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# Nursing Progress Notes

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**Region: New Mexico**

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**WEXFORD MILLER 001796**

## Corporate Authorization

This Nursing Treatment Protocols has been reviewed and approved by the following individual(s):



\_\_\_\_\_  
Dr. Stephen Ritz  
*Chief Medical Officer, Wexford Health Sources, Inc.*

**Last Updated:** August 17, 2022

The Nursing Treatment Protocols are reviewed annually but may not require revision. If a change is made, a revision date will be added and updated accordingly.

**The contents of this manual are proprietary and confidential. This manual must be returned to Wexford Health's Corporate Office upon employee termination or end of contract.**



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## Preface

It is the expectation that these protocols are utilized with every patient contact. They are to be used as guidelines to efficiently and effectively evaluate a patient's health status. Protocols may be instituted after written diagnosis by MD/PA/NP. Licensed nursing staff should refer to a provider as indicated on the protocols, or at any other time in their professional opinion a referral to a provider is indicated. Licensed nurses must always practice within the scope of practice defined by their state.

Institutions not using the protocols should ensure that inmates presenting for sick call for primary care problems be automatically referred to the physician, physician's assistant (PA), or nurse practitioner (NP).

Although not explicitly stated in each protocol, it is the expectation that an allergy history is obtained prior to the use of any topical or oral agent. It must also be highlighted that universal precautions are to be utilized at all times.

These protocols are appropriate to utilize with both our adult and juvenile populations. Prior to the utilization of any of the protocols, a training session must be held certifying that the individual who is to use them fully understands their use.

### MEDICATIONS

All medications that are suggested in the protocols must be approved by the medical director, followed by an in-service given by the medical director or his designee to nursing staff annually. All patients who fail to adequately respond to treatment should be referred to sick call or for off-site care.

Select prescriptive medications listed on the protocol may be given in emergency, life threatening situations only. Emergency administration of these medications requires a subsequent provider's order.

Medication dosages are intended for adults and adjustments for juveniles may be necessary. All patients who fail to respond to treatment should be referred to MD sick call.

Nursing staff may elect not to give OTC medication without a physician's written signature or verbal order.

### IMPORTANT NOTE

All protocols are to be used for a maximum of 3 days duration unless indicated differently on the protocol. If no improvement of symptoms, automatically refer to the physician, physician's assistant, or nurse practitioner. All complaints should refer to the provider on the 3rd request for healthcare about the same complaint.

### REVIEW AND APPROVAL

This document must be reviewed and approved by the facility medical director prior to the application of these protocols. Additionally, the Facility Approval Page of this document must be executed by the corporate medical director, the facility medical director, and the site manager annually.

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## Abrasions and Lacerations – Mild

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Abrasions result from scraping or rubbing away of the skin surface by friction, such as a skinned knee.

Lacerations are openings (cuts or splits) in the skin surface that result from contact with a sharp object, or by various types of direct trauma.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. What caused the injury (accidental, work related, assault, self-inflicted)?
  - 2. Where did it happen?
  - 3. What time did it happen?
  - 4. What type of object caused the injury?
  - 5. Any history of excessive bleeding?
  - 6. Do you have a medical condition, or are you taking any medication that would cause excessive bleeding or problems healing?
  - 7. Do you have any allergies to medication?
  - 8. When was your last tetanus?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Level of consciousness and orientation
  - 3. Size and location of injury
  - 4. Presence of contaminants or ground-in debris
  - 5. Bleeding or drainage: note amount and characteristics
  - 6. Characteristic and severity of pain
  - 7. Swelling, edema, and/or any disfigurement
  - 8. Document depth of laceration
  - 9. Tetanus toxoid status
  - 10. Signs and symptoms of impaired circulation
  - 11. Any loss of range of motion or disfigurement

### III. ASSESSMENT

- A. Altered skin integrity
- B. Altered comfort

#### IV. PLAN

- A. MD/PA/NP referral by nurse
  - 1. Wounds with ground-in debris
  - 2. Signs of infection present
  - 3. Uncontrolled bleeding
  - 4. Those over joints or covering a large and/or deep area
  - 5. Assault wounds to head, face, chest, back, or abdomen
  - 6. Requires sutures
  - 7. Lacerations of eyelids, lips, ears, or over joints/fingers
  - 8. Exchange of body fluid
  - 9. Last tetanus toxoid was > 5 years ago
  - 10. Wounds not responding to protocol treatment
  - 11. If injury is self-inflicted, refer to mental health
- B. Nursing intervention
  - 1. Cleanse with antiseptic soap
  - 2. If wound is on the face, use Phisoderm or equivalent. Rinse with normal saline.
  - 3. Apply direct pressure to wound with sterile compress if needed to control bleeding – elevate if possible
  - 4. Acetaminophen 325 mg, 2 tablets p.r.n. b.i.d. x 6 days p.r.n.
  - 5. Triple antibiotic ointment b.i.d. x 3 days
  - 6. Dress abrasion as necessary, butterfly/Steri-strip if necessary
  - 7. Complete an injury report
- C. Patient teaching
  - 1. Signs of infection (swelling, pus formation, redness, heat, streaking, etc.)
  - 2. Signs of impaired circulation (cold extremities, blanching nails, etc.)
  - 3. If injury could have been prevented, instruct on safety measures
  - 4. Need for follow-up referral at sick call if infection and/or impaired circulation develop

#### V. FOLLOW-UP

Wound check in the clinic or by sick call nurse in 24 hours; p.r.n. thereafter, depending on severity and patient's ability to provide self-care

