Uncomplicated Cellulitis (Ward/Stepdown)

Physician's Orders - Admission

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

I. Admit To: **Service**	**Unit/Ward:**	**Change of Service/Team as of:**
MD/NP/PA:	**Pager No.: ( )**	______ /______ /_______ **Time:** ______________
MD/NP/PA:	**Pager No.: ( )**	
Sr. Resident:	**Pager No.: ( )**	**To:**____
Attending M.D.:	**Pager No.: ( )**	

Instructions: All patients will be placed on this clinical pathway unless excluded for one or more of the following reasons:

II. Inclusion Criteria:

No exclusions, place on pathway for:
- ☐ Medical management of uncomplicated cellulitis

III. Excluded for:
- ☐ Abscess requiring operative management in the operating room
- ☐ Crepitus/necrotizing fasciitis/gangrene
- ☐ Bite injuries/diabetic foot infection/pressure ulcers
- ☐ Osteomyelitis
- ☐ Less than 16 years of age
- ☐ Periorbital/facial, hand or perineal cellulitis
- ☐ Diabetic ketoacidosis
- ☐ Sepsis (severe signs of infection ie: hypotension, lactic acidosis, ARDS, renal insufficiency, DIC/coagulopathy)

IV. Diagnosis: Uncomplicated cellulitis of the ____________

V. Clinically Significant Co-Morbidity(s): ☐ None

- ☐ Alcoholism
- ☐ Diabetes
- ☐ Hepatic disease (synthetic dysfunction)
- ☐ Renal disease (creatinine greater than 2.5 mg per dL)
- ☐ Homelessness
- ☐ Intravenous drug abuse
- ☐ On research protocol
- ☐ HIV +
- ☐ Tobacco use
- ☐ ______________________
- ☐ ______________________

VI. Allergies:

☐ Known allergies (specify) ☐ No known allergies

a. ____

b. ____

c. ____

VII. Height/Weight: (To be completed by RN) **Height:** ________**cm** **or** ________**in** **Weight:** ________**kg** **or** ________**lb**

VIII. Condition: ☐ **Good** ☐ **Fair** ☐ **Serious** ☐ **Critical**

CPR Status and Patient Directives

A. CPR status order: All patients are "Full Code" unless one of the following DNR boxes is selected:
- ☐ **DNR: Do not start CPR -** *Continue all other medical/surgical management unless excluded in section [B] below*
- ☐ **DNR: Do not start CPR -** *Patient is terminally ill and requests comfort measures (pain and symptom management) only*

B. Patient directives during this hospitalization:
- ☐ No intubation
- ☐ No blood draws
- ☐ No blood products
- ☐ No antibiotics
- ☐ No invasive procedures
- ☐ No pressors
- ☐ No dialysis
- ☐ Other: ____________________________

Attending Physician Sig: ______________________________ ID#: ___________ Date: ____ /____ /_____ Time: ___________

These orders require concurrent attending approval documented in the progress notes with attending' s signature of order within 24 hrs.

Provider Last Name (Print):		
Provider Signature:	ID#:	
Date: / /	Time: :	AM / PM
RN Last Name (Print):		
RN Signature:	Initials:	
Date: / /	Time: :	AM / PM
Clerk/LVN Signature:	Initials:	
Date: / /	Time: :	AM / PM

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Uncomplicated Cellulitis (Ward/Stepdown)

Physician's Orders - Day 1 of 4

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please"X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Assessment:

- ☑ Vital signs Q8 hrs
- ☑ Obtain old chart
- ☐ Contact precautions (suspected MRSA)
- ☐ Demarcation of cellulitic area - outline with pen

Physician Notification: ***Notify provider for any of the following:***

- ☑ Systolic BP less than 90 or greater than 160 mm Hg
- ☑ Diastolic BP less than 60 or greater than 110 mm Hg
- ☑ Moderate to severe pain not relieved by medication (pain 4 or greater on a scale of 0-10)
- ☑ Temp. greater than 38.9° C (102.0° F)
- ☑ Resp. rate less than 12 or greater than 24
- ☑ Pulse less than 50 or greater than 120 BPM

Activity:

- ☑ Elevate cellulitic area if extremity and no vascular compromise
- ☐ Ad lib with affected extremity elevated while in bed or chair
- ☐ Out of bed into chair or wheelchair with bathroom privileges

Diet:

- ☐ Regular
- ☐ Other:
- ☐ Consistent Carbohydrate (ADA)

Treatment:

- ☐ IV ______________________at______mL per hr
- ☐ Insert saline lock, flush per Unit protocol

Consults:

- ☐ Occupational therapy for:
- ☐ Social services for:
- ☐ Respiratory therapy for:

Medication Reconciliation: List all patient's home medications (include samples, OTC, vitamins, herbals, and others); Select Continue or Discontinue. **Do not duplicate orders written here in the next medication order sections.** (Prohibited abbreviations: qd, qod, U, IU, lack of leading zero .X, trailing zero X.0, MS, MSO4, MgSO4)

Information source:_____________________________ ☐ Patient not currently taking medication ☐ Medication history not available

☐ NKDA ☐ Allergies/specify reactions:____ ☐ Pregnant ☐ Breastfeeding

Weight:________kg_______lbs ☐ Measured ☐ Stated Height:______ cm _____ ft _____ in

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			

Provider Last Name (Print):			
Provider Signature:		ID#:	
Date: / /	Time: :	AM / PM	
RN Last Name (Print):			
RN Signature:		Initials:	
Date: / /	Time: :	AM / PM	
Clerk/LVN Signature:		Initials:	
Date: / /	Time: :	AM / PM	

