

Assessment and Diagnostic Guideline: Integumentary

Registered Nurses who hold **Remote Nursing** Certified Practice designation are authorized to manage, diagnose, and/or treat the following integument conditions:

- Localized Abscess only (adults only)
- Localized Abscess with Cellulitis (adults only)
- Cellulitis only (adults & **children 2 years of age and older**)
- Impetigo (adults & **children 2 years of age and older**)
- Minor Bites and Scratches (adults & **children 2 year of age and older**)

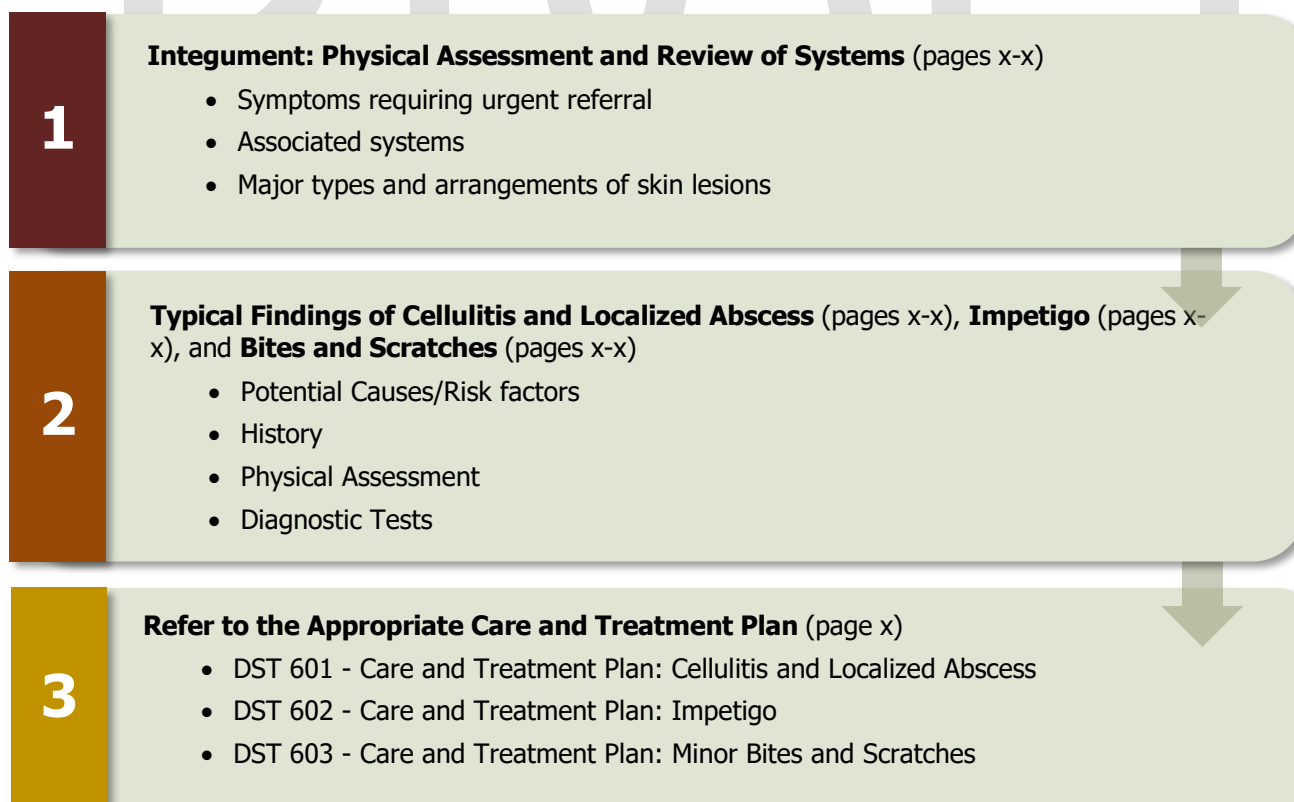
Note: In BC, the term pediatrics is often defined as an individual under the age of 19.¹ For the purposes of certified practice DSTs, pediatrics refers to individuals under the age of 19 unless otherwise specified.