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## Acne

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Acne is an inflammatory, papulopustular skin eruption occurring usually in or near the sebaceous glands on the face, neck, shoulders, and upper back. Its cause is unknown but involves bacterial breakdown of sebum into fatty acids irritating to surrounding subcutaneous tissue.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have you had this problem?
  - 2. Has something changed in your life to cause a flare-up (i.e. stress)?
  - 3. Describe your dietary patterns (greasy or chocolate foods).
  - 4. Describe current hygiene practices
  - 5. Past treatment and results (explore compliance to treatment)?
  - 6. Are you allergic to any medications?
  - 7. Females only:
    - a. Are menstrual periods regular?
    - b. Is there a pre-menstrual flare-up?
    - c. Use of birth control pills or other hormones?
    - d. Cosmetic usage?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Presence of white and/or blackheads, cysts
  - 3. Secondary infection (cellulitis/purulent drainage)
  - 4. General skin condition (fair skin, dark skin, dry skin, oily skin)
  - 5. Distribution and severity

### III. ASSESSMENT

Altered skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse
  - 1. If it's a chronic problem that has not responded to treatment within 4 weeks
  - 2. Secondary infections (e.g. cellulitis, purulent drainage)
  - 3. Extensive involvement
  - 4. New onset of post-adolescent acne with severe or extensive involvement

**B. Nursing intervention**

1. Cleanse area b.i.d. with mild soap
2. Wash hair frequently to keep it clean and oil free
3. Topical Benzoyl Peroxide 10% gel to affected area q. day or b.i.d. (1.5 oz.) x 4 weeks

**C. Patient teaching:**

1. Avoid greasy foods
2. Drink plenty of water
3. Try to identify predisposing factors which may be eliminated or modified (i.e., stress, hot humid weather) avoiding over use of oils, pomades, etc.
4. Vigorous washing can worsen the lesions
5. Wash hair at least 3 times per week
6. Keep hands away from the area and avoid picking
7. Acne takes a long time to clear. Even after it has cleared, proper skin care should be continued.
8. Females should utilize no makeup or use water-based cosmetics only

**V. FOLLOW-UP**

Return to sick call in 1 month if no improvement or if symptoms significantly worsen

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## Alcohol Withdrawal

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Alcohol withdrawal syndrome occurs when an individual with a high tolerance to alcohol suddenly decreases the amount of intake of alcohol. The signs and symptoms of withdrawal include: tremors or shakes of the hands; increased pulse, respiration, and temperature, anxiety, panic, any type of hallucination, and confusion.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When was your last drink?
  - 2. Amount?
  - 3. Usual daily consumption?
  - 4. History of withdrawal symptoms? Describe
  - 5. History of alcohol withdrawal seizures?
  - 6. Do you have a history of hypertension?
  - 7. Any insomnia or restlessness?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Observe for signs of agitation, tremors, and diaphoresis
  - 3. Gait: normal, unsteady, needs assistance
  - 4. Mental Status: normal, oriented, confused, disoriented, anxiety, panic

### III. ASSESSMENT

Altered health status

### IV. PLAN

- A. Notify physician anytime alcohol withdrawal is suspected or confirmed
- B. CIWA protocol:
  - 1. Must have provider order to administer medications

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## Allergic Reaction/Anaphylactic Reaction

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An allergic reaction is a hypersensitivity immune-mediated response to a sensitizing substance, such as a drug, vaccine, certain food, serum, allergen extract, insect venom, or chemical. Symptoms and severity vary widely in individuals with allergic reactions, ranging from local pain or swelling, to a rash, to anaphylaxis.

Anaphylaxis is a severe and sometimes-fatal systemic hypersensitivity reaction to a sensitizing substance. This condition may occur within seconds from the time of exposure to the sensitizing agent and is commonly marked by respiratory distress and vascular collapse. The more quickly any systemic reaction occurs in the individual after exposure, the more severe the associated shock is likely to be.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Exposure to potential allergens (drug, food, environmental, etc.)
  - 2. History of past allergies or similar reactions
  - 3. Symptoms experiencing (i.e., rash, itching, shortness of breath, etc.)
  - 4. Any difficulty breathing or swallowing?
  - 5. Any feeling of tongue swelling or throat closing?
  - 6. Are you itching, choking or coughing a lot?
  - 7. Do you have any medical conditions?
  - 8. Are you taking any medications?
  - 9. Are you allergic to any medications?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. If rash is present, note location, size, description, exudate, and severity
  - 3. Auscultate lungs and note extent of respiratory effort
  - 4. Level of consciousness and orientation
  - 5. Airway patency (tongue size, pharyngeal swelling)

### III. ASSESSMENT

Altered health maintenance

#### IV. PLAN

- A. MD/PA/NP Referral by nurse
  - 1. Any reaction secondary to medications
  - 2. A reaction resistant to treatment, and/or severe reaction (i.e., shortness of breath, severe swelling)
  - 3. Abnormal vital signs
  - 4. Any previous history of a severe reaction
  - 5. Any rash involving the chest, torso or more than 1 extremity
- B. Nursing intervention (verify medications and allergies prior to treatment)
  - 1. For local allergic reaction
    - a. Hydrocortisone cream 1% bid x 2 weeks p.r.n. for minor skin allergies
  - 2. For emergent anaphylaxis (airway compromise, hypotension, and/or altered level of consciousness):
    - a. For emergent reactions, activate EMS, notify provider, and record vital signs q. 5 minutes until transported
    - b. Administer oxygen
    - c. Establish IV of normal saline at 20 cc/hour rate (open wide if hypotension is present)
    - d. Administer 0.3 cc Epinephrine 1:1000 (adult dose) subcutaneously stat. (use with extreme caution in patients who are elderly or have heart disease)
    - e. Carry out additional emergency medicine orders per provider

