

Adult/Geriatric Critical Thinking Worksheet

Student Name: Ashley Reyna

Unit:

Pt. Initials:

Date: [Click here to enter a date.](#)

1. Disease Process & Brief Pathophysiology

Cellulitis is an acute spreading infection of the dermis or subcutaneous layer of the skin. It may follow damage to the skin such as a bite or wound. As the cellulitis spreads fever, erythema and lymphangitis may occur. Persons with a chronic illness such as diabetes mellitus immunodeficiency or peripheral artery disease contributing health problems such as diabetes, immunodeficiency or impaired circulation have an increased risk for cellulitis. If treated promptly the prognosis is usually good. (P)

4. Diagnostic Tests pertinent or confirming of diagnosis

The diagnosis of cellulitis is based on clinical manifestations

Increased WBC

Culture and gram stain results

Using the "Touch" preparation

2. Factors for the Development of the Disease/Acute Illness

Bacterial infections commonly with group A beta-hemolytic streptococcus.

In patients with diabetes or decreased immune function (P)

In children less commonly caused by pneumococci and group B

5. Lab Values that may be affected

WBC

HGB

RBC

3. Signs and Symptoms

Erythema & edema due to inflammatory response usually well demarcated (P)

Pain at site and possibly in surrounding area (P)

Fever and warmth

6. Current Treatment

Pain medication as needed (P)

warm soaks to the sites to help relieve pain and decrease edema by increasing vasodilation (P)

Penicillin Oral or IV

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7. Focused Nursing Diagnosis:

Impaired Tissue integrity

8. Related to (r/t):

inflammatory process damaging skin and underlying tissue

9. As evidenced by (aeb):

Wounds, edema & redness at bilateral lower extremities

10. Desired patient outcome:

Wednesday at 12 noon both wounds on lower extremities will decrease by 25 % in size and will have increased granulation tissue

11. Nursing Interventions related to the Nursing Diagnosis in #7:

1 .Inspect and monitor the site of impaired tissue integrity at least once daily for color changes, redness, swelling, warmth,pain or other signs of infection

Evidenced Based Practice:

Determine whether the patient is experiencing changes in sensation or pain

2. Avoid positioning the patient on the site of impaired tissue integrity

Evidenced Based Practice:

Reposition the patient based on level of tissue tolerance and overall condition

3. Select a topical treatment that maintains moist, wound healing environment and also allows absorption of exudate and filling of dead space

Evidenced Based Practice:

Choose dressing that provide a moist healing environment

12. Patient Teaching:

1. Patient will demonstrate understanding of plan to heal tissue and prevent reinjury

2. Teach skin and wound assessment and ways to monitor for signs and symptoms of infections, complications and healing

3. Instruct patient when dressing needs to be changed

13. Discharge Planning/Community Resources:

1. Provide clear simple instructions about care plan

2. Follow up with physician, give date and time of scheduled appointment

3. If needed give patient the case manager name and phone number for any questions

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