

**PUSTULAR LESIONS**  
(example - Acne)

**Subjective Data:**

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

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

Location of pustular lesions: (face, chest, upper back, shoulders) \_\_\_\_\_ Onset of symptoms: \_\_\_\_\_

**Current treatment/medications:**

Over the counter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe: _____
Prescription	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Describe: _____

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

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

<input type="checkbox"/> Redness	<input type="checkbox"/> Drainage	<input type="checkbox"/> Swelling	<input type="checkbox"/> Inflammation	<input type="checkbox"/> Itching
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**Grades:**

<input type="checkbox"/> Grade I	Presence of closed white heads or black heads( comedo) and non-inflammation papules
<input type="checkbox"/> Grade II	Pustules, nodules, cysts, inflammation and drainage
<input type="checkbox"/> Grade III	Features of Grade I and II plus deeper inflammatory nodules
<input type="checkbox"/> Grade IV	Features of Grades I-III with cysts formation and scarring

**NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:**

Fever present

**Refer to Medical Provider If:**

Case is severe

Signs of infection

Unresponsive to above treatment

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

**Assessment:**

Alteration in skin integrity related to pustular lesions

**Plan:**

**Nursing Intervention Routine:**

Benzoyl Peroxide 5% cream /gel to affected area twice a day – issue one tube

Issue “clipper-no shave” if indicated

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

**Patient Education:**

Instructed to keep hands away from face/area, do not squeeze lesions as this may cause infection, wash affected area with soap and water at least 2 times daily, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

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

**RN/Provider Signature/credentials:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

Name  
(Last, First)

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