This Assessment and Diagnostic Guideline is for RN(C)s when conducting assessments, screening, and diagnostic tests related to integumentary conditions that can be managed and/or treated under the Certified Practice framework. RN(C)s maintain an RN scope of practice, which is expanded for the RN(C) to diagnose and treat specific conditions listed above.

RN(C)s must ensure they complete and document their clinical reasoning through assessments according to regulatory practice standards and their practice setting requirements. Upon arriving at a diagnosis, RN(C)s should consult the relevant *Care and Treatment Plans* to inform the management and treatment of the condition.

Note: A consultation refers to the RN(C) collaborating with members of the care team, such as a physician, nurse practitioner, or pharmacist, to support decision-making processes related to the diagnosis, treatment and management of the diseases, disorders, and conditions that the RN(C) are authorized to diagnose, treat and manage. A referral is when an RN(C) refers a patient to a medical care provider for further treatment, care or management. This occurs when patients are presenting with symptoms outside of what is provided in this document, including symptoms that require urgent referral.

Visual Summary of Guideline



1) Integumentary: Physical Assessment and Review of System

*Refer to the Assessment and Diagnostic Guideline: General as needed.

Symptoms Requiring Urgent Consultation and/or Referral

The first step is to differentiate a major skin eruption, infection, or event that requires a referral and those conditions that can be managed safely by an RN(C). RN(C)s should consider consultation or referral when they are unable to meet the BCCNM Registered Nurse (Certified Practice): Acting within Autonomous Scope of Practice standard

Cellulitis and Localized Abscess

Contraindications to treatment of localized abscess or cellulitis by RN(C):
(in addition to all **localized abscesses** in **children less than 2 years of age**)

- Infection located in post-surgical sites
- Subsequent to a primary infection or ulceration (such as diabetic or pressure wounds)
- Locations with a high concentration of vascular structures or nerves, including the **face/neck, hands** and near **groins**
 - All facial cellulitis requires urgent referral to rule out orbital/peri-orbital cellulitis, which is a medical emergency
- If there is rapid progression of disease or any signs of sepsis/systemic infection, including **fever**
- Multiple or compounding abscesses and/or cellulitis
- Illness began with a bite injury, fresh-water or salt-water exposure
- Requiring incision and drainage (I+D) or intravenous antibiotics
- Diabetic and/or immunocompromised client (including neutropenia)
- Significant or rapidly worsening pain
- Cellulitis or abscess that is recurrent or unresponsive to treatment
- Unilateral pain, redness or swelling in extremities with risk factors for blood clots (such as active malignancy, pregnancy or prolonged immobilization)
- There has been no improvement after 48 hours of previous antibiotic treatment initiation

Impetigo

Contraindications to treatment of impetigo by RN(C) include:
(in addition to **children less than 2 years of age**)

- **Ecthyma** is suspected, with ulcerative vesicles or pustules involving deeper layers of tissue **including the dermis**
- Signs of systemic infection or sepsis suspected, including **fever**

Minor Bites and Scratches

Contraindications to treatment of minor bites and scratches by RN(C) include:
(in addition to **children less than 2 years of age**)

- Any injuries/wounds that are significantly infected or purulent at time of assessment, including suspicion of systemic illness/sepsis or ongoing **fever**
- Significant bites or scratches that have damaged multiple layers of skin tissue or any underlying anatomical structures
- All cases where the animal species involved in the interaction is unknown, or known to be from a species other than cat, dog or human
- Any suspicion of rabies, exposure, including all suspected human interactions with **bats**
- All facial bites
- All **human** bite wounds including “fight bites” over the knuckle, or potentially involving other underlying structures (bones, tendons, etc)

