so this is an actual problem and not a risk of pressure injury. It rests on prolonged pressure and an open sore over a bony area. The plan aims for the wound to reduce in size, stay free of infection, keep pressure relieved and improve nutrition.

W4 Difficulty caring for a stoma

Group: Wounds and skin | Type: Actual problem

Definition: The person or carer struggles to manage a stoma and its appliance.

Possible causes: New ostomy; low confidence; skin problems; poor appliance fit

Signs and symptoms: Leaks; skin irritation; fear; poor technique

Scenario. A new colostomy patient cannot change the bag.

S: "I don't know how to change the bag."

O: New colostomy; leaks; skin irritation; afraid.

Tools: CP-SKIN · Braden Scale, TIME wound chart **CarePath diagnosis:** Difficulty caring for a stoma related to new ostomy, as evidenced by leaks and skin irritation. **Interventions and rationale** | Intervention | Rationale | |---|---| | Teach and practice. | Showing the steps and letting her practice with guidance builds skill and confidence and prepares her for care at home. | | Check skin. | Checking the skin around the stoma finds irritation early so it can be treated before it breaks down. | | Use a skin barrier. | A skin barrier protects the skin from stool and adhesive, which reduces irritation and helps the appliance seal. | | Support emotionally. | Fear and shame are common with a new stoma, and emotional support helps her accept it and take part in care. | | Refer to a stoma nurse. | A stoma nurse has specialist knowledge to check fit, solve leaks and give ongoing advice. | **Expected outcomes** - Within 1 week: changes the bag correctly, skin intact, says she feels confident. **Linking the data to the diagnosis** The patient says, 'I don't know how to change the bag.' She has a new colostomy, leaks, skin irritation and is afraid. The difficulty is already present and causing skin harm, so this is an actual problem. It rests on the new ostomy, with leaks and skin irritation as evidence. The plan aims, within 1 week, for her to change the bag correctly, keep the skin intact and say she feels confident.

CarePath diagnosis: Difficulty caring for a stoma related to new ostomy, as evidenced by leaks and skin irritation.

Intervention	Rationale
Teach and practice.	Showing the steps and letting her practice with guidance builds skill and confidence and prepares her for care at home.
Check skin.	Checking the skin around the stoma finds irritation early so it can be treated before it breaks down.
Use a skin barrier.	A skin barrier protects the skin from stool and adhesive, which reduces irritation and helps the appliance seal.
Support emotionally.	Fear and shame are common with a new stoma, and emotional support helps her accept it and take part in care.
Refer to a stoma nurse.	A stoma nurse has specialist knowledge to check fit, solve leaks and give ongoing advice.

Expected outcomes: Within 1 week: changes the bag correctly, skin intact, says she feels confident.

Linking the data: The patient says, 'I don't know how to change the bag.' She has a new colostomy, leaks, skin irritation and is afraid. The difficulty is already present and causing skin harm, so this is an actual problem. It rests on the new ostomy, with leaks and skin irritation as evidence. The plan aims, within 1 week, for her to change the bag correctly, keep the skin intact and say she feels confident.

W5 Fragile skin or skin tears

Group: Wounds and skin | Type: Risk problem

Definition: Thin or dry skin tears or bruises easily.

Risk factors: Aging; steroids; dehydration; poor nutrition

Warning signs: Thin shiny skin; tears; bruises

Scenario. An 82-year-old on long-term steroids has thin, dry skin on her forearms and needs help dressing.

S: "My skin is so thin."

O: Thin dry skin; purple patches on the forearms; on steroid tablets; skin intact; sleeves pulled over her arms during dressing.

Tools: CP-SKIN · Braden Scale, TIME wound chart ****CarePath diagnosis:**** Fragile skin or skin tears related to aging, steroids and dry skin (risk factors); no signs of the problem are present yet.

****Interventions and rationale**** | Intervention | Rationale | |---|---| | Handle gently. | Thin skin tears from shearing, pulling and friction, so slow, careful handling and lifting instead of dragging lowers the chance of injury. | | Keep skin moist. | Moisturized skin is more flexible and less likely to split, and it helps repair the dry surface. | | Protect limbs. | Padding or sleeves on arms and legs guard against knocks, rubbing and catching on furniture or equipment. | | Avoid strong adhesives. | Strong adhesives can pull off the top layer of fragile skin, so gentler dressings or tapes avoid causing a tear. | | Pad edges. | Padding hard edges on beds, chairs and rails reduces bumps that can tear or bruise thin skin. | ****Expected outcomes****
- No new tears. - Skin moisturized. - Patient states protective measures. ****Linking the data to the diagnosis**** The patient says, 'My skin is so thin.' She is 82, takes steroid tablets, and has thin dry skin and purple patches on her forearms. The skin is intact, with no tears, so the problem has not occurred. This is why a risk statement fits, and it rests on aging, steroids and dry skin. The nurse notes that her sleeves are pulled over her arms during dressing, a clear risk of injury. The plan aims for no new tears, moisturized skin and for her to state protective measures.

CarePath diagnosis: Fragile skin or skin tears related to aging, steroids and dry skin (risk factors); no signs of the problem are present yet.

Intervention	Rationale
Handle gently.	Thin skin tears from shearing, pulling and friction, so slow, careful handling and lifting instead of dragging lowers the chance of injury.
Keep skin moist.	Moisturized skin is more flexible and less likely to split, and it helps repair the dry surface.
Protect limbs.	Padding or sleeves on arms and legs guard against knocks, rubbing and catching on furniture or equipment.
Avoid strong adhesives.	Strong adhesives can pull off the top layer of fragile skin, so gentler dressings or tapes avoid causing a tear.
Pad edges.	Padding hard edges on beds, chairs and rails reduces bumps that can tear or bruise thin skin.

Expected outcomes: No new tears. · Skin moisturized. · Patient states protective measures.

Linking the data: The patient says, 'My skin is so thin.' She is 82, takes steroid tablets, and has thin dry skin and purple patches on her forearms. The skin is intact, with no tears, so the problem has not occurred. This is why a risk statement fits, and it rests on aging, steroids and dry skin. The nurse notes that her sleeves are pulled over her arms during dressing, a clear risk of injury. The plan aims for no new tears, moisturized skin and for her to state protective measures.

W6 Skin reaction to cancer treatment

Group: Wounds and skin | Type: Actual problem

Definition: Radiation or drugs cause redness, peeling, or soreness of the skin.

Possible causes: Radiation; chemotherapy; sun; friction

Signs and symptoms: Redness; dryness; peeling; itching; pain

Scenario. A patient has red peeling skin in the radiation area.

S: "My skin is burning and peeling."

O: Red peeling skin in the radiation area; itching; pain 4/10.

Tools: CP-SKIN, CP-PAIN · Braden Scale, TIME wound chart, NRS 0–10, FLACC, PAINAD **CarePath diagnosis:** Skin reaction to cancer treatment related to radiation, as evidenced by redness and dryness. **Interventions and rationale** | Intervention | Rationale | | Clean gently. | Gentle cleaning with mild products avoids rubbing and chemical irritation that can worsen already sore skin. | | Apply moisturizer as ordered. | Moisturizer helps relieve dryness and itching and supports the skin barrier, and ordered products are used to avoid interfering with treatment. | | Advise loose cotton clothes. | Loose cotton clothing reduces friction and trapped heat, which lessens irritation and discomfort over the treated area. | | Avoid sun. | Treated skin burns easily and heals poorly, so shielding it from sun prevents further damage. | | Report breakdown. | Broken skin can become infected or need a different treatment, so early reporting allows prompt care. **Expected outcomes** - Skin heals. - Pain 2/10 or lower. - Patient follows the skin care plan. **Linking the data to the diagnosis** The patient says, 'My skin is burning and peeling.' The skin in the radiation area is red and peeling, with itching and pain of 4/10. The reaction is already present, so this is an actual problem and not a risk. It rests on radiation, with redness and dryness as evidence. It is chosen over a general rash statement because the cause is cancer treatment. The plan aims for the skin to heal, pain of 2/10 or lower and for the patient to follow the skin care plan.

CarePath diagnosis: Skin reaction to cancer treatment related to radiation, as evidenced by redness and dryness.

Intervention	Rationale
Clean gently.	Gentle cleaning with mild products avoids rubbing and chemical irritation that can worsen already sore skin.
Apply moisturizer as ordered.	Moisturizer helps relieve dryness and itching and supports the skin barrier, and ordered products are used to avoid interfering with treatment.
Advise loose cotton clothes.	Loose cotton clothing reduces friction and trapped heat, which lessens irritation and discomfort over the treated area.
Avoid sun.	Treated skin burns easily and heals poorly, so shielding it from sun prevents further damage.
Report breakdown.	Broken skin can become infected or need a different treatment, so early reporting allows prompt care.

Expected outcomes: Skin heals. · Pain 2/10 or lower. · Patient follows the skin care plan.

Linking the data: The patient says, 'My skin is burning and peeling.' The skin in the radiation area is red and peeling, with itching and pain of 4/10. The reaction is already present, so this is an actual problem and not a risk. It rests on radiation, with redness and dryness as evidence. It is chosen over a general rash statement because the cause is cancer treatment. The plan aims for the skin to heal, pain of 2/10 or lower and for the patient to follow the skin care plan.

W7 Rash or skin infection

Group: Wounds and skin | Type: Actual problem

Definition: Skin shows rash, redness, warmth, or pus from irritation or infection.

Possible causes: Bacteria; fungus; allergy; poor hygiene; scratching

Signs and symptoms: Redness; heat; swelling; pus; itching; fever

Scenario. A child has red crusted sores on his face.

S: "These sores are spreading."

O: Child with crusted red sores on the face; itching; no fever.

Tools: CP-SKIN, CP-INFECT · Braden Scale, TIME wound chart, qSOFA / sepsis screen **CarePath diagnosis:** Rash or skin infection related to bacteria, as evidenced by crusted red sores on the face and itching. **Interventions and rationale** | Intervention | Rationale | | Wash hands. | Hand washing before and after care stops germs passing from the sores to other people and to other areas of the child's skin. | | Clean skin. | Gentle cleaning removes crusts and bacteria, which helps medicine reach the skin and reduces spread. | | Give medicine as ordered. | Ordered antibiotic cream or tablets treat the bacteria causing the infection, so they are given at the right dose and for the full course. | | Prevent spread. | These sores are contagious, so separate towels and covering the sores lower the chance of passing them to others. | | Teach hygiene. | Teaching the family about hygiene and not scratching helps stop spread and prevents the infection returning. **Expected outcomes** - Sores heal within 7-10 days. - Spread prevented. - Handwashing taught. **Linking the data to the diagnosis** The parent says, 'These sores are spreading.' The child has crusted red sores on the face with itching and no fever. The sores are present, so this is an actual problem and not a risk, and the focus is on the infection and spread. The statement rests on bacteria, though redness and heat are not recorded and the evidence is better described by crusted sores and itching. The plan aims for the sores to heal within 7 to 10 days, spread to be prevented and handwashing to be taught.

CarePath diagnosis: Rash or skin infection related to bacteria, as evidenced by crusted red sores on the face and itching.

Intervention	Rationale
Wash hands.	Hand washing before and after care stops germs passing from the sores to other people and to other areas of the child's skin.
Clean skin.	Gentle cleaning removes crusts and bacteria, which helps medicine reach the skin and reduces spread.
Give medicine as ordered.	Ordered antibiotic cream or tablets treat the bacteria causing the infection, so they are given at the right dose and for the full course.
Prevent spread.	These sores are contagious, so separate towels and covering the sores lower the chance of passing them to others.
Teach hygiene.	Teaching the family about hygiene and not scratching helps stop spread and prevents the infection returning.

Expected outcomes: Sores heal within 7-10 days. · Spread prevented. · Handwashing taught.

Linking the data: The parent says, 'These sores are spreading.' The child has crusted red sores on the face with itching and no fever. The sores are present, so this is an actual problem and not a risk, and the focus is on the infection and spread. The statement rests on bacteria, though redness and heat are not recorded and the evidence is better described by crusted sores and itching. The plan aims for the sores to heal within 7 to 10 days, spread to be prevented and handwashing to be taught.