

Patient Name: _____

Date: _____



ONYCHOMYCOSIS PODORTHO NURSING CARE PLAN



Mark and **X** on the affected toenails

Nursing Diagnosis: (Circle relevant Nursing Diagnosis or add custom diagnosis in lines provided below)

1. Self-care deficit R/T: Inability to care for toenails at home due to
2. Self-care deficit R/T: compromised hygienic practices
3. Decreased Toenail Integrity R/T: trauma causing decreased tissue perfusion
4. Decreased toenail integrity R/T: reoccurring Onychomycosis
5. Risk for skin breakdown as evidence by paronychia R/T: Onychomycosis
6. Thickened yellowish discolored nails R/T: Onychomycosis
7. Risk for body image disturbances R/T: disfigured nails caused by; Onychomycosis
8. Acute pain at toenail _____ R/T: thick involuted ingrown nails cause by; Onychomycosis
9. Decreased tissue perfusion R/T: post chemotherapy treatments causing yellow, dystrophic nails suggesting onychomycosis
10. Impaired comfort R/T: thick overgrown toenails
11. Risk for impaired liver failure R/T: use of oral anti-fungicides
12. Impaired physical mobility R/T: Overgrown thickened involuted nails causing pain when wearing shoes, walking and ambulating
13. Impaired ability to follow onychomycosis protocol at clinic R/T: economic constraints
14. Impaired skin integrity R/T: Tinea Pedis

15. Risk for skin infection R/T: chronic reoccurrence of onychomycosis

16. _____

17. _____

18. _____

19. _____

20. _____

Nursing Assessment:

1st Initial Assessment:

Thickness of nail scale: (1-5) record under treatment category for each nail

Relevant Comorbidities:

Culture Done: Yes No (circle) Date: _____ Result: + - inconclusive (circle)

Physician or NP who ordered: _____ Physician Dx: _____

Rx'd Medications for tx. of Onychomycosis:

Home Remedies tried and time frame:

Onychomycotic pattern presentation:

- ☐ Distal Subungual Onycho
- ☐ White Superficial Onycho
- ☐ Proximal Subungual Onycho
- ☐ Total Subungual (severe) Onycho

Plan:

Type of laser treatment that will be used:

1. Thermal 2. non-thermal 3. meth blue with genesis (circle)
2. Additional Adjunctive Therapy's:

3. Home Care Kit given with first Tx. with instruction sheet ☐
4. Additional Product recommendations

5. Jublia Rx. Sent to physician ☐

6. Images taken (Date): _____

Tx. #1: _____ **with nail debridement**

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

Progress notes:

Tx. #2: _____

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

Progress notes:

Tx. #3: _____

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

Tx. #4: _____ (with nail debridement)

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

Re-Assess at the 24 weeks Date: _____

- ☐ **Clear no Further Treatment Required**
- ☐ **Physical evidence of fungal activity Additional treatments required**

#5: _____

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

#6: _____

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

#7: _____

R-G.T. _____ R-2nd _____ R-3rd _____ R-4th _____ R-5th _____

L-G.T. _____ L-2nd _____ L-3rd _____ L-4th _____ L-5TH _____

Evaluation:

Podortho Nurse _____