#### V. FOLLOW-UP

As indicated by physician

## Altered Mental Status

An altered mental status may result from a variety of conditions including but not limited to hypoglycemia, drug overdose, and stroke.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. How long have the symptoms been present?
  2. Have you ever had this problem before? If yes, when? Describe.
  3. Abnormal behavior observed by whom?
  4. If signs of trauma are present, describe the injury.
  5. Use of alcohol or drugs in the past 2 weeks? Describe.
  6. Any fever, chills, diaphoresis?
  7. Any dizziness, blurred vision, headache, loss of consciousness?
  8. Any hallucinations? Explain.
  9. Any nausea/vomiting? If so, describe frequency and duration.

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, weight
2. Neurological examination
  - a. Level of consciousness
  - b. Behavior
  - c. Speech pattern
  - d. Eye examination
  - e. Facial symmetry
  - f. Hand grips
3. Breath sounds
4. Skin evaluation
  - a. Temperature
  - b. Color
5. Apparent injury
6. Glasgow Coma Scale
7. Fingertstick blood sugar
8. Urine dip

Response	Description	Points	Score
<b>Opens Eyes</b>	Spontaneous	4	
	To voice	3	
	To painful stimuli	2	
	No response	1	
<b>Verbal Response</b>	Oriented	5	
	Confused, disoriented	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	No response	1	
<b>Motor Response</b>	Obeys commands	6	
	Localizes painful stimuli	5	
	Flexion/withdrawal from painful stimuli	4	
	Abnormal flexion to painful stimuli (decorticate response)	3	
	Extension to painful stimuli (decerebrate response)	2	
	No response	1	
		<b>SCORE</b>	

### III. ASSESSMENT

Disturbed thought process(es)

### IV. PLAN

#### A. Urgent MD/PA/NP Referral by nurse

1. Abnormal vital signs (T > 100, P > 100, SBP < 100)
2. Glasgow coma scale ≤ 13
3. Nausea/vomiting x ≥ 24 hours
4. Weak/abnormal hand grips
5. Unequal pupils
6. Facial asymmetry
7. Headache and stiff neck
8. Abnormal fingerstick (non-diabetic: < 60 or > 200; diabetic: < 70 or > 240)
9. Abnormal urine dip

#### B. Nursing interventions

1. CPR as indicated
2. Oxygen at 2 LPM via nasal cannula
3. EMS activated (document arrival and transport times, and facility transferred to)
4. Notify provider as indicated

#### C. Patient education

1. Notify medical if symptoms persist or worsen
2. Patient verbalizes understanding

### V. FOLLOW-UP

#### A. Follow up with nurse

#### B. Follow up with practitioner

#### C. Follow up with practitioner for possible CCC enrollment

#### D. Other

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## Amenorrhea (Absence of Menses)

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Amenorrhea means the absence of menstruation for at least 3 months in a young woman who has previously menstruated.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When was your last period?
  - 2. What is your menstrual cycle history?
  - 3. Have you been sexually active?
  - 4. Have you ever been on birth control pills?
  - 5. Have you recently lost weight?
  - 6. Have you recently begun a program of intense exercise?

### II. OBJECTIVE

- A. Examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Assess abdomen and bowel sounds and document findings
  - 3. Assess nutritional status and document findings
  - 4. Obtain height and weight and compare to baseline
  - 5. Assess stress level

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse
  - 1. Patient is pregnant
  - 2. If amenorrhea has been of 90-day duration or longer
  - 3. If symptoms of extreme anxiety present refer to mental health
- B. Nursing intervention (verify allergies prior to treatment)
  - 1. Urine pregnancy test
  - 2. High calorie diet/nutritional supplement, such as Boost, if recent weight loss of 10% of body weight or more
  - 3. Decrease physical exercise if strenuous exercise regime recently began

C. Patient teaching:

1. Nutritional needs
2. Encourage maintenance of menstrual cycle calendar to monitor cycles

**V. FOLLOW-UP**

Return to sick call in 30 days

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## Asthma – Adult (Over Age 17)

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Asthma is an episodic, reversible reactivity of the airway resulting in cough, wheezing, and shortness of breath.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. Any past history of asthma?
  2. What symptoms are you experiencing (shortness of breath, wheezing, exercise-induced breathing problems, sleep disturbance, etc.)?
  3. Are you on, or were you ever on, medication for your breathing? What is the name of the medication, and when was the last time you took this medication?
  4. Have you required previous hospitalization and/or ER visits for respiratory difficulties?
  5. Are there any conditions that make your breathing worse (smoke, dust, exercise)?
  6. Any recent colds or coughs?
  7. How often have you been using your inhaler? How long since last puff?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Any presence of audible wheezing
  3. Any appearance of respiratory distress
  4. Measure Peak Expiratory Flow Rate (PEFR), O<sub>2</sub> Sat
  5. Skin color/temperature

### III. ASSESSMENT

Altered respiratory status

### IV. PLAN

- A. MD/PA/NP Referral by nurse
1. HR > 100, RR > 28, O<sub>2</sub> Sat < 94% or failure to improve with treatment
  2. PEFR is < 300 and/or inmate appears to be in respiratory distress
  3. Attacks are increasing in frequency and/or severity, and if no inhaler has been previously prescribed, immediately refer to MD

