

Student Name: Jackie Martinez Unit: S7 Pt. Initials: M Date: 01/05/2022

Adult/Geriatric Critical Thinking Worksheet

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| <p>1. Disease Process & Brief Pathophysiology- Methicillin-resistant Staphylococcus aureus has evolved to develop numerous immune evasion strategies to combat neutrophil-mediated killing, such as neutrophil activation and migration to the site of infection. This type of infection has become resistant to many antibiotics used to treat ordinary staph infections. MRSA most often causes skin infections, if left untreated can cause sepsis. The bacterium remains within the skin or mucosa where it has established colonization. Problems arise when MRSA on the skin surface in a colonized person enters the skin through a wound or other opening and invades deeper structures.</p> | <p>2. Factors for the Development of the Disease/Acute Illness- Neutropenia Diabetes IV drug abuse Foreign bodies (P) Trauma Prolong Hospital stays</p> | <p>3. Signs and Symptoms- Redness to skin (P) Swelling (P) Pain (P) Fever Chills Malaise Inability to heal wounds (P) Drainage from wound (P)</p> |
| <p>4. Diagnostic Tests pertinent or confirming of diagnosis- Cefoxitin disk diffusion test FDA-approved assays Anti-PBP2A monoclonal antibodies Wound Culture (P)</p> | <p>5. Lab Values that may be affected- CBC (P) ESR C-reactive protein</p> | <p>6. Current Treatment- I&D (P) Antibiotic Therapy (P)</p> |

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| <p>7. Focused Nursing Diagnosis: Impaired skin integrity</p> | <p>11. Nursing Interventions related to the Nursing Diagnosis in #7: 1. Adequate nutrition and Hydration. I as the nurse will make sure patient has pitcher of water and food tray at bedside and within reach throughout the day, assisting with feeding if necessary</p> | <p>12. Patient Teaching: 1. Do not scratch and avoid rubbing this can cause further injury and delay healing. Trim nails if necessary</p> |
| <p>8. Related to (r/t): Swelling and redness that may result in skin break down.</p> | <p>Evidenced Based Practice: Sufficient hydration and nutrition help maintain skin turgor, moisture and suppleness.</p> | <p>2. Educate on proper nutrition. A high-protein, high-calorie diet to promote healing</p> <p>3. Instruct patient proper care of the wound cleansing, dressing changes and handwashing.</p> |
| <p>9. As evidenced by (aeb): These conditions can cause inflammation, resulting in disruptions to skin integrity and reduce its barrier function</p> | <p>2. Using pillows or foam wedges to keep bony prominences from direct contact within each other.</p> <p>Evidenced Based Practice: These measures reduce shearing forces on the skin</p> | <p>13. Discharge Planning/Community Resources: 1. Nutritionist to help with specific dietary needs to meet adequate nutritional and hydration goals to promote healing.</p> |
| <p>10. Desired patient outcome: Patient will have absence of redness and irritation. Skin will show optimal healing and further breakdown will be prevented.</p> | <p>3. Keep skin clean, dry and moisturized, particularly bony prominences.</p> <p>Evidenced Based Practice: Smooth suppled skin is more resistant to injury. These measures prevent evaporation away from skin.</p> | <p>2. Communicate with WOCN staff to assist the patient and family with education and development of a prevention plan.</p> <p>3. Follow up appointment with infectious disease specialist</p> |

Adopted: August 2016

References and Sources

Baranoski, S., & Ayello, E. A. (2008). Wound care essentials: Practice principles. Lippincott Williams & Wilkins.

Carpenito-Moyet, L. J. (2006). Handbook of nursing diagnosis. Lippincott Williams & Wilkins.