- Any moderate to severe injuries to the hands or feet, or with risk of permanent functional or aesthetic harm
- All cases where IV antibiotics **may** be needed
- All cases where suturing **may** be required, but is outside the scope of practice of RN(C)
- All immunocompromised clients (including diabetes, neutropenia, HIV, etc)
- All severe wounds, taking into consideration size/number of injuries, and significant tissue tearing or loss
- All cases where there is any loss of function identified to any anatomical or nervous system
- All cases where intentional harm or abuse is suspected, with particular consideration for Intimate Partner Violence (IPV) and cases involving children

This *Assessment and Diagnostic Guideline* informs RN(C)s about the diseases, disorders, and conditions that RN(C) are authorized to diagnose, treat and manage. Patients presenting with symptoms outside of what is provided in this document require referral to a physician or nurse practitioner.

Integument Review of System Questions

- See *Assessment and Diagnostic Guideline: General* – ‘Review of system: Integument’ section if not already done.

Major Types and Characteristics of Skin Lesions

Table 1: Major Types of Skin Lesions²⁻⁵

Type of Lesion	Characteristics
Primary Lesions	Physical changes caused directly by a disease process or exposure
Macule and Patches²⁻⁵	Flat and non-palpable discoloured spots. Size and shape vary (e.g., freckle or mole). Macules less than 1cm; Patches greater than 1cm.
Nodule²⁻⁵	A palpable, solid raised lesion (e.g., keratinous cyst, small lipoma, fibroma). Greater than 1cm.
Papule²⁻⁵	Solid raised lesion (e.g., wart, psoriasis, syphilitic lesion, pigmented mole). Less than 1cm in diameter.
Petechiae, Purpura and Ecchymosis (bruise)^{2,5}	Extravasation of blood in the skin causing non-blanchable red macules and/or patches. Petechiae less than 2mm. Ecchymosis (bruises) more than 2mm. Purpura are clusters of petechiae and or ecchymosis that may flat or raised.
Plaque²⁻⁵	Dry and circumscribed raised lesions greater than 1cm (e.g., eczema, psoriasis). May be a coalescence of papules.
Pustule²⁻⁵	Superficial raised lesion containing pus (e.g., acne, folliculitis)
Telangiectasia^{2-3,5}	Permanently dilated superficial blood vessels. Blanchable and often appearing as thin red lines.
Ulcer²⁻⁵	Tissue loss including the full depth of the epidermis and at least part of the dermis (e.g., trauma or vascular compromise). May extend into deeper tissues depending on severity.
Vesicle²⁻⁵	Elevated lesion containing non-pustulent liquid (e.g., herpes, contact dermatitis)
Bulla (blister)²⁻⁵	Elevated lesion containing non-pustulent liquid greater than 1cm (e.g., bullous impetigo)

Wheal (hive) ²⁻⁵	Transient, elevated, changeable lesion caused by local edema (e.g., allergic reaction, insect bites, sunlight). Can, erythematous, neutral or pale.
Secondary Lesions	May evolve from primary lesions, or be caused by external sources such as trauma, infection, and scratching
Atrophy ²⁻⁵	Thinned or depressed skin, potentially wrinkled or 'papery'
Crust (scab) ²⁻⁵	Dry exudate on the surface of the skin (e.g., scabs, dried blood)
Erosion ²⁻⁵	Loss of tissue from the epidermis only. May be caused by tissue separation secondary to epidermal elevation from bullae or other disease processes.
Excoriation ^{2-3,5}	Superficial and often linear skin erosion, usually caused by scratching or picking.
Lichenification ^{2-3,5}	Thickened skin due to chronic rubbing, scratching or irritation, often causing accentuated (leathery) skin markings (e.g., atopic dermatitis)
Pigmentation changes ⁵	Hyperpigmentation: increased skin pigment Hypopigmentation: decreased skin pigment Depigmentation: complete loss of skin pigment)
Scales ³⁻⁴	Accumulation of flaking from plaques, building up on the most external layer of the epidermis (e.g., psoriasis, seborrheic dermatitis, fungal infection, chronic dermatitis)
Scar ³⁻⁵	Areas of fibrosis resulting from replacement (healing) of previously damaged skin.
Keloid ³⁻⁴	Hypertrophic scars extending past the original margins of damage.