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**B. Nursing intervention**

1. If PEF is > 300 and patient is on a prescribed fast-acting p.r.n. inhaler, give 2 puffs now. May repeat q. 10 minutes to maximum of 3x if needed.
2. If patient is experiencing emergent asthma episode give nebulizer treatment with Albuterol (2.5 mg/3 ml unit dose vials) and obtain subsequent order.
3. If condition remains emergent give .3 cc of 1:1000 epinephrine subq.
4. Activate EMS (911) if condition worsens or shows no improvement with treatment
5. Obtain PEF and O<sub>2</sub> Sat before and after nebulizer treatment
6. May repeat nebulizer treatment q. 15 minutes x3 with physician order
7. Administer O<sub>2</sub> via NC at 2–3 liters/minute if SOB; place patient in sitting position

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## Asthma – Juvenile (Under Age 18)

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Asthma is an episodic, reversible reactivity of the airway resulting in cough, wheezing, and shortness of breath.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. Any past history of asthma?
  2. What symptoms are you experiencing (shortness of breath, wheezing, exercise induced breathing problems, etc.)?
  3. Are you on, or were you ever on, medication for your breathing? What is the name of the medication, and when was the last time you took this medication?
  4. Are there any conditions that make your breathing worse (smoke, dust, exercise)?
  5. Any history of hospitalizations and or ER visits due to episode?
  6. Any recent colds or coughs?
  7. How often have you been using your inhaler? How long since last puff?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Presence of audible wheezing
  3. Appearance of being in respiratory distress
  4. Measure Peak Expiratory Flow Rate (PEFR) and O<sub>2</sub> Sat
  5. Skin color and temperature

### III. ASSESSMENT

Altered respiratory status

### IV. PLAN

- A. MD/PA/NP referral by nurse
1. HR > 110, RR > 30, O<sub>2</sub> Sat < 95% or if no improvement after treatment
  2. PEFR is < 200 and/or inmate appears to be in respiratory distress
  3. Attacks are increasing in frequency and/or severity, and if no inhaler has been previously prescribed, immediately refer to MD

B. Nursing intervention

1. If patient is experiencing emergent asthma episode, give nebulizer treatment with Albuterol (2.5 mg/ 3 ml unit dose vial) and obtain subsequent order
2. If PEFr is > 300 and inmate is presently on an inhaler, nurse should have inmate use inhaler, 2 puffs stat. May repeat every 10 minutes up to 3x if needed
3. Vital signs every 10 minutes while under treatment
4. PEFr and O<sub>2</sub> Sat before and after every treatment and every 10 minutes thereafter until condition stabilizes
5. Notify MD

C. Patient teaching

1. Medications as prescribed
2. Use of inhaler and technique (if ordered)
3. Avoidance of triggering factors
4. Importance of follow-up referral to MD if symptoms recur and/or worsen

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## Athletes Foot and Jock Itch (Tinea Pedis and Tinea Cruris)

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Athlete's foot (or tinea pedis) is an acute and chronic superficial fungal infection of the foot, especially of the skin between the toes and on the soles.

Jock itch (or tinea cruris) is a superficial fungal infection of the groin.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. How long have you had this problem, and where is it located?
2. Is this a recurring problem?
3. Does the area itch and/or burn?
4. Any past history of this? If so, how was it treated, and was it successful?
5. Are you taking any medications?
6. Are you allergic to any medications?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, Pulse, Respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Note location and size of areas involved (check feet, head, groin, and hands)
3. Appearance of rash, secondary infection, dry, flaky, macerated patches, fissures, cracking, and/or open sores
4. Presence of unilateral or bilateral erythema
5. Note any area with short, slightly raised, border which contain vesicles
6. Distribution of groin area (usually not scrotum)
7. Well-defined border

### III. ASSESSMENT

Altered skin integrity

### IV. PLAN

A. MD/PA/NP referral by nurse if:

1. All diabetics with open foot sore
2. If a recurring problem without healing given use of treatment protocol
3. Any open sores present
4. Signs of secondary infection
5. Temperature > 99.5°F
6. If patient is allergic to topical antifungal agent

**B. Nursing intervention**

1. Cleanse area with soap and water
2. Tolnaftate 1% cream b.i.d. x 4 weeks; instruct patient on use of anti-fungal cream, i.e., use sparingly, etc.

**C. Patient teaching**

1. FOR ATHLETES FEET:
  - a. Expose feet to air whenever possible
  - b. Keep feet clean and dry thoroughly between the toes
  - c. If available, wear shower shoes in the shower, and canvas shoes in daytime.
  - d. Wear clean socks (cotton preferred)
  - e. Put socks on before underwear to avoid spreading infection to groin
  - f. Medication instruction
  - g. Importance of follow-up if symptoms worsen or do not subside within 4 weeks
2. FOR JOCK ITCH:
  - a. Dry affected area thoroughly after bathing, and evenly apply medication
  - b. Keep skin clean and dry
  - c. Wear loose-fitting clothing, which should be changed daily (especially cotton underwear, if available)
  - d. Give antifungal cream as above