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Day 1

Medicine DVT Risk Assessment Tool

Contraindications to Anticoagulation (consider sequential compression device alone if anticoagulation is contraindicated)	**Risk Factors** **(1 point each unless otherwise noted)**
Absolute ☐ Active hemorrhage ☐ History of heparin induced thrombocytopenia (HIT) ☐ Current severe hypertension (BP ≥190/110) **Relative** ☐ Active intracranial lesion/neoplasm ☐ Biopsy sites inaccessible to hemostatic control ☐ GI or GU bleed within past 4 weeks ☐ Previous cerebral hemorrhage ☐ Proliferative retinopathy ☐ Recent intraocular or intracranial surgery ☐ Thrombocytopenia or other coagulopathy ☐ Traumatic or repeated epidural or spinal puncture **Relative Contraindications to Sequential Compression Device** ☐ Acute superficial or deep vein thrombosis ☐ CHF (class III or IV) ☐ Severe peripheral artery disease	**Stasis** ☐ Acute COPD exacerbation ☐ Acute MI ☐ Age 40 years or greater ☐ Anticipated immobilization/bed confinement (greater than 24 hrs) ☐ CHF (class III or IV) **(3 points)** ☐ Leg swelling, ulcers or varicose veins ☐ Mechanical ventilation **(3 points)** ☐ Obesity (BMI 30 or greater) ☐ Patient hospitalized, in SNF or nursing home within 90 days **(3 points)** ☐ Pneumonia ☐ Recent confining travel (air or ground) greater than 4 hrs ☐ Spinal cord injury with paresis **(3 points)** ☐ Stroke with paresis **(3 points)** **Hypercoagulability** ☐ Documented history of DVT or PE **(3 points)** ☐ Estrogenic hormone use (estrogen, tamoxifen, etc.) ☐ Family history of DVT or PE ☐ Hypercoagulable states (lupus anticoagulant, etc.) **(3 points)** ☐ Indwelling central venous catheter ☐ Inflammatory bowel disease or systemic vasculitis ☐ Myeloproliferative disorder (non-hemorrhagic) ☐ Nephrotic syndrome ☐ Pregnant, or postpartum less than 1 month ☐ Severe systemic infection or sepsis ☐ Visceral malignancy

Risk Categories and Suggested DVT Prophylaxis

Early ambulation recommended for all patients, if possible.

Low Risk **1 point or less**	**Moderate Risk** **2 points**	**High Risk** **3 points**	**Very High Risk** **4 points or greater**
Early ambulation	Heparin or Sequential compression device	Heparin or Enoxaparin [LOVENOX]	Heparin or Enoxaparin [LOVENOX] and Sequential compression device

Anti-coagulation Medication Dosing

Medication	**Usual Dose**	**Comments**
Heparin	5,000 units subcutaneous Q8 hrs	No adjustment needed in renal insufficiency Consider lower dose for small/frail/elderly patient
Enoxaparin [LOVENOX]	40 mg subcutaneous Q24 hrs	For CrCl less than 30 mL per min: 30 mg subcutaneous Q24 hrs

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Uncomplicated Cellulitis (Ward/Stepdown)

Physician's Orders - Day 1 of 4

FOR THIS ADMISSION	CURRENT HOME MEDICATIONS	DOSE	ROUTE	FREQ
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			
☐ Continue ☐ Discontinue	Instructions/Indications			

Comfort Medications - Do not exceed 4 grams acetaminophen per 24 hrs

- ☐ Acetaminophen [TYLENOL] 650 mg PO Q4 hrs PRN. Specify PRN indication(s) below.
  Mild pain Temp. greater than 38.5° C (101.3° F)
- ☐ Acetaminophen [TYLENOL] 1000 mg PO Q6 hrs PRN for. Specify PRN indication(s) below.
  Mild pain Temp. greater than 38.5° C (101.3° F)
- ☐ Docusate [COLACE] 100 mg PO BID (hold for diarrhea)
- ☐ Milk of magnesia 30 mL PO Q12 hrs PRN constipation
- ☐ Aluminum hydroxide/magnesium hydroxide/simethicone [MYLANTA] 30 mL PO Q4 hrs PRN dyspepsia
- ☐ Diphenhydramine [BENADRYL] 50 mg PO Nightly PRN insomnia
- ☐ Other:

DVT Prophylaxis (Calculate DVT risk from DVT Risk Assessment Tool); Consider lower dose for small/frail/elderly patient

- ☐ Risk assessment completed: pharmacologic prophylaxis risk outweighs benefit
- ☐ Heparin 5,000 units subcutaneous Q8 hrs (moderate, high, or very high DVT risk)
- ☐ Enoxaparin [LOVENOX] 40 mg subcutaneous Q24 hrs (high or very high DVT risk)
- ☐ Enoxaparin [LOVENOX] 30 mg subcutaneous Q24 hrs (high or very high DVT risk, and CrCl less than 30 mL per min)
- ☐ Sequential compression device to lower extremities
- ☐ Other:

Immunization (Give to patients with history of primary immunization and more than 10 years since last dose)

- ☐ Diphtheria, tetanus, acellular pertussis vaccine (DTaP) ☐ 0.5 mL IM Once

M.D. Signature: ______________ ID#: ______________

Date: ______________ Time: ______________

R.N. Signature: ______________ Init: ______________

Date: ______________ Time: ______________

Clerk Signature: ______________ Init: ______________

Date: ______________ Time: ______________

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Day 1

Uncomplicated Cellulitis (Ward/Stepdown)