Table 2: Major Arrangements of Skin Lesions²⁻⁵

Arrangement of Lesion	Characteristics
Annular	Arranged in a circular pattern
Coalescent (confluent)	Merge and run together (e.g., exanthema)
Discrete	Individual, separate and distinct (e.g., insect bites)
Generalized	Scattered over the body (e.g., measles)
Grouped	Clustered (e.g., herpes simplex)
Linear	Forming a line
Serpiginous	Snakelike formation (e.g., cutaneous larva migrans)
Polycyclic	Multiple annular rings (e.g., drug reactions, urticaria)
Zosteriform (dermatomal)	Linear arrangement along a nerve branch (e.g., shingles)

Note: The above vocabulary charts were created using a summary of recommendations from the sources cited, with each term noted for which sources specifically contributed, selecting from the Dermatological Societies revised glossary,² Merk Manual,³ One Health guide,⁴ and UpToDate.⁵

2) Typical Findings

Cellulitis and Localized Abscess

Potential Causes^{6,7}

- *Streptococcus* and *Staphylococcus* species are the most prevalent
 - *Streptococcus* most common for cellulitis
 - *Staphylococcus aureus* most common for localized abscess

Note: for illnesses that are progressing despite treatment covering for these common pathogens, consideration of other causative organisms must be considered.

Predisposing Risk Factors^{6–10}

- Local skin trauma (lacerations, burns, bites or penetrating wounds including intravenous drug use, ulcers, etc)
- Skin infections (including impetigo, scabies, furuncle, tinea pedis, varicella or previous cellulitis)
- Skin breakdown (including fissures between toes and due to poor hygiene)
- Immunocompromise
- Diabetes mellitus
- Obesity
- Edema secondary to venous insufficiency or lymphedema
- Inflammation (including eczema, psoriasis or following radiation therapy)
- Known MRSA positive (personal history or close contact, such as household member)
- Recent hospitalization (within 12 months) or antibiotic use (within 6 months)

History^{6–9}

- Known MRSA (client or household members)
- Previous injury, bites, or local trauma
- Redness, warmth and/or painful to touch
- Mild systemic symptoms: low-grade fever, chills, and malaise may be present

Note: Cellulitis most commonly presents unilaterally and in the absence of a fever. If bilateral symptoms or fever are noted, systemic infection or other potential causes must be investigated and a referral to a physician or nurse practitioner is required.

Physical Assessment: Cellulitis and Localized Abscess^{6–9}

Cellulitis:

- Unilateral erythema and edema of area
- Warmth and tenderness to touch
- Diffuse advancing edge of affected area, not sharply demarcated
- Edema to affected area and/or lymph node enlargement/tenderness
- May include bullae, vesicles or purulence/drainage, including fluid leaking from tissues (weeping)
- May resemble “peau d’orange” (edema around hair follicles)

Localized Abscess:

- Fluctuant, erythematous and localized nodule
- Swelling localized around an identifiable center of infection
- Often painful to touch, with pressure under the skin building over time as pus/inflammation accumulates in the tissues
- Spontaneous rupture of purulence may occur

Note: The presence of a significant amount of purulent drainage is more indicative of a skin abscess, although a skin abscess may also be located within a broader area of cellulitis.

Systemic Signs:

- Increased temperature
- Increased pulse
- Lymphadenopathy of regional lymph nodes and/or lymphangitis

Note: Signs of significant systemic infection or potential sepsis, such as fever, hypotension, tachycardia, elevated respiratory rate, or decreased LOC are not consistent with a definition of *localized* abscess and require a referral to a physician or nurse practitioner.