**V. FOLLOW-UP**

Importance of follow-up if symptoms worsen or persist for more than 4 weeks

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## Backache – Mild

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Back pain in this context is defined as pain in the thoracic, lumbar, or lumbosacral regions of the back. Back pain, particularly low back pain, affects 60-80% of the adult population at some time in their lives. The vast majority of cases of back pain are due to mechanical stressors in the form of sprains and strains. Most episodes of back pain resolve within a few weeks with little residual effect. The pain of a herniated intervertebral disc is usually one-sided and may involve radiating pain, numbness or weakness of the leg or foot of the affected area.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. What caused the pain (i.e., lifting, fall, sports)?
  2. Was the pain immediate or delayed?
  3. How long has the pain been present?
  4. Describe the location and pattern of the pain (i.e., radiation, numbness, what worsens/eliminates the pain?)
  5. How severe is the pain? What makes it worse?
  6. Presence of fever, chills, night sweats, dysuria?
  7. Increase pain with cough?
  8. Pain on urination? Frequency? What color is your urine?
  9. And change in range of motion?
  10. Are you taking any medications?
  11. Are you allergic to any medications?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Note appearance, distress, or pain with movement
  3. Note gait disturbance
  4. Observe change from sitting to standing
  5. Inspect local area for swelling, redness, bruises, tenderness to touch, limitation of movement
  6. Examine color and clarity of urine (cloudy, red, dark yellow)
  7. Note apparent congestion or wheezing in lower lungs

### III. ASSESSMENT

Alteration in comfort

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. Abnormal vital signs or temperature > 100.5°F
2. Loss of sensation apparent
3. Difficulty walking
4. Patient complains of numbness
5. Patient appears in severe pain
6. Abnormal vital signs
7. Urine is dark or bloody
8. Foot drop is present
9. No relief after 48-hour trial of treatment protocols side

## B. Nursing intervention (verify medications and allergies prior to treatment):

1. Apply cool compresses to the affected areas p.r.n. or moist heat p.r.n.
2. Avoid sporting activities until pain has been gone for at least 2 weeks
3. If patient does not have a contraindication to NSAIDs: give Ibuprofen 200 mg 2 tabs p.o. b.i.d. p.r.n. x 6 days
4. If patient has a contraindication to NSAIDs: give Acetaminophen 325 mg 2 tabs p.o. b.i.d. p.r.n. x 6 days

## C. Patient teaching:

1. Sports restriction (avoid weight lifting/strenuous activity)
2. Proper body mechanics
3. If injury could have been prevented, instruct on safety measures

**V. FOLLOW-UP**

Return to sick call if discomfort worsens or persists past 5 days or prevents normal activities

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## Benzodiazepine Withdrawal

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Benzodiazepine withdrawal occurs when a person who has been taking and most often, abusing benzodiazepines suddenly stops taking the medication.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. Drug used?
2. Amount used?
3. Last time used?
4. Pattern of use?
5. History of previous withdrawal?
6. Other drugs or ETOH used?
7. History of other medical problems?

### II. OBJECTIVE

A. Examine the patient and document the following in the record:

1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
2. Any apparent respiratory distress?
3. Level of distress: mild, moderate, severe, calm, cooperative
4. Tremor present?
5. Gait: normal, unsteady, needs assistance
6. Abdomen: soft, bowel sounds, tender, rebound
7. Pupil size: pin point, normal, reactive, dilated
8. Skin: pale, flushed diaphoretic, dry, warm, cool

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

A. MD/PA/NP referral:

1. Anytime benzodiazepine withdrawal is known or suspected

B. Nursing intervention (verify medications and allergies prior to treatment):

1. Refer to MD

C. CIWA-B protocol:

1. Must have provider order to administer medications

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## Bites

---

A bite is the result of cutting, tearing, holding, or gripping with the teeth. Snakebite: a wound resulting from penetration of the flesh by the fangs of a snake.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Do you know what bit you (insect, snake, animal, human)?
  - 2. How long ago did the bite occur?
  - 3. Any history of allergies?
  - 4. Any difficulty breathing?
  - 5. Any pain or numbness?
  - 6. Did the bite break the skin and cause bleeding?
  - 7. Any exchange of body fluids?
  - 8. Description of snake or insect?
  - 9. Are you taking any medications?
  - 10. Are you allergic to any medications?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Any noted respiratory distress, pallor, pain, or anxiety
  - 3. Diaphoresis, clamminess, pallor, or cyanosis
  - 4. Any swelling, redness, heat, streaks, or bleeding
  - 5. Location of bite marks
  - 6. Tetanus immunization status

### III. ASSESSMENT

- A. Altered skin integrity
- B. Alteration in comfort

---

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. Vital signs abnormal, shortness of breath apparent
2. Patient reports body fluid exchange
3. Tetanus toxoid > 5 years ago
4. Bleeding is uncontrolled
5. Depth of puncture wound is unknown
6. Assaultive wounds to head, face, chest, or back
7. Area appears infected
8. Patient appears in acute distress
9. Minor animal, and/or human bite without above symptoms can be referred next provider sick call.

## B. Nursing intervention:

1. SNAKE BITE: All snake bites should be referred to MD stat.
  - a. Have victim lie down
  - b. Keep victim calm
  - c. Call EMS Transport
  - d. Do not place tourniquet on the affected limb
  - e. Do not cut the area of the bite nor attempt to suction the victim
  - f. Immobilize affected area
  - g. Take vital signs q. 5 minutes
2. INSECT/SPIDER BITE
  - a. Remove any visible, protruding stinger using forceps, being careful not squeeze stinger thereby injecting more venom
  - b. Apply ice pack to area
  - c. Apply Calamine lotion to insect stings as necessary. Dispense 1 tube.
  - d. Have spider brought to healthcare for identification if possible