Physician's Orders - Day 1 of 4

Analgesic (Pain) - If PRN drug ordered, indicate pain scale (mild, moderate, severe, or 1-10 scale). If more than one dose per medication ordered, write pain scale next to dose. Do not exceed 4 gm acetaminophen per 24 hrs. Consider stool softeners when using narcotics. Ibuprofen may decrease inflammation.		
☐ Hydrocodone 5 mg and acetaminophen 500 mg [VICODIN] PRN (___________________pain)	☐ 1 tab PO Q4 hrs PRN	☐ 2 tabs PO Q6 hrs PRN
☐ Ibuprofen [MOTRIN]	☐ 600 mg PO Q6 hrs while awake	☐ 400 mg PO Q6 hrs while awake
Antibiotic (Considerations: The most common pathogens are Grp A streptococci (GAS) and Staph aureus (SA). Preferred therapy is cefazolin (alternatives are cephalexin or dicloxacillin)		
☐ Cefazolin [ANCEF]	☐ 1 gm IVPB Q8 hrs	☐ 1 gm IVPB Q12 hrs (CrCl 10-50 mL per min)
☐ Cephalexin [KEFLEX]	☐ 500 mg PO Q6 hrs	
☐ Dicloxacillin	☐ 500 mg PO Q6 hrs	
Antibiotic (MRSA considerations: Treat abscess as suspected methicillin-resistant SA (MRSA). If MRSA is suspected, add trimethoprim/sulfamethoxazole or doxycycline. Rifampin should only be used for synergy with trimethoprim/sulfamethoxazole or doxycycline, never as a single agent. Consider vancomycin 1 gm IVPB Q 12 as a single agent for cephalosporin allergy or serious MRSA infections (suspected or proven)		
☐ Trimethoprim/sulfamethoxazole [BACTRIM - DS] (Do not use if CrCl is less than 30 mL per min)	☐ 1 tab PO Q12 hrs	☐ 2 tabs PO Q12 hrs
☐ Doxycycline	☐ 100 mg PO BID	
☐ Rifampin (only with other agent(s))	☐ 600 mg PO Daily	
☐ Other:		

M.D. Signature: ______________________ ID#: ______________

Date: ______________ Time: ______________

R.N. Signature: ______________________ Init: ______________

Date: ______________ Time: ______________

Clerk Signature: ______________________ Init: ______________

Date: ______________ Time: ______________

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Day 1

Uncomplicated Cellulitis (Ward/Stepdown)

Physician's Orders - Day 1 of 4

Insulin: **Fingerstick glucose level:** ☐ Before each mealtime and at bedtime ☐ Other:_______________________

Maintenance insulin:
Give subcutaneous NPH/Regular insulin **30 minutes before meals.**
Give subcutaneous rapid acting (Lispro) insulin **with meals.**
If patient NPO: ☐ Hold Regular/rapid acting insulin. Give ½ maintenance NPH insulin dose
☐ Other:

	Breakfast	Lunch	Dinner	Bedtime
NPH	_____units		_____units	_____units
Regular	_____units	_____units	_____units	
Other:				
Other:				

Supplemental: *(Correction dose)* (1) **With each fingerstick glucose level before meals**, give additional subcutaneous Regular insulin per glucose level below, unless patient is NPO. (2) **At bedtime**, if glucose is 250 or less, give NO supplemental insulin. If glucose 251 or greater at bedtime, give ½ the supplemental dose selected. (3) If more than 8 units of supplemental insulin required in 24 hrs, call provider to re-assess and adjust maintenance insulin dose.

Less than 70 mg per dL: Hold maintenance Regular or rapid acting insulin for this one dose; continue other insulin. If alert and able to tolerate PO fluids, give 120 mL juice PO now; otherwise give 25 mL D50 slow IVP now. Repeat fingerstick glucose level in 20 min. Call provider to re-assess and adjust insulin dose.

71-150 mg per dL: No supplemental dose required.

☐ **Lower dose:**	☐ **Higher dose:**	☐ **Other:**
151-200: 2 units (None if at bedtime)	151-200: 4 units (None if at bedtime)	151-200: ___ units (None if at bedtime)
201-250: 4 units (None if at bedtime)	201-250: 6 units (None if at bedtime)	201-250: ___ units (None if at bedtime)
251-300: 6 units (3 units if at bedtime)	251-300: 8 units (4 units if at bedtime)	251-300: ___ units (___units if at bedtime)
301-350: 8 units (4 units if at bedtime)	301-350: 10 units (5 units if at bedtime)	301-350: ___ units (___units if at bedtime)
Greater than 350: 10 units, call MD	Greater than 350: 12 units, call MD	Greater than 350: ___ units, call MD

Labs/Tests: **All orders are "next routine" (next a.m. for blood/urine) unless ordered otherwise.**

☑ HIV (requires signed consent)
☐ AST, ALT, alk phos, bili-T, bili-D
☐ Na, K, Cl, C02, BUN, Cr, Glu
☐ Blood culture X 2 (now, before antibiotic)
☐ CBC with differential
☐ Send abscess specimen for stat gram stain and routine cultures

Other:

M.D. Signature: ______________ ID#: ______________

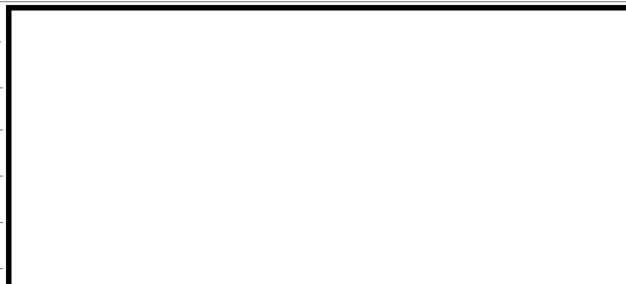
Date: ______________ Time: ______________

