RN Protocol: Inflammatory Skin Conditions/Rash

I. POLICY

A. Function: To facilitate and guide the Registered Nurse (RN) in the assessment and treatment of patients presenting with minor inflammatory skin conditions/rash.

B. Circumstances under which the RN may perform the function:
   1. Setting: Outpatient clinic.
   2. Supervision: No direct supervision required.

II. PROTOCOL

A. Definition: This protocol covers the assessment and treatment of patients presenting with minor inflammatory skin conditions/rash consistent with eczema, hives, tinea pedis (athlete's foot), and poison oak.

Eczema is an inflammatory skin condition most often characterized by dry, red, itchy patches on the face, neck, and inner aspect of the elbows, knees, and ankles. Chronic scratching causes the skin to take on a thickened, leathery appearance. It is believed that contact with certain soaps, detergents, disinfectants, dust mites, and juices from fresh fruits may trigger an outbreak in persons genetically predisposed to develop eczema. Stress may exacerbate the condition. Patients with eczema often have a history of allergic rhinits and/or asthma. Eczema is not contagious, and identifying and avoiding the offending agent may reduce the severity and frequency of outbreaks.

Urticaria, commonly known as hives, is a skin condition caused by the release of histamine, bradykinin, and other substances. These substances cause capillary and venous dilation which results in intradermal edema. Most cases of urticaria occur following exposure to specific foods or drugs. Other causes of urticaria include insect bites, infection (e.g., herpes simplex, mononucleosis, upper respiratory infection, tooth abscess, urinary tract infection, gastrointestinal infection), emotional stress, exercise, exposure to heat, cold or sunlight, and firmly stroking or scratching the skin. Urticaria is characterized by itchy, red, raised, palpable wheals on the surface of the skin. Acute urticaria is often self-limited and usually resolves within 24 hours, but may last up to six weeks. Urticaria does not typically result in serious long-term consequences.

Tinea pedis, also known as athlete's foot is a fungal infection. The fungi or dermatophytes live on dead tissue of the outer skin layers and thrive in warm moist areas. Poor hygiene, closed footwear, and prolonged wetness of the skin increases susceptibility to the infection. Tinea pedis is characterized by a red, itchy rash between the toes and on the plantar surface of the foot. Scaling may also be present. Tinea pedis is contagious and can be spread by direct skin-to-skin contact and indirectly through towels, shoes, and floors.

Poison oak is an acute dermatitis that occurs as a result of contact with the resin of the poison oak plant. While most cases occur from contact with the leaves of the plant, outbreaks may also result from contact with the smoke of burning plants, unwashed contaminated clothes, and dried plants that still contain resin. Poison oak is characterized by large blisters, smaller vesicles, and edematous, red, pruritic patches appearing in a linear pattern on the skin. Early lesions may be erythematous and raised without vesicles. Contact with the vesicle fluid does not transfer the allergen. However, scratching the skin and re-exposure to contaminated clothes and inanimate objects containing the allergen can spread the dermatitis.

B. Subjective:
   1. Chief complaint (document in the patient's own words).
   2. Date and time of onset. For suspected poison oak try to determine the nature of exposure (e.g., contact with leaves of the plant or contact with smoke of a burning plant).
   3. Assess for dyspnea and difficulty swallowing.
   4. Location of skin lesions.
   5. Description of symptoms:
      a. Pruritis
      b. Burning
      c. Tenderness
      d. Fever, malaise, chills
      e. Cracking between the fissures of the hands/feet
   6. Is the condition worse at a particular time?
   7. Previous episodes?
   8. Frequent exposure to potential irritants (e.g., detergents, dyes, rubber, plants, weeds/bushes, sun).
   9. Is there a history of minor trauma to the skin (e.g., insect bite, animal bite, human bite, abrasion)?
   10. Past medical history (i.e., asthma, hay fever, allergic rhinitis, urticaria, arthritis, and/or family history of atopic dermatitis or psoriasis).
   11. Food and medications allergies.
   12. Current medications.

C. Objective:
   1. Vital signs.
   2. Assess ventilatory effort listening for signs of respiratory distress (congestion, stridor, shortness of breath). Observe for swelling of the lips, tongue, and uvula.
   3. Assess breath sounds bilaterally (clear, wheezes, crackles, diminished, absent).
   4. Inspect skin lesions and note the location, size, distribution, and pattern.
   5. Inspect affected area (s) for redness, vesicles, pustules, drainage, swelling, excoriations from scratching; or any weeping, crusting, or fissuring.

6. Look for skin thickening and pigmentation changes.
7. Evaluate regional/proximal lymph nodes for swelling, tenderness.