3. ANIMAL BITE
    - a. Notify MD
    - b. Call preventive medicine office to report and seek guidance for determination of rabies prophylaxis
    - c. Contact local animal control authorities to report bite
    - d. If a local reaction is observed with minimal swelling and/or erythema, vital signs within normal limits and no shortness of breath, then wash wound thoroughly with Betadine (Normal Saline if allergic)
    - e. If edema is present and extremity involved, elevate and apply ice pack
    - f. Apply dry, sterile dressing (small puncture wounds may be left open and gently irrigated). Schedule daily dressing changes as needed.
    - g. Return to clinic the following day for re-evaluation
  4. HUMAN BITE
    - a. Wash wound thoroughly with Betadine (normal saline if allergic)
    - b. Apply dry, sterile dressing (small puncture wounds may be left open and gently irrigated). Schedule daily dressing changes as needed.
    - c. Return to clinic the following day for re-evaluation
    - d. Refer to MD
    - e. May give Acetaminophen 325 mg 1–2 tabs p.o. b.i.d. p.r.n. x 6 days for pain/discomfort.
- C. Patient teaching:
1. Rationale of ice usage
  2. Reinforce need for immediate care of bites and need of appropriate follow-up for human bites
  3. Instruct patient on signs of infection
  4. For insect bites, avoid wearing cologne, as insects are attracted to the smell
  5. Need for follow-up referral to physician if area increases in size and/or shows signs of infection

## V. FOLLOW-UP

As indicated by physician

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## Bleeding – Severe

---

Severe bleeding is defined as venous or arterial bleeding that persists more than 5 minutes after intervention.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How, where and when did the injury occur?
  - 2. Any history of anemia and/or bleeding disorder?
  - 3. Date of last tetanus
  - 4. Are you on anticoagulants or daily aspirin?
  - 5. Are you experiencing any dizziness?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Location, size, depth of wound, and amount of bleeding
  - 3. Assess level of consciousness
  - 4. Note presence of any tourniquets

### III. ASSESSMENT

Altered health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Any severe and/or uncontrolled bleeding
- B. Nursing intervention: WHILE OBTAINING ORDERS FROM MD
  - 1. For emergent situations start IV Normal Saline at 10 cc/hour and obtain subsequent order
  - 2. Expose the wound and apply direct pressure
  - 3. Utilize pressure points if direct pressure is insufficient
  - 4. Elevate the area if possible, and apply dry sterile dressing
  - 5. Monitor vital signs every 5 minutes
  - 6. Oxygen per nasal cannula at 5 liters/minute
  - 7. Continuous monitoring of level of consciousness
  - 8. Call ambulance if patient appears unstable

C. Patient teaching:

1. Reassurance
2. As implementing protocol, talk to the patient (i.e., oxygen will make it easier to breathe; the IV will help replace the fluids lost, etc.)

---

## Blisters

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A swelling formed by a collection of fluid below or within the epidermis.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. What caused the blister?
  - 2. How long has this blister been present?
  - 3. How painful is the blister?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Evaluate the size and depth of blister
  - 3. Discoloration and/or signs of infection
  - 4. Limitation of movement or difficulty in ambulation as pertaining to the limb involved

### III. ASSESSMENT

Altered skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Blister shows signs of infection
  - 2. Blister is large and needs extensive debridement
- B. Nursing intervention:
  - 1. Cleanse area with antibacterial soap or solution (Betadine)
  - 2. Apply Band-Aid or dressing as needed
  - 3. Refer to MD if further debridement needed
  - 4. Antibacterial ointment if indicated
- C. Patient teaching:
  - 1. Avoid conditions that cause blisters
  - 2. Keep blister area clean and dry

### V. FOLLOW-UP

Return to sick call if symptoms worsen or persist

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## Boils

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Boils are painful, deep, bacterial infections of hair follicles. Boils are common and contagious. The skin and hair follicles are involved.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When did the boil appear?
  - 2. Any other recent illness?
  - 3. Self or family history of diabetes?
  - 4. Any recent use of medications (especially those that may be immunosuppressive)?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Size of affected area
  - 3. Presence or absence of symptoms of infection
  - 4. Hygiene
  - 5. Assess for swelling of lymph glands

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral:
  - 1. All diabetics
  - 2. Fever present of 99.4°F or above
  - 3. If MRSA is suspected
  - 4. If boil is over 1½ cm in size
  - 5. If new boils develop
- B. Nursing intervention (verify medications and allergies prior to treatment):
  - 1. Culture area as ordered by provider
  - 2. Cleanse gently with antiseptic soap
  - 3. Warm soaks or compresses as indicated
- C. Patient teaching:
  - 1. Cleansing of area
  - 2. Appropriate hygiene practices

**V. FOLLOW-UP**

Return to sick call in 3–4 days or sooner if pain worsens, new boils appear, or if patient develops a temperature

---

## Breast Lump

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A breast lump is a palpable mass in breast that may be solid or cystic.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. When did you first notice the lump?
  2. Is there any pain, redness, discharge?
  3. Has the lump changed in any way since you first discovered it?
  4. Any history of fibrocystic breast disease or cancer?
  5. Any past breast surgeries?
  6. Vomiting? Diarrhea?
  7. Do you do self-breast examinations (SBE)?
  8. Have you had a mammogram? If so, when was your last one? Results?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. General appearance: flushed, diaphoretic, pale? Skin: warm, hot, cool, dry, clammy?
  3. Breasts: Asymmetrical? Symmetrical?
  4. Location of the lump and description of the lump (size, consistency, movable)
  5. Any noted dimpling, asymmetry, tenderness, redness, nipple discharge, or scars
  6. Document axillary exam and presence or absence of tenderness, swelling, or apparent mass
  7. Any noted chest wall abnormalities?