R.N. Signature: ______________ Init: ______________

Date: ______________ Time: ______________

Clerk Signature: ______________ Init: ______________

Date: ______________ Time: ______________



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Day 1

Uncomplicated Cellulitis (Ward/Stepdown)

Physicians Orders - Day 2 of 4

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INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Activity:

☐ Ambulate with assistance PRN

Treatment:

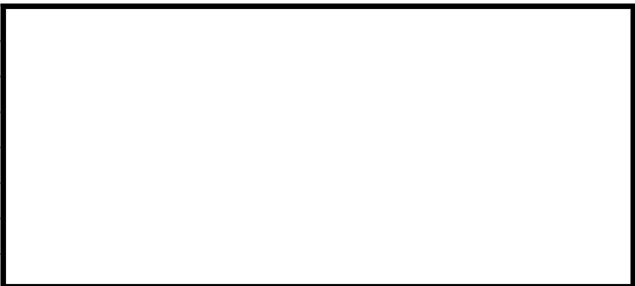
☐ Convert IV to saline lock; flush per Unit protocol
☐ Discontinue IV
☐ Discontinue saline lock

Antibiotic (Discontinue IV antibiotics and start PO antibiotics when patient is improving. If organism identified, base therapy on sensitivities. If no pathogen identified and patient responded to cefazolin as a solo agent, cephalexin or dicloxacillin preferred. Rifampin should only be used for synergy with trimethoprim/sulfamethoxazole or doxycycline, never as a single agent.)

☐ Discontinue IV antibiotics		
☐ Cephalexin [KEFLEX]	☐ 500 mg PO Q6 hrs	
☐ Dicloxacillin	☐ 500 mg PO Q6 hrs	
☐ Trimethoprim/sulfamethoxazole [BACTRIM - DS] (Do not use if CrCl is less than 30 mL per min)	☐ 1 tab PO Q12 hrs	☐ 2 tabs PO Q12 hrs
☐ Doxycycline	☐ 100 mg PO Q12 hrs	
☐ Rifampin (only with other agent(s))	☐ 600 mg PO Daily	

Other:

Provider Last Name (Print):				
Provider Signature:		ID#:		
Date: / /		Time:	:	AM / PM
RN Last Name (Print):				
RN Signature:			Initials:	
Date: / /		Time:	:	AM / PM
Clerk/LVN Signature:			Initials:	
Date: / /		Time:	:	AM / PM



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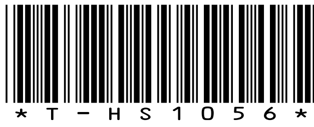


Day 2

FORM NO. HS1056 (01/02/2008)

Uncomplicated Cellulitis (Ward/Stepdown)

Physicians Orders - Day 3 of 4

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Treatment:

☐ Discontinue IV ☐ Discontinue saline lock

Antibiotic (Discontinue IV antibiotics and start PO antibiotics when patient is improving. If organism identified, base therapy on sensitivities. If no pathogen identified and patient responded to cefazolin as a solo agent, cephalexin or dicloxacillin preferred. Rifampin should only be used for synergy with trimethoprim/sulfamethoxazole or doxycycline, never as a single agent.)

☐ Discontinue IV antibiotics

☐ Cephalexin [KEFLEX]	☐ 500 mg PO Q6 hrs	
☐ Dicloxacillin	☐ 500 mg PO Q6 hrs	
☐ Trimethoprim/sulfamethoxazole [BACTRIM - DS] (Do not use if CrCl is less than 30 mL per min)	☐ 1 tab PO Q12 hrs	☐ 2 tabs PO Q12 hrs
☐ Doxycycline	☐ 100 mg PO Q12 hrs	
☐ Rifampin (only with other agent(s))	☐ 600 mg PO Daily	

Labs/Tests: (If patient is not substantially improved, consider imaging to detect occult abscesses)

☐ CT of:_________________________(occult abscess)

Discharge Plan:

☐ Anticipate discharge within the next 24 hrs

GOALS:

- ► Write discharge order by 9:00 a.m. and discharge patient by 12:00 noon
- ► Send discharge medication prescription(s) to pharmacy today
- ► Arrange for home durable medical equipment/supplies as needed

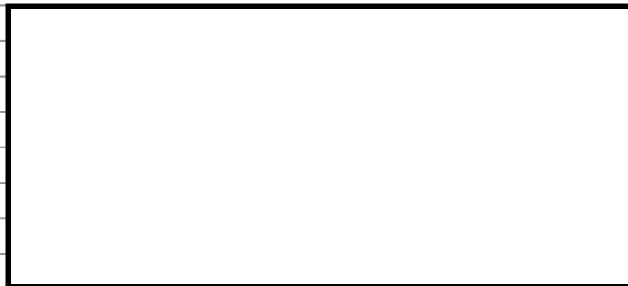
Schedule follow-up outpatient clinic appointment in __________days__________week(s)

Specify clinic/location/MD:____

☐ Discharge unlikely within the next 24 hrs

Other:

Provider Last Name (Print):	
Provider Signature:	ID#:
Date: / /	Time: : AM / PM
RN Last Name (Print):	
RN Signature:	Initials:
Date: / /	Time: : AM / PM
Clerk/LVN Signature:	Initials:
Date: / /	Time: : AM / PM



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Uncomplicated Cellulitis (Ward/Stepdown)

Physicians Orders - Day 4 OR Discharge Day

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INSTRUCTIONS: If an order is desired, please "X" the box; leave blank if not desired. If a pre-checked order is not desired, you may cancel the order by drawing a line through it, followed by your initials.

