

OKLAHOMA DEPARTMENT OF CORRECTIONS  
NURSING PRACTICE PROTOCOLS  
BLISTERS

MSRM 140117.01.6  
(R 12/15)

**Subjective Data:**

**Allergies:** \_\_\_\_\_

Chief complaint: \_\_\_\_\_

Location: \_\_\_\_\_ Size: \_\_\_\_\_

**Associated Symptoms:**

Itching     Burning     Diabetic     Pain    Pain scale (0-10) \_\_\_\_\_

**Objective Data:** (clinically indicated VS)

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp. \_\_\_\_\_ Wt. \_\_\_\_\_

Bleeding     Intact     Broken     Drainage     Redness     Swelling

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

**Refer to Medical Provider If:**

- Signs of infection present
- Possible herpes, shingles
- Condition not responding to nursing intervention
- Patient has poorly controlled diabetes
- If open wound and last Tetanus/Diphtheria shot more than 5 years.

**Medical Provider Notified: Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Orders Received for Treatment:**  Yes  No

**Assessment:**

- Alteration in skin integrity related to blister(s)

**Plan: Nursing Intervention Routine:** (check all that apply)

- Check in assessment only for medical providers visit.
- Assessment completed. Chief complaint resolved prior to appointment. Instructed offender to follow-up sick call for signs/symptoms warranting further evaluation.
- Cleanse gently with mild antiseptic soap. Take care not to break the blister
- Apply "Polysporin" ointment to open blisters and non-adhering dressing to area for protection – issue one tube
- Mole-skin to affected area
- Cover with non-adhering dressing if draining
- Provide patient with supply of non-adhering dressing
- Medical Lay-in/restrictions
- Education/Intervention: Instructed signs and symptoms of infection, keep wound clean and dry and not to perforate blister(s), medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

**Progress Note:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medical Provider Signature/Credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**QHCP Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Name  
(Last, First)

DOC #