

Concept Map

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Assessment finding:

- 1) BP: 117/67, Pulse:115, T:100.7, O2: 99%.
- 2) Lung sounds are clear no adventitious sounds.
- 3) Heart sounds are remarkable, no S3, S4, no murmurs.
- 4) Skin: Disseminated macule lesion on the

Medical Diagnosis: Cellulitis, Rhinovirus
Key assessment: Assess skin integrity, assess for pain,
Medication: Clindamycin, cefixime, and acetaminophen.
Past history: Tonsillitis.

Nursing Dx: Impaired skin integrity, related to disseminated macule lesion, secondary to infection process.

Nursing Interventions:

- 1) Assess the skin integrity and look for signs of edema, redness, and warmth every 2 hours
- 2) Administer antibiotic as per HCP orders every 8 hours.
- 3) Monitor vital signs especially temperature every 4 hours.
- 4) Educate the parents about signs of further compromised skin integrity such as increased in warmth, redness, and increment in macule sizes by the end of the shift.

Expected Outcome: The patient maintains skin integrity with no signs of complications by the end of the shift.

Evaluation: The patient did not experience signs of further compromised skin integrity by the end of the shift.

Nursing Dx: Risk for acute pain related to edematous extremity, secondary to inflammatory process.

Nursing Interventions:

- 1) Perform pain assessment every 4 hours.
- 2) Use pillow to elevate the affected area throughout the shift.
- 3) Administer pain medication as per provider order every 4-6 hours.
- 4) Educate the parents and patient about non-pharmacological methods to utilize to decrease pain and discomfort by the end of the shift.

Expected Outcome: The patient reports satisfactory pain control at a score of 2 or less on a pain scale of 0-10 by the end of the shift.

Evaluation: The patient expressed no pain during the pain assessment throughout the shift.

Nursing Dx: Risk for ineffective tissue perfusion secondary to edema.

Nursing interventions:

- 1) Elevate the affected arm throughout the shift.
- 2) Assess for pulses and capillary refills every 4 hours.
- 3) Measure the area and extension of the edema every 4 hours.
- 4) Apply warm compress to the area to decrease inflammation every 2-4 hours.

Expected outcome: The patient exhibits effective tissue perfusion and good pulse and skin condition by the end of the shift.

Evaluation: The patient maintained effective tissue perfusion by the end of the shift.

Nursing Dx: Deficient knowledge related to unfamiliarity of cellulitis, as evidenced by Patient's mom said "I do not understand what cellulitis is"

Nursing Interventions:

- 1) Educate the parent about cellulitis, related complications and safety considerations for the patient by the end of the shift.
- 2) Demonstrate to the parent how to monitor the patient temperature, and to look for signs of complications throughout the shift.
- 3) Inform the parent about the benefits of hydration and handwashing as methods to prevent diseases or infections process by the end of the shift.
- 4) Encourage the parent to ask questions to reinforce and clarify information every 2-3 hours.

Expected Outcome:

The mother recognizes signs/symptoms of cellulitis, such as skin redness, increase in warmth, increase of papule/macule lesions on the skin that necessitate immediate reporting to the healthcare practitioner by the end of the shift.

Evaluation: The mother stated three signs and symptoms that she needed to report immediately to the healthcare provider by the end of the shift.

References

Herdman, H., & Kamitsuru, S. (2019). Supplement to NANDA International Nursing Diagnoses: Definitions and Classification, 2018-2020 (11th Edition) (1st ed.). Thieme. Retrieved from <https://www.perlego.com/book/964105/supplement-to-nanda-international-nursing-diagnoses-definitions-and-classification-20182020-11th-edition-new-things-you-need-to-know-pdf>