Treatment:

- ☐ Discontinue saline lock

Discharge Plan:

- ☐ Discharge patient today (Goal: discharge by 12:00 noon)
  - ☐ Discharge discussed with attending and attending concurs
  - ☐ Influenza vaccine and Pneumovax considered prior to discharge
  - ☐ Schedule follow-up appointment within 1-2 weeks
- ☐ Do not discharge today due to: (Note: pathway orders will continue)
  - ☐ Temp. greater than 38.0° C (100.4° F)
  - ☐ Pain greater than 3 with oral medications
  - ☐ Other:

Other:

Provider Last Name (Print):		
Provider Signature:	ID#:	
Date: / /	Time: :	AM / PM
RN Last Name (Print):		
RN Signature:	Initials:	
Date: / /	Time: :	AM / PM
Clerk/LVN Signature:	Initials:	
Date: / /	Time: :	AM / PM

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T-HS1056

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 1 of 4

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Admission Date: ___/___/____ **Time:**____________	**On Pathway Date:** ___/___/____ **Time:**____________

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(N) Shift			(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment													
1. Old chart available within 12 hrs of MD order	☐				☐	☐							
2. Physician Notification													
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mm Hg • Diastolic BP less than 60 or greater than 110 mm Hg • Temp. greater than 38.9° C (102.0° F) • Pulse less than 50 or greater than 120 BPM • Resp. rate less than 12 or greater than 24 • Moderate to severe pain not relieved by medication (pain 4 or greater on a scale of 0 - 10)													
3. Consults													
1. All consults obtained as ordered	☐				☐	☐							
4. Diet													
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐		☐	☐	
5. Activity													
1. Ordered activity tolerated	☐	☐	☐		☐	☐		☐	☐		☐	☐	
2. Patient tolerated out of bed to chair	☐	☐	☐		☐	☐		☐	☐		☐	☐	
3. Affected limb elevated as ordered	☐	☐	☐		☐	☐		☐	☐		☐	☐	
6. Teaching Plan													
1. Patient verbalizes understanding of pain scale and pain intervention options					☐	☐							
2. CRM inpatient teaching guide given to patient/family/significant other					☐	☐							
7. Medication													
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐		☐	☐	
8. Treatment													
1. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐		☐	☐	
9. Labs/Tests													
1. All diagnostic tests performed as ordered	☐				☐	☐							

Signature/Title:______________________ Init.:________ Date: ________

Signature/Title:______________________ Init.:________ Date: ________

Signature/Title:______________________ Init.:________ Date: ________

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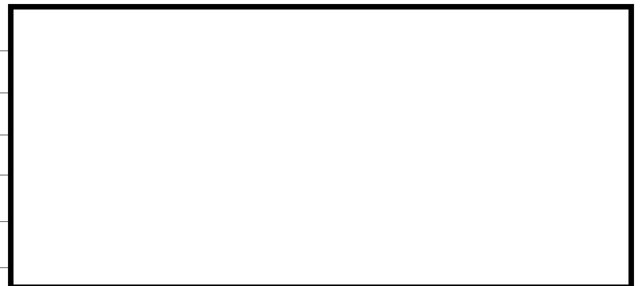
Signature/Title:______________________ Init.:________ Date: ________



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Day 1

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 1 of 4

Care Elements: Care Events/Outcomes	Not Ordered	(N) Shift			(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.	Y	N	Init.
10. Discharge Plan													
1. Discharge plan initiated					☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:______ Init.:______ Date:______

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T-HS1056

Day 1

FORM NO. HS1056 (01/02/2008)

Uncomplicated Cellulitis (Ward/Stepdown)
Daily Care Documentation - Day 1 of 4

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
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Day 1

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 2 of 4

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. Cellulitic area measured	☐	☐	☐		☐	☐		☐	☐	
2. *Temp. less than 38.3° C (101° F)*		☐	☐		☐	☐		☐	☐	
3. **Pain 4 or less on a scale of 0 - 10 after pain intervention given**		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mm Hg • Diastolic BP less than 60 or greater than 110 mm Hg • Temp. greater than 38.9° C (102.0° F) • Pulse less than 50 or greater than 120 BPM • Resp. rate less than 12 or greater than 24 • Moderate to severe pain not relieved by medication (pain 4 or greater on a scale of 0 - 10)										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ordered activity tolerated	☐	☐	☐		☐	☐		☐	☐	
2. Ambulation as tolerated	☐	☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. *Patient/family/significant other verbalizes understanding of CRM inpatient teaching guide*		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

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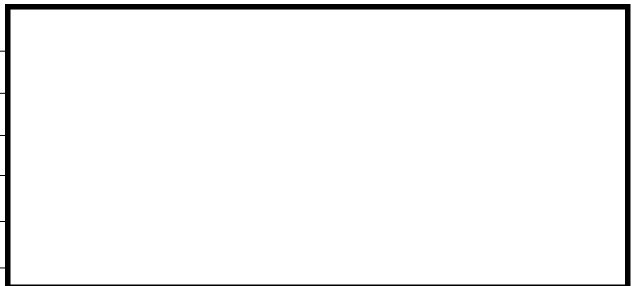

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Day 2

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 2 of 4

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
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Day 2

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 3 of 4

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. **Cellulitic area smaller**		☐	☐							
2. **Temp. less than 38.3° C (101° F)**		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mm Hg • Diastolic BP less than 60 or greater than 110 mm Hg • Temp. greater than 38.9° C (102.0° F) • Pulse less than 50 or greater than 120 BPM • Resp. rate less than 12 or greater than 24 • Moderate to severe pain not relieved by medication (pain 4 or greater on a scale of 0 - 10)										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ambulation as tolerated	☐	☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. CRM post-discharge teaching guide given to patient/family/significant other		☐	☐							
7. Medication										
1. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
2. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							
10. Discharge Plan										
1. Discharge transportation arranged/confirmed		☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:__________ Init.:_____ Date:_____

