

Please note this is an EXAMPLE NURSING TIP SHEET and is to serve as an educational and organizational resource only. **Please always follow the policies and procedures for your institution and practice. Please always follow treating physician's orders.**

Nursing tip: Nursing Care for Surface Skin HDR Brachytherapy

Assessment & Nursing Diagnosis

Successful treatment starts with identifying baseline conditions and patient-specific risks.

- **Initial & Ongoing Assessment:** Perform a thorough skin assessment before treatment. Document erythema, pigment changes, or skin breakdown.
- **Risk Identification:** Be alert for factors that may delay healing or increase infection risk:
 - **Comorbidities:** Diabetes (elevated Hgb A1c), immunosuppression.
- **Nursing Diagnoses:** Identify risks for impaired skin integrity, altered comfort (pain/itching), and treatment-related anxiety.

Intervention & Treatment Flow

1. **Consultation & Simulation:** Baseline mapping and treatment planning.
 1. Initial nursing assessment performed
2. **Treatment Delivery:** Assisting with fractionated HDR treatments and wound care as needed
3. **Monitoring:** Tracking cumulative skin reactions throughout the course; alerting APP/MD as needed for skin integrity concerns

Standard of Care: Skin Protection

Consistent patient education is the primary intervention for preventing severe radiation dermatitis.

The "Do's"	The "Don'ts"
Sun Safety: Use wide-brimmed hats, high-UPF clothing, and sunscreen once permitted.	No Irritants: Avoid scrubbing, scratching, or picking at the treatment site.

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The "Do's"	The "Don'ts"
Moisturizing: Apply only approved fragrance-free, alcohol-free lotions to intact skin .	No Chemicals: Avoid makeup, perfumes, or harsh topical products in the treatment field.
Friction Control: Use soft barriers (silicone or gauze) if clothing or skin folds cause rubbing.	No Trauma: Avoid adhesive tapes directly on the treated area.

Physician Notification Criteria

Notify the radiation oncologist or APP immediately if the patient presents with:

- **Signs of Infection:** Localized warmth, swelling, or purulent (pus) drainage.
- **Systemic Distress:** Fever >101°F- 38.3°C
- **Severe Reactions:** Rapidly progressing skin breakdown or pain that interferes with daily activities.

Documentation Standards (EMR)

Ensure the following are captured in the daily treatment record:

- **Assessment:** Detailed description of skin integrity.
- **Visual Evidence:** Photographs of the site (per institutional policy).
- **Education:** Confirmation that the patient understands self-care and sun protection.
- **Care Plan:** Documentation of team communication (e.g., updates from huddles or weekly rounds).