

PROTOCOL FOR: Cellulitis: Care of the Patient with Upper or Lower Extremity

DESIRED
PATIENT OUTCOMES:

1. Patients skin integrity will return to optimal level.
2. Patient will verbalize adequate relief of pain.
3. Patients mobility will return to optimal level.

CLINICAL
ASSESSMENT/
AND CARE:

1. Infection:
 - a. Assess vital signs per MD order (usually q4° x 24° then per routine).
 - b. Assess for fever, chills, malaise.
 - c. Assess lab results.
 - d. Assess wound for any drainage, color, quantity, odor.
 - e. Assess extremity for lymphangitis streaks, usually identified by a deep general flush with a raised border on the affected limb.
 - f. Apply and change sterile dressings per MD order, refer to skin/wound protocol.
 - g. Culture wound per MD order.
2. Circulation:
 - a. Assess color, sensation, movement (CSM) to extremity q8° and prn or per MD order.
 - b. Assess erythema, edema to affected extremity.
 - c. Maintain patient on bed rest with extremity elevated.
 - d. Immobilize extremity for at least 48-72 hours or per MD order.
 - e. If cellulitis is upper extremity may use sling to immobilize and keep elevated; as per MD order.
3. Pain Management:
 - a. Have patient rate pain on scale 0-10 (0 = no pain, 10 = worst pain imaginable).
 - b. Medicate for pain as needed or per MD order.
 - c. Institute comfort measures: positioning, diversional activities, active ROM to unaffected extremities.
 - d. Apply warm/cold compresses per MD order.

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DOCUMENTATION: Document assessments/findings/interventions on the appropriate forms: unit flowsheet, MAR, infusion record, and patient family teaching record.

REPORTABLE
CONDITIONS:

1. Vital signs outside MD parameters.
2. Increased redness or edema to extremity.
3. Positive cultures.
4. Change in lab values.
5. Inadequate pain management.

APPROVAL: Medical-Surgical Standards Review
Nursing Standards Committee

EFFECTIVE DATE: 4/94

REVISION DATES: 12/97, 5/03, 9/05