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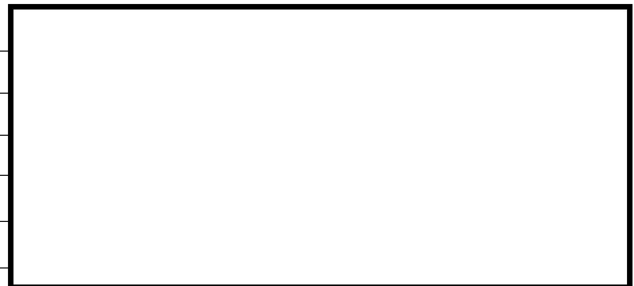

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Day 3

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 3 of 4

Date: ___/___/____

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

Instructions: 1-Record Care Element # (for Pathway Milestones, use "M"), Care Event #, Date & Time; 2-Use Problem statement or NsgDx to describe variance; 3-Record action(s) taken; 4-Initial entry and sign at bottom; 5-Record date, time and outcome(s); 6-Initial entry and sign at bottom.

Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
		Init.:	Date: / / Time: Init.:

Element #:	Event #:	Time:	Outcome:
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Day 3

Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 4 OR Discharge Day

This is a general guideline and does not represent a professional care standard governing provider obligations to patients. Care is revised to meet individual patient needs.

INSTRUCTIONS: Every Pathway Milestone and Care Event must have a "Y","N" or "Not ordered"response. "Y" = Pathway Milestone or Care Event met; "N" = not met. If "N", complete Variance Documentation form. For Care Events only requiring one documentation per 24 hrs., document in Day (D) Shift box and initial in actual shift. Pathway Milestones are in bold. Micro Indicators are italicized.

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
1. Assessment										
1. **Temp. less than 38.1° C (100.5° F)**		☐	☐							
2. Physician Notification										
1. *Emergent signs and symptoms absent*		☐	☐		☐	☐		☐	☐	
• Systolic BP less than 90 or greater than 160 mm Hg • Diastolic BP less than 60 or greater than 110 mm Hg • Temp. greater than 38.9° C (102.0° F) • Pulse less than 50 or greater than 120 BPM • Resp. rate less than 12 or greater than 24 • Moderate to severe pain not relieved by medication (pain 4 or greater on a scale of 0 - 10)										
3. Consults										
1. All consults obtained as ordered	☐	☐	☐							
4. Diet										
1. Consumed and tolerated ordered diet		☐	☐		☐	☐		☐	☐	
5. Activity										
1. Ambulation as tolerated	☐	☐	☐		☐	☐		☐	☐	
6. Teaching Plan										
1. *Patient/family/significant other received CRM post-discharge teaching guide and verbalizes understanding of diet, activity and exercise, medications, smoking cessation and counseling including secondhand smoke, follow-up appointment, what to do if symptoms worsen and when to seek medical care*		☐	☐							
7. Medication										
1. *Influenza vaccine given*	☐	☐	☐							
2. *Pneumovax vaccine given*	☐	☐	☐							
3. *All medication administered as ordered*	☐	☐	☐		☐	☐		☐	☐	
4. *Patient free of adverse drug reaction*	☐	☐	☐		☐	☐		☐	☐	
8. Treatment										
1. All treatments completed as ordered	☐	☐	☐		☐	☐		☐	☐	
9. Labs/Tests										
1. All diagnostic tests performed as ordered	☐	☐	☐							
10. Discharge Plan										
1. *A clinic follow-up appointment is scheduled within the next 30 days*	☐	☐	☐							
2. *Patient has sufficient medication to last until first clinic appointment*	☐	☐	☐							
3. *Patient/family/significant other accepted and demonstrated understanding of need for continuation of oral antibiotics*	☐	☐	☐							

Signature/Title:______________________ Init.:________ Date:________

Signature/Title:______________________ Init.:________ Date:________

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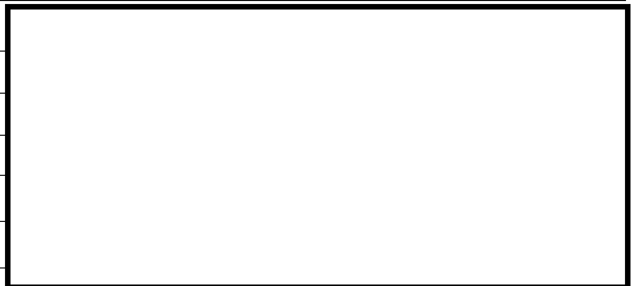

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Uncomplicated Cellulitis (Ward/Stepdown)
Daily Care Documentation - Day 4 OR Discharge Day

Care Elements: Care Events/Outcomes	Not Ordered	(D) Shift			(E) Shift			(N) Shift		
		Y	N	Init.	Y	N	Init.	Y	N	Init.
10. Discharge Plan										
4. *Patient demonstrates achievement of activity level sufficient for basic self care*		☐	☐							
5. **Patient to be discharged today**		☐	☐							
6. **Discharge orders written by 9:00 a.m.**		☐	☐							
7. **Patient discharged by 12:00 Noon**		☐	☐							

Additional documentation:(not for variance tracking - for unusual patient activity not recorded on any other existing patient care form)

Signature/Title:______ Init.:______ Date:______

Signature/Title:______ Init.:______ Date:______

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Uncomplicated Cellulitis (Ward/Stepdown)

Daily Care Documentation - Day 4 OR Discharge Day

Date: ___/___/____

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Element #:	Event #:	Time:	Outcome:
Description:			
Action:			
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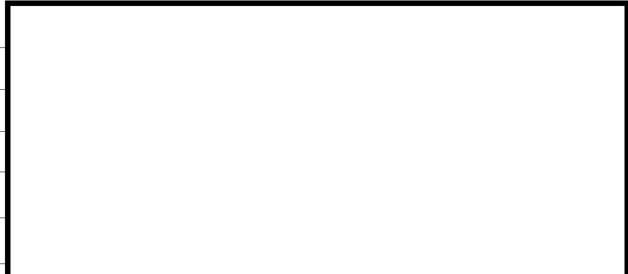

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You are recovering from cellulitis…what's next?

You are recovering from a skin infection caused by bacteria. We want you to be as comfortable as possible while you recover. **Here's what will happen in the next few days:**

What will I be able to eat?

- You will be given a healthy diet that will help you get well.
- Unless you have specific restrictions, you will eat a regular diet.

When will I be able to get out of bed?

- You may require help getting out of bed the first time, so ask your nurse.
- You should spend as much time out of bed as is comfortable.
- If you are having any pain, you may ask your nurse for pain medication before walking.
- Be sure to tell your nurse if you are light headed or dizzy.

What if I have pain?

- If you have pain, tell your nurse. You will be asked to rate your pain on a scale of 0 to 10 (0 = no pain and 10 = worst pain).
- You may get medication by IV, a shot or pills.

How do I know if I'm getting better?

- Your blood pressure, pulse, temperature and breathing will be checked during the day and night. If there are changes, the doctor will be called.
- You should have less redness and pain.

What else will happen while I'm here?

- The nurse will check your skin at least once a day.
- If you have a bandage on your wound, the nurse will check it at least once a day and teach you how to care for it.
- You may have blood drawn for lab tests.
- You may be seen by a social worker.
- The nurse will teach you to be aware of the signs and symptoms of an infection.

When can I go home?

- Your doctor or nurse will tell you when you will be ready to go home.
- The nurse will go over ALL discharge instructions with you.
- Your IV catheter will be removed.
- Please plan to have someone pick you up by 12 noon.
- You may get prescriptions/medication(s) before going home and a clinic appointment will be scheduled.
- Your doctor will talk to you about limits on your activity, and when you can return to work.

What else do I need to know?

- If you smoke, STOP! Smoking slows healing so it will take longer to get better.
- Talk to your doctor or nurse if you need help quitting. You can also call 1-800-No-Butts (1-800-662-8887). You are not alone, we can help.
- If you have any questions or are not sure about something, ask your nurse.

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Usted esta recuperándose de celulitis…que sigue?

Usted esta recuperándose de una infección de la piel causada por bacteria. Queremos que se sienta lo mas cómodo posible mientras se recupera. **Aquí es lo que va a pasar durante los siguientes días:**

Que es lo que puedo comer?

- Se le dará una dieta saludable que le ayudara mejorarse.
- A menos que usted tenga restricciones especificas, usted puede comer una dieta regular.

Cuando podré levantarme de la cama?

- Puede ser que usted necesite ayuda levantándose de la cama por primera vez, por lo cual debe de preguntarle a su enfermera.
- Usted debe de pasar el mayor tiempo posible fuera de cama, tal es confortable**.**
- Si usted tiene algún dolor, puede pedirle medicamento para el dolor a su enfermera antes de caminar.
- Asegúrese de decirle a su enfermera si tiene sensación de desmayo o mareos.

Y si tengo dolor?

- Si usted tiene dolor, dígale a su enfermera. Se le pedirá que describa su dolor en una escala del 0 al 10 (0 = ningún dolor y 10 = el peor dolor).
- Puede ser que le den medicamento por medio de suero, inyección o pastillas.

Como reconozco si estoy mejorando?

- Su presión de sangre, pulso, temperatura y respiración se le revisara durante el día y la noche. Si hay algún cambio, se le llamara al doctor.
- La enfermera le medirá lo que consuma (todo lo que come y bebe) y lo que desecha (orina y excremento) para asegurar que su organismo ha regresado a sus funciones normales.
- El enrojecimiento y dolor que tiene se le irá disminuyendo.

Que mas pasara mientras estoy aquí?

- La enfermera le revisara la piel por lo menos una vez al día.
- Si usted tiene una venda en su herida, la enfermera lo(a) revisara por lo menos una vez al día y le enseñara como cuidar la herida.
- Puede ser que le saquen sangre para análisis de laboratorio.
- Puede ser que sea visto por un trabajador social.
- La enfermera le enseñara a estar conciente de los signos y síntomas de una infección.

Cuando puedo irme a mi casa?

- Su doctor o enfermera le dirá cuando usted esta listo(a) para irse a casa.
- La enfermera revisara TODAS las instrucciones de alta con usted.
- Su sonda de suero (IV) será terminado.
- Por favor proponga que alguien venga por usted para las 12 del medio día.
- Puede ser que usted reciba receta/medicamento(s) antes de irse a casa y una cita de clínica será establecida.
- Su doctor le hablara de los limites de su actividad y cuando puede regresar a trabajar.

Que mas debo saber?

- Si fuma, PARE! Fumar lo(a) hará sanar lentamente y tardara mas para que mejore.
- Hable con su doctor o enfermera si necesita ayuda para dejar de fumar. También puede llamar al 1-800-No-Butts (1-800-662-8887). Usted no esta solo(a), podemos ayudar.
- Si tiene alguna pregunta o no esta seguro(a) de algo, pregúntele a su enfermera.