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
1. Any new lump
  2. Any change in status of a lump and/or nipple discharge
  3. Temp > 101°F
  4. Vomiting, or diarrhea is present
  5. Heat or redness is present at site
  6. Check last mammogram; if different, refer to MD

B. Nursing intervention:

1. Moist heat (warm water) to area if indicated
2. Acetaminophen 325 mg – take 2 tablets p.o. b.i.d. x 6 days  
OR
3. Ibuprofen 200 mg – take 2 tablets p.o. b.i.d. x 6 days

C. Patient teaching:

1. Reassurance
2. Take medications as instructed
3. Instruction on self-breast exam
4. Dietary modification with fibrocystic breast disease (avoidance of caffeine, fatty foods)

**V. FOLLOW-UP**

Follow up/refer to physician if lump changes or symptoms worsen

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## Burns

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A burn is any injury to body tissues caused by heat, electricity, chemicals, radiation, or gases in which the extent of the injury is determined by the amount of exposure of the cell to the agent and to the nature of the agent.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Note cause of the burn (fire, gasoline, chemical, sun, electrical) [electrical requires immediate referral]?
  - 2. Inquire as to when and where
  - 3. Level of pain
  - 4. Note chronic diseases
  - 5. Previous history and treatment
  - 6. Note allergies
- B. IMMEDIATE MD REFERRAL FOR ELECTRICAL BURN OR BURNS INVOLVING POSSIBLE SMOKE INHALATION!

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Evaluate the area, size, depth, and degree of the burn
    - a. Superficial (1st degree): Pink to red, dry, slightly edematous
    - b. Partial thickness (2nd Degree): vesicles (blisters) and edema
    - c. Full thickness (3rd Degree): full thickness skin loss; skin can appear white in color, leathery, absence of pain; sloughs off
  - 3. Evaluate for respiratory distress and/or declining level of consciousness
  - 4. Tetanus toxoid status
  - 5. Signs of infection – draining? Yellow, green?

### III. ASSESSMENT

- A. Alteration in skin integrity
- B. Alteration in comfort

### IV. PLAN

- A. Findings requiring hospital referral:
  - 1. Burns are full thickness
  - 2. Burns resulted from radiation or electricity
  - 3. If burn is full thickness, and/or patient is experiencing symptoms of shock, elevate legs

## B. MD/PA/NP referral by nurse if:

1. Any burn > 10% of body surface
2. If burn involves face, joints, groin, or palms/soles
3. If burn is painless, charred, white, or has rigidity
4. Large broken blisters; and/or electrical burns
5. Absence of pain or evidence of third-degree burn
6. Signs of infection are present
7. History of diabetes or if immunocompromised

## C. Nursing intervention:

1. For emergent situation may start IV N/S TKO and obtain subsequent order
2. For superficial burns:
  - a. Apply cold packs or run continuous cool water over affected areas for 20 minutes
  - b. If extremity is involved, elevate extremity
  - c. Wrap in a bulky, sterile dressing
  - d. Give Acetaminophen 325 mg 1–2 tabs b.i.d. p.r.n. x 6 days
3. For partial thickness burns:
  - a. Apply cold packs or run continuous cool water over affected areas
  - b. Flush CHEMICAL burns with LARGE amounts of water
  - c. If extremity is involved, elevate extremity
  - d. Non-adherent (or Vaseline gauze) with sterile dressing
  - e. Give Acetaminophen 325 mg 2 tabs p.o. b.i.d. p.r.n. x 6 days
  - f. Notify provider and carry out orders received
4. Eye chemical burn – refer to eye injury protocol
5. Update tetanus immunizations if received more than 5 years ago or status unknown

## D. Patient teaching:

1. Keep wound clean and dry
2. Monitor for any signs of infection
3. Increase fluid intake
4. Do not break blisters (unless occur spontaneously or by medical personnel)
5. Cover exposed burn areas while in the sun (i.e., long sleeves, hats) and limit time exposed in the sun
6. If injury could have been prevented, instruct on safety measures

**V. FOLLOW-UP**

Return to sick call for dressing changes daily until affected area heals, or at once if symptoms worsen

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## Callouses

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A thickened or hardened area of the skin.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has the problem existed?
  - 2. Do calluses affect walking?
  - 3. Have you begun to wear new shoes recently?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Condition of feet
  - 3. Location of calluses
  - 4. Size and distribution
  - 5. Redness or infection

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Signs of infected and/or recurring calluses
- B. Nursing intervention
  - 1. Soak foot 15–30 minutes weekly followed by scraping with a pumice stone.
- C. Patient teaching:
  - 1. Use pumice stone (not a razor blade)
  - 2. Several treatments are needed before results are seen
  - 3. Pad feet before wearing shoes (calluses are the result of friction)
  - 4. Use foot powder, wear 2 pair of socks, wear shoes that fit properly

### V. FOLLOW-UP

Return to sick call if no improvement after 2 weeks

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## Cellulitis

---

Cellulitis is an inflammation of deeper structures of skin and subcutaneous tissues generally due to infection.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. Have you had any trauma to the area recently (i.e., laceration, puncture wound, human or animal bite)?
  2. Do you have a history of diabetes, IV drug abuse, chronic sinusitis, foreign body, surgical procedure (vascular surgery in past), flu, dental work, or skin ulcers?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Size, tenderness, pain, redness, swelling
  3. If about the face, check for malaise, anorexia, vomiting, itching, dysplasia, anterior neck swelling, lid edema, conjunctival hyperemia, and limitation to ocular motion

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral:
1. Anytime cellulitis is suspected
  2. Cellulitis can worsen rapidly and be very dangerous. Always refer patient to the MD.
- B. Nursing intervention:
1. Immobilization and elevation of the affected limb
  2. Sterile saline dressings to decrease local pain
  3. Applications of moist heat may help to localize infection for 10 minutes q.i.d.
- C. Patient teaching:
1. Keep affected limb elevated

### V. FOLLOW-UP

Return to sick call for dressing changes daily until affected area heals, or if any change in tenderness, swelling, or redness occurs

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## Chemical Gas Exposure (Pepper Spray and Others)

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Chemical gas exposure is the local and systemic reaction that results from exposure to various chemical agents.