D. Assessment:
- Impaired skin integrity related to/evidenced by:
- Risk for infection related to/evidenced by:

E. Plan:

IF PATIENT HAS A HISTORY OF SKIN TRAUMA AND PRESENTS WITH LYMPHADENOPATHY, OOZING SKIN LESIONS COVERED WITH A THIN, LIGHT BROWN OR HONEY-COLORED CRUST, OR PRURITIC BLISTERS FILLED WITH YELLOW OR HONEY-COLORED FLUID REFER PATIENT TO A PHYSICIAN ON A STAT OR URGENT BASIS.

1. **Eczema**, manifested as dry, red, itchy patches of skin where papular eruptions form, then dry and become crusty.
   a. Try to identify and remove the offending agent.
   b. Hydrocortisone Topical Cream 1%: apply to affected area no more than 3-4 times/day while symptoms persist
   c. If no improvement after 7 days, instruct the patient to return to the RN clinic for follow-up.
2. **Urticaria (hives).** If the patient presents with urticara accompanied by dyspnea, wheezing or shortness of breath see **Allergic Reaction Protocol** for treatment.
   a. Discontinue use of non-prescription analgesics and canteen purchased medications. Contact physician before discontinuing any other medications.
   b. If no improvement after 3 days, schedule for follow-up with physician within 24 hours.
3. **Tinea Pedis**, manifested as peeling, cracking and scaling between the toes. Redness and blisters may be present on the soles and along the sides of the feet.
   a. Tolnaftate Topical Cream 1% to affected area BID X 4 weeks. If condition worsens discontinue medication and notify physician.
   b. If no improvement after 3 weeks, instruct the patient to return to the RN clinic for follow-up.
4. **Poison Oak**, manifested as itching with erythema and vesicle formation. The patient has been working in the environment around plants that are poisonous.
   a. Take a cool shower, with soap to remove toxin. Make sure to wash all clothing that came in contact with the plant.
   b. Calamine lotion: apply to affected areas 2x/day while symptoms persist
   c. Hydrocortisone Topical Cream 1%: apply to affected area no more than 3-4 times/day while symptoms persist
   d. If no improvement after 3 days, instruct the patient to return to the RN clinic for follow-up.

5. **Dry, flaky skin**:
   a. Recommend a mild soap (available through canteen)
6. For all other skin conditions/rashes, refer patient to a physician on a **STAT**, urgent or routine basis as appropriate.

F. Patient Education:
1. Assess patient's potential for understanding the health information to be provided.
2. Patient education consistent with the assessment of the condition.
3. Document the education provided and the patient's level of understanding on the nursing protocol encounter form.
4. Refer patient to other resources as needed, for additional information, specialized instruction, or support. Document all referrals on the nursing protocol encounter form.
5. Advise the patient to resubmit a Health Care Request form (CDC 7362) if symptoms persist.

G. Documentation:
All information related to the patient's complaint shall be documented on the appropriate nursing protocol encounter form. The encounter form(s) shall be filed in the patient's unit health record.

III. REQUIREMENTS FOR RN

A. Education/Training: The Registered Nurse shall attend an in-service on the assessment and treatment of patients presenting with minor inflammatory skin conditions/rashes, and achieve a minimum score of 80% on the written post test examination.
B. Experience: None.
C. Certification: None.
D. Initial Evaluation: Initial competence will be validated onsite through simulated exercises, mock scenarios, and return demonstrations. The Registered Nurse must satisfactorily demonstrate all critical behaviors identified on the Competence Validation Tool to be considered competent to perform standardized procedure functions.

A written performance appraisal shall be performed by the Supervising Registered Nurse or designee six months after initial competence has been validated. Methods to evaluate performance shall include but not be limited to direct observation, feedback from colleagues and physicians, and chart review.

E. Ongoing Evaluation: Ongoing competence will be validated annually using case study analysis.

IV. REGISTERED NURSES AUTHORIZED TO PERFORM THIS PROCEDURE

A current list of all Registered Nurse authorize to perform this procedure shall be maintained on file in the Office of the Director of Nursing.

V. DEVELOPMENT AND APPROVAL OF THE STANDARDIZED PROCEDURE

This standardized procedure was developed and approved by authorized representatives of administration, medicine, and nursing. The procedure will be reviewed annually.

REVIEW DATE: _____ REVISION DATE: _____
_____ _____
_____ _____

THE PROTOCOL WAS APPROVED BY:

_____ DATE:_____
Chief Nurse Executive/Director of Nursing

_____ DATE:_____
Chief Medical Executive