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Thank you for choosing the County of Los Angeles Department of Health Services as your Health Care Provider

Clinical
Resource
Management
Pathways to Excellence

Questions/Notes

____

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____

____

____

____

Your Follow-up Appointment(s)

Date______________Time____________

Location__________________________

Phone Number______________________

Date______________Time____________

Location__________________________

Phone Number______________________

It is very important to keep all appointments for follow-up care. If you are unable to keep your clinic appointment(s), please call and let us know.

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County of Los Angeles Department of Health Services

Recovering from cellulitis:

Now that you are home from the hospital, it is important that you rest and take care of yourself.

This guide will help you get healthy again. It will tell you about caring for yourself.

We hope you feel better very soon!

Uncomplicated Cellulitis

What is cellulitis?

Cellulitis is a severe infection of the skin caused by bacteria. It may take up to four weeks before you are able to get back to your normal activities.

How active should I be?

- During your first weeks at home, let comfort be your guide. Rest as much as you need to. Start normal activities as soon as possible.
- Walk as much as is comfortable. Rest when you feel tired.

What activities should I avoid?

- Do not drive or operate machinery while taking pain medication(s) because it may cause drowsiness.
- Do not drink alcohol while taking pain medication(s).

What should I do at home?

- If instructed to do so, rest affected arm or leg on pillows.
- Check skin for new redness or swelling.
- Change your bandage as shown to you by the nurse.
- Keep the skin area around the wound clean.

How do I avoid getting an infection?

- Wash your hands before and after you touch the bandage.

What should I eat?

Eat a well balanced diet.

You may become constipated from taking your medication. To avoid this, eat plenty of fruits and vegetables each day. Drink lots of water too!

Will I have to take medication?

You may get antibiotics and pain medication(s). It is very important to take all of your antibiotics even if you feel better. Antibiotics only work if you take ALL of them. Follow all directions given to you by the doctor or nurse.

Is it okay if I smoke?

If you smoke, STOP. Smoking slows healing so it takes longer to get better. Talk to your doctor or nurse if you need help quitting. You can also call 1-800-No-Butts (1-800-662-8887). You are not alone, we can help.

When should I call my doctor/clinic?

- If you have redness, swelling, or tenderness on any part of your skin.
- If you have a change in sensation on the extremity that is affected.
- If you get a fever (temperature over 101° F).
- If you are sick to your stomach, vomit or unable to take your antibiotics.
- If you have a rash or hives after taking medication(s).

Gracias por elegir El Departamento de Salud del Condado de Los Ángeles como el Proveedor del Cuidado de su Salud

Clinical Resource Management

Pathways to Excellence

Preguntas/Notas

____

____

____

____

____

____

Su próxima cita(s)

Fecha________________Hora____________

Lugar______________________________

Numero de teléfono_____________________

Fecha________________Hora____________

Lugar______________________________

Numero de teléfono_____________________

Es muy importante que mantenga todas sus citas. Si usted no puede presentarse a su cita(s) de clínica, haga el favor de llamarnos con tiempo.

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El Departamento de Servicios de Salud del Condado de Los Ángeles

Recuperando de celulitis:

Ahora que esta de regreso del hospital y en casa, es importante que usted descanse y se cuide.

Este guía le ayudara a usted obtener su salud nuevamente. Le dirá como cuidarse.

Esperamos que se sienta mejor muy pronto!

Celulitis sin Complicaciones

Que es celulitis?

Celulitis es una grave infección de la piel causado por bacteria. Puede tomar hasta cuatro semanas antes de que usted pueda regresar a sus actividades normales.

Que activo(a) debo de ser?

- Durante sus primeras semanas en casa, deje que su comodidad sea su guía. Descanse tal como usted lo sienta necesario. Regrese a sus actividades lo más pronto posible.
- Camine los mas que pueda a su comodidad. Descanse cuando se sienta cansado(a).

Que actividades debo de evitar?

- No maneje ni opere maquinaria mientras este tomando medicamento(s) para el dolor porque puede causarle somnolencia.
- No tome bebidas alcohólicas mientras este tomando medicamento(s) para el dolor.

Que debo de ser en casa?

- Si se le indica, descanse el brazo o pierna afectado en almohadas.
- Revise su piel para enrojecimiento o hinchazón tierna.
- Cambie su venda tal como se lo enseñe la enfermera.
- Mantenga limpia el área de la piel alrededor de su herida.

Como evito de conseguir una infección?

- Lávese las manos antes y después de tocar su venda

Que debo comer?

Coma una dieta balanceada.

Puede estreñirse por causa de los medicamentos. Para evitar estreñimiento, coma bastante frutas y vegetales cada día. Tome mucha agua también!

Es necesario que tome medicamento?

Puede ser que reciba antibióticos y medicamento(s) para el dolor. Es muy importante que tome todo su(s) antibióticos aunque se sienta mejor. Los antibióticos solo son efectivos cuando son tomados TODOS! Siga todas las ordenes que le de su doctor o enfermera.

Esta bien que fume?

Si fuma, PARE. Fumando lo(a) hará sanar lentamente y tardara más para que mejore. Hable con su doctor o enfermera si necesita ayuda para dejar de fumar. También puede llamar al 1-800-No-Butts (1-800-662-8887). No esta solo(a), podemos ayudar.

Cuando debo de llamar a mi doctor/clinica?

- Si tiene enrojecimiento, hinchazón o ternura en cualquier parte de su piel.
- Si tiene un cambio de sensación en la extremidad afectada.
- Si tiene fiebre (temperatura mas de 101° F).
- Si se siente mal del estomago, vomita o no puede tomar sus antibióticos.
- Si después de tomar su medicamento(s), le salen ronchas o sarpullido.