OKLAHOMA DEPARTMENT OF CORRECTIONS
NURSING PRACTICE PROTOCOLS

PRURITIC LESIONS/SCALING
(example-Athlete's Foot (Tinea Pedis)

Subjective Data: **Allergies:** ______________________

Chief complaint: ____

Onset:________________________ ❑ New Onset ❑ Reoccurrence ❑ Constant

Affected area: ❑ Left foot ❑ Right foot ❑ Bilateral feet

Associated Symptoms:

❑ Itching ❑ Burning ❑ Diabetic ❑ Pain Pain scale (0-10) ____________

Current treatment/medications:

Over the counter ❑ Yes ❑ No Describe:________________________________

Prescription ❑ Yes ❑ No Describe:________________________________

Objective Data: (clinically indicated VA)

BP______________Pulse______________Resp. ______________Temp. ______________Wt.______________

❑ Rash	❑ Pruritic cracking	❑ Scaling	❑ Inflammation	❑ Crusting	❑ Red streaks
❑ Dry	❑ Drainage	❑ Odor	❑ Blisters	❑ Discoloration	❑ Edema

Refer to Health Care Provider if: *If during clinic hours thehealth care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.*

❑ Worsening of condition after treatment started
❑ Allergy to Antifungal agent-documented
❑ Presence of secondary infection
❑ Suspected underlying infection

Health Care Provider: ________________ **Time Notified:** _______ **Orders Received for Treatment:** ❑ Yes ❑ No

If physical exam is negative for any of the above s/s and/or there is no need for additional medication/treatment, proceed with nursing interventions.

Plan: Interventions:

❑ Check in assessment only for health care providers visit.
❑ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.
❑ Tolnaftate cream to affected area twice daily for 30 days PRN.
OR
❑ Tolnaftate powder to affected area twice daily for 30 days PRN.
❑ Assign nursing protocol to Infectious Disease nurse if positive for athlete's foot
❑ **Education/Intervention:** Instructed on hygiene - care of feet, signs and symptoms of secondary infection, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: ____

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Health Care Provider Signature/Credentials: ________________________ **Date:** _________ **Time:** ________

RN/LPN Signature/credentials: ________________________________ **Date:** _________ **Time:** ________

Inmate Name DOC #
(Last, First)