At the scene:

Health care unit nursing staff (preferably in protective uniform) will respond to the scene with the following items: oropharyngeal airway, intranasal oxygen cannula, face mask, Ambu bag, portable oxygen cylinder, stretcher, portable suction, wet cloths and eye irrigant.

### I. SUBJECTIVE

- A. The nurse will ask the patient and document the following in the record:
  - 1. Direct or secondary exposure?
  - 2. When, where and how did exposure occur
  - 3. Any chemical burns present, degree of burn, and location

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Level of consciousness
  - 3. Any apparent respiratory distress
  - 4. Lung sounds
  - 5. Any apparent irritation of eye or nasal areas

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Respiratory compromise
  - 2. Symptoms show no improvement or worsen
- B. Nursing intervention:
  - 1. Respiratory distress – conscious
    - a. Clean face, eyes, nose, mouth with wet cloths soaked in fresh water
    - b. If coughing or any breathing problems, oxygen by intranasal cannula at 2 liters/minute.
    - c. Suction oropharyngeal area, as necessary

2. Respiratory distress - unconscious
  - a. Activate EMS (911)
  - b. Notify provider and carry out orders
  - c. Keep supine; if breathing is adequate, insert airway and suction secretions
  - d. Oxygen by face mask at 10 liters/minute
  - e. If no respirations, initiate mouth to mouth breathing or via Ambu bag
  - f. Check carotid pulse; if absent, initiate cardiac compressions
3. Skin/eye exposure
  - a. Flush skin with cool water for 10 minutes
  - b. Eyes should be flushed for 15 minutes (remove contacts)

C. Patient teaching:

1. Major discomfort should disappear within 10–20 minutes
2. Avoid rubbing eyes, scratching skin, etc.
3. Continue self-administered cool water compresses/rinses, p.r.n. if necessary
4. Avoid the use of topical creams, as they may trap the chemical and cause future burns

## V. FOLLOW-UP

Follow up in sick call if no improvement or if symptoms worsen

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## Chest Pain – Presumed Cardiac Origin

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Chest pain may be symptomatic of cardiac disease such as angina pectoris, myocardial infarction; or pericarditis; or disease of the lungs such as pneumonia, pneumothorax, pulmonary embolism or pleurisy; or caused by muscular or joint inflammation (costochondritis); or result of aortic dissection; or manifestation of referred pain from biliary or peptic ulcer disease.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. How long has the pain been present?
  2. How did it start (i.e., with activity, at rest, etc.)?
  3. Any past medical history of family history of heart problems?
  4. Describe the pain (sharp, knife-like, tightness, squeezing, dull, stabbing, etc.)
  5. Any recent injury or muscle strain to the chest?
  6. Any associated symptoms? (Nausea, vomiting, dyspnea, dizzy, diaphoresis)
  7. Pain level (1–10): At worst? Present?
  8. What relieves the pain? What intensifies the pain (coughing, breathing, activity)?
  9. Allergies (foods/meds)
  10. Pain/numbness radiating to arm, shoulder, mandible, or neck
  11. Family history or personal history of cardiac disease

## II. OBJECTIVE

- A. The nurse will examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. EKG
  3. Check the heart rhythm; note any irregularities
  4. Auscultate the lungs
  5. O<sub>2</sub> Sat
  6. Evaluate level of distress: mild, moderate, or severe
  7. Note general appearance (diaphoretic, SOB, skin coloring, fatigued)
  8. Note general orientation: alert, oriented, confused, or disoriented
  9. Observe for the following objective conditions and document presence or absence of:
    - a. Shortness of breath
    - b. Abnormal vital signs
    - c. Diaphoresis
    - d. Dizziness
    - e. Nausea/vomiting
    - f. Cyanosis
    - g. Weakness
    - h. Skin color (pink, mottled, cyanotic, gray, pale, flushed)
    - i. Skin temperature (warm, hot, cool, clammy, dry)
    - j. Swelling or edema in lower extremities, note if either is apparent in 1 or both extremities

## III. ASSESSMENT

Altered health maintenance

## IV. PLAN

- A. MD/PA/NP referral by nurse:
1. Age 35 or greater
  2. Personal history of CAD, family history of early CAD, hypertension, diabetes, high cholesterol, cocaine, or other stimulant use
  3. Severe pain, cardiac and/or respiratory distress
  4. SOB and any abnormal vital signs
  5. Abnormal skin color or peripheral circulation
  6. Strong suspicion of cardiac origin
  7. If unable to reach MD in reasonable time or is patient is unstable, call for an ambulance

## B. Nursing intervention:

1. Place patient in comfortable position, preferably lying down with head up
2. Notify physician
3. If patient does not have a contraindication to aspirin: chew 1 regular strength aspirin (325 mg)
4. Record vital signs
5. Reassure patient
6. Document status and treatment administered
7. Document history of pain, location, radiation, duration
8. Start oxygen at 2 liters/minute
9. If condition appears emergent, start IV any fluid and obtain subsequent order at 10 cc/hour
10. If condition appears emergent, administer Nitroglycerine Sublingual 0.4 mg if SBP > 100, document blood pressure reading and obtain subsequent order.
11. Be prepared to perform CPR/have AED available
12. Hold Nitroglycerine if blood pