## PROLONGED BED REST NURSING CARE PLANS

Assessment	Nursing Diagnosis	Goal/Expected Outcome	Intervention/Planning	Implementation	Rationale	Evaluation
Subjective Data:  - The patient reports discomfort on bony prominences. Objective Data: - Redness on the sacral area indicates early pressure ulcers.	Risk for Pressure Ulcers related to prolonged bed rest and immobility.	Short-Term: - Within 48 hours, the patient will show reduced redness and no new pressure ulcers. Long-Term: - The patient will maintain intact skin integrity through regular repositioning.	Reposition every two hours; use pressure-relieving devices; apply barrier creams; conduct skin assessments.	Document repositioning; monitor skin condition each shift; educate the patient and family.	Regular repositioning and skin care prevent prolonged pressure and reduce skin breakdown.	The patient's skin remains intact, and no new ulcers develop as documented in daily reports.
Subjective Data:  - The patient feels weak and unable to move without assistance. Objective Data: - Limited range of motion and reduced muscle	Impaired Physical Mobility related to deconditioning from prolonged bed rest.	Short-Term: - Within 72 hours, the patient will participate in passive range-ofmotion exercises. Long-Term: - The patient will show improved	Develop an exercise program; perform passive and active range-of-motion exercises; consult physical therapy; encourage assisted ambulation.	Initiate exercises twice daily; document progress in mobility and strength; adjust the plan based on patient tolerance.	Regular exercise preserves muscle strength and joint flexibility, which improves overall mobility.	The patient demonstrates improved mobility and increased strength during follow-up assessments.

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