Note: Unilateral leg pain, redness, and swelling with risk factors for blood clots (such as active malignancy, pregnancy or prolonged immobilization) should prompt consideration of deep vein thrombosis (DVT) and requires referral to physician or nurse practitioner.

Diagnostic Tests^{6,7}

- If wound discharge is present, a swab for culture and sensitivity (C&S) may be collected to ensure antibiotic sensitivity and inform further clinical decision making

Note: Blood samples for C&S are only required for severe and/or systemic infections where sepsis needs to be ruled out. These cases (suspected sepsis) do not fall within RN(C) scope of practice and require a referral or consultation with a physician or nurse practitioner.

Note: RN(C)s are authorized to initiate a client-specific ordering for screening and diagnostic tests only when outlined in the decision support tools for their certified practice designation(s) and, according to employer policies, processes, and resources in place, as outlined by BCCNM.^{11,12}

Impetigo^{13,14}

Potential Causes¹³⁻¹⁵

- *Staphylococcus aureus* alone is most common (80% of cases)
- Beta-hemolytic *Streptococcus* species, including Group-A *Streptococcus* (GAS) (alone in 10% of cases, or in conjunction with *Staph. aureus* in 10% of cases)

Predisposing Risk Factors^{13,14}

- Local skin trauma such as insect bites, wounds, abrasions
- Warm, humid climate
- Skin lesions from other disorders such as eczema, scabies, atopic dermatitis
- **Age:**
 - All forms of impetigo: most common in preschool and young children (age 2-5)
 - Bullous impetigo: most common in children less than 2 years of age (90%)
- Crowded living conditions
- Close contact with someone with impetigo
- Poor hygiene
- Known carriers and household members of those with *Staphylococcus aureus* and/or Group-A *Streptococcus* are at increased risk

Additional Pediatric Considerations

- Children in frequent close contact, including daycare, school, or crowded living conditions

History^{13,14}

- Rapid development of lesions frequently on face, scalp, and hands, but can occur anywhere on the body, particularly where there has been a disruption to normal skin condition

- Bullous impetigo is more common in intertriginous areas (such as armpits, groin, or under breasts) and the trunk of the body. It can also occur in buccal membranes
- Non-bullous more common on face and extremities, and with new areas evolving due to self-inoculation
- More common in warm climates and humid weather, including during summer
- Highly contagious and can spread via direct contact or fomites
 - Evolving and secondary lesions usually due to further self-inoculation
- Rash begins as tiny red lesions, which may be itchy
- Lesions that rapidly became small vesicles, and may have coalesced into pustules
- Lesions are typically painless

Physical Assessment: Impetigo^{13,14}

- Numerous skin lesions at various stages of progression/healing (vesicles, pustules, crusts, and bullae, including serous or pustular drainage)
 - Lesions are often initially arranged in clusters due to spread by self-inoculation, before coalescing into larger areas of crusting lesions at different stages of development
 - Common locations include the peri-oral and peri-nasal areas, and the extremities
- Pustules can rupture and drain, with exudate forming honey-colored crusts in non-bullous impetigo, or remain as intact bullae in bullous impetigo
 - Progression from vesicles to crust/bullae typically occurs over around 7 days
- Thick, golden/yellow, crusted lesions on a red base
- Lesions and surrounding skin may feel warm to touch
- Bullae of bullous impetigo may be present, and are most common in young children (less than 2 years of age)
- Lymph node involvement (more common in bullous impetigo)

Note: Fever in bullous impetigo is a concerning indication of deeper tissue involvement, including potential for development of ecthyma or systemic infection (including sepsis). In cases of impetigo where a fever is present on examination, referral or consultation with a physician or nurse practitioner is required.

Diagnostic Tests

Identification of impetigo may be made upon consideration of clinical features and presentation alone.

- A swab for culture and sensitivity (C&S) may be obtained if MRSA or GAS is suspected

Note: Risk of MRSA is higher in specific populations with high contact density such as hospitals, daycare centers and correctional facilities.

Note: RN(C)s are authorized to initiate a client-specific ordering for screening and diagnostic tests only when outlined in the decision support tools for their certified practice designation(s) and, according to employer policies, processes, and resources in place, as outlined by BCCNM.^{11,12}

Minor Bites and Scratches

Potential Causes^{16–19}

Note: Infectious complications are more common with animal/human bites and scratches due to the associated bacterial pathogens, in comparison to wounds from other sources.

Animal bites

- Most often caused by dogs (85-90%) and cats (5-10%)
- Most common in children

Human Bites

- In older adolescents and adults, indirect human “bite” wounds are more commonly caused by a blow from the fist (fight) or impact of body (sports) to another person’s teeth and have their own specific pattern of injury (“fight bites,” closed-fist injuries, etc.)
- In children, bite injuries are more commonly bites resulting from rough play

Note: If any form of abuse to either adults or children is suspected, special consideration is required regarding Trauma Informed practice, duty to report, employer policies, and consultation/follow-up requirements. Contact should be made with the appropriate authorities, and a referral or consultation with a physician or nurse practitioner is required.

Animal and Human Scratches

- The potential causes and spectrum of injury for scratches is wide and non-specific, including those associated with animal attacks or human interactions that can involve both bite and scratch injuries

Note: Bite and scratch injuries from sources other than humans or domesticated species (including cat and dog) are wide-ranging in their presentation and potential complications, including risk of rabies exposure (particularly from bats in BC). A full discussion of these considerations cannot be reflected within the scope of this document. Clients with bite or scratch wounds suspected to be from a species other than dog, cat or human require a referral or consultation with a physician or nurse practitioner.

History^{18–21}

- Determine cause of injury (human, animal, accidental, etc.)
- For animal bites:
 - Determine if the bite was caused by a provoked or unprovoked animal (increased rabies concern)
 - If possible, determine vaccination status of the animal
 - If concern for bat exposure or rabies, refer to [BCCDC, Management of Specific Diseases - Rabies \(2025\)](#)
- For human bites:
 - If possible, inquire to determine exposure risk to the bloodborne viruses’ Hepatitis B virus (HBV), Hepatitis C virus (HCV), Syphilis, and Human Immunodeficiency Virus (HIV).
 - If concern for bloodborne illness exposure, refer to [BCCDC, Communicable Disease Control, Blood and Body Fluid Exposure Management \(2021\)](#)
- Determine time elapsed since injury/injuries
- Determine potential contaminants:
 - Wound contact with rust, dirt, manure and livestock implements, or other contaminants will differentiate the risk of infection and tetanus concerns
- For significant bleeding injuries, estimate the amount of blood lost
- Document immunization history, including tetanus and hepatitis
- Assess if client or household contacts are known carriers for methicillin-resistant staphylococcus aureus (MRSA)
- Assess client medical history for conditions that may increase infection risk, including disorders affecting immune function and healing (diabetes mellitus, immunocompromise, venous insufficiency, prosthetic medical devices, previous infection, etc.)

Note: Significant injuries, especially those to the face and hands, or with risk of permanent functional or aesthetic harm, may require urgent surgical intervention and require an immediate consultation or referral with a physician or nurse practitioner.

Physical Assessment: Bites and Scratches^{18–21}

Complete a full head to toe assessment, including:

- Assess for secondary wound sites and other subsequent injuries or complications
 - Dog bites can cause underlying crush injuries related to the force of the bite/attack

- Vascular injuries and puncture wounds are a risk factor for developing compartment syndrome
- Consider mechanism of injury and potential associated concerns
 - E.g. “fight-bites” or other closed fist injuries often affect the metacarpal or phalangeal joints (knuckles)
- Assess dimensions and depth of each wound
- If there is any significant wound opening(s), assess for involvement or damage to underlying structures
- Differentiate lacerations versus punctures
- Assess for tissue loss
- Assess for signs of infection (erythema, warmth, tenderness, discharge, local lymphadenopathy)
- Inspect the wound area(s) for inclusions, including dirt or other foreign bodies

Note: If a physical altercation or human assault is suspected, especially in the context of intoxication and/or clients unable to verbally communicate, careful assessment for injuries to common locations including the hands and face is required.

Assess the integrity of underlying structures (muscles, tendons, ligaments, nerves, blood vessels, bones) for:

Note: Assess sensation before administering anesthesia.

- Vascular injury:
 - Assess for presence of blood or ongoing bleeding
 - Capillary refill should be checked distal to the injury site(s) on each affected limb
- Nerve injury:
 - Assess muscle strength, movement distal to wound site(s)
 - Assess for normal color, warmth, movement, sensation in injured areas (CWMS)
- Tendons, ligament and muscle injury:
 - Assess the range of motion (ROM) and muscle tone of all anatomical structures surrounding the wound site(s)
 - Assess for changes in ROM or muscle tone distal to wound site(s)
- Bones:
 - Assess for open fractures or other suspected fractures, depending on the mechanism of injury or injuries

Additional Pediatric Considerations

- If any pattern of injuries to a child raise suspicion of intentional harm or abuse, special consideration is required regarding Trauma Informed practice, duty to report, employer policies, and consultation/follow-up requirements. Contact should be made with the appropriate authorities, and a referral or consultation with a physician or nurse practitioner is required.

Note: Wounds and injuries from cat attacks may be less visually significant than from dog or human, with potentially less obvious damage to the skin or affected tissues. It is important to assess injuries from cats thoroughly as cat bites and scratches have a much higher risk of infection in comparison to those from dogs. Due to the depth and shape of penetration injuries from cats, bacteria often become inoculated more deeply and lead to more frequent and significant infections.

Diagnostic Tests^{18,19,21}

- Swab wound(s) and/or discharge for Culture and Sensitivity (C&S) if infection or MRSA colonization is suspected
- For animal bite injuries, see [BCCDC, Management of Specific Diseases - Rabies \(2025\)](#)
- For human bite injuries, see [BCCDC, Communicable Disease Control, Blood and Body Fluid Exposure Management \(2021\)](#)

Note: RN(C)s are authorized to initiate a client-specific ordering for screening and diagnostic tests only when employer policies, processes and/or resources are in place, as outlined by BCCNM.^{11,12}

3) Refer to the Appropriate Care and Treatment Plan

Based on the differential diagnosis established with assessment and diagnostic tests above, proceed to the appropriate care and treatment plan:

- **DST 601** - Care and Treatment Plan: Cellulitis and Localized Abscess
- **DST 602** - Care and Treatment Plan: Impetigo
- **DST 603** - Care and Treatment Plan: Minor Bites

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References

1. Coughlin K. Medical decision-making in paediatrics: Infancy to adolescence. Canadian Paediatric Society. January 24, 2024. Accessed June 28, 2025. <https://cps.ca/en/documents/position/medical-decision-making-in-paediatrics-infancy-to-adolescence#:~:text=The%20age%20of%20majority%20is,in%20a%20minor's%20best%20interests>.
2. Nast A, Griffiths CEM, Hay R, Sterry W, Bologna JL. The 2016 International League of Dermatological Societies' revised glossary for the description of cutaneous lesions. *British Journal of Dermatology* . 2016;174(6):1351-1358.
3. Benedetti J, Merola JF. Description of Skin Lesions. Merck Manual. January 2024. Accessed January 21, 2026. <https://www.merckmanuals.com/professional/dermatologic-disorders/approach-to-the-dermatologic-patient/description-of-skin-lesions>
4. First Nations and Inuit Health Branch (FNIHB). Clinical Practice Guidelines for Nurses in Primary Care: Chapter 9 - Skin. OneHealth. December 2017. Accessed January 21, 2026. <https://www.onehealth.ca/Portals/1/Adult%20-%20Skin%20%28Dec%202017%29.pdf>
5. Armstrong C. Approach to the clinical dermatologic diagnosis. UpToDate. April 2, 2025. Accessed January 21, 2026. <https://www.uptodate.com/contents/approach-to-the-clinical-dermatologic-diagnosis>
6. Baddour L. Cellulitis and skin abscess: Epidemiology, microbiology, clinical manifestations, and diagnosis - UpToDate. UpToDate. 2024. Accessed November 8, 2025. <https://www.uptodate.com/contents/cellulitis-and-skin-abscess-epidemiology-microbiology-clinical-manifestations-and-diagnosis>
7. Brown BD, Watson KLH. Cellulitis. *StatPearls [Internet]*. Published online August 7, 2023:33-34. doi:10.1007/978-3-319-65106-4_13
8. Kaplan SL. Skin abscesses, cellulitis, and erysipelas in children >28 days: Evaluation and management - UpToDate. UpToDate. September 16, 2025. Accessed October 27, 2025. <https://www.uptodate.com/contents/skin-abscesses-cellulitis-and-erysipelas-in-children-greater-than28-days-evaluation-and-management>
9. Pastorino A, Tavarez M. Incision and Drainage. StatPearls. July 24, 2023. Accessed December 21, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK556072/>
10. Anderson D. Methicillin-resistant Staphylococcus aureus (MRSA) in adults: Epidemiology. UpToDate. January 12, 2026. Accessed March 26, 2026. https://www.uptodate.com/contents/methicillin-resistant-staphylococcus-aureus-mrsa-in-adults-epidemiology?search=MRSA&source=search_result&selectedTitle=2~150&usage_type=default&display_rank=2#
11. BCCNM. Acting Within Autonomous Scope of Practice (Certified Practice). BCCNM. Accessed June 28, 2025. <https://www.bccnm.ca/RN/PracticeStandards/Pages/CPAutonomousSoP.aspx>
12. BCCNM. Screening and Diagnostic Tests & Imaging. BCCNM. Accessed June 27, 2025. <https://www.bccnm.ca/RN/PracticeStandards/Pages/ScreeningDiagnosticTestsImaging.aspx>
13. Baddour LM. Impetigo. UpToDate. April 22, 2025. Accessed October 27, 2025. <https://www.uptodate.com/contents/impetigo>
14. Nardi N, Schaefer T. Impetigo. StatPearls. July 31, 2023. doi:10.1007/978-3-031-15130-9_45
15. Public Health Agency of Canada. Group A Streptococcal diseases: For health professionals - Canada.ca. Government of Canada. February 7, 2024. Accessed October 27, 2025. <https://www.canada.ca/en/public-health/services/diseases/group-a-streptococcal-diseases/health-professionals.html>
16. Maniscalco K, Edens MA. Human Bites. StatPearls. July 10, 2023. Accessed November 23, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK430764/>
17. Baddour L, Harper M. Patient education: Animal and human bites (Beyond the Basics). May 29, 2024. Accessed November 23, 2025. https://www.uptodate.com/contents/animal-and-human-bites-beyond-the-basics?topicRef=7671&source=related_link
18. Baddour LM, Harper M. Human bites: Evaluation and management. UpToDate. January 31, 2024. Accessed October 27, 2025. <https://www.uptodate.com/contents/human-bites-evaluation-and-management>



19. Baddour LM. Animal bites (dogs, cats, and other mammals): Evaluation and management - UpToDate. UpToDate. November 19, 2024. Accessed October 27, 2025. <https://www.uptodate.com/contents/animal-bites-dogs-cats-and-other-mammals-evaluation-and-management>
20. Maniscalco K, Edens MA. Human Bites. StatPearls. July 10, 2023. Accessed November 23, 2025. <https://www.ncbi.nlm.nih.gov/books/NBK430764/>
21. Maniscalco K, Marietta M, Edens MA. Animal Bites. StatPearls. April 10, 2025. doi:10.1542/peds.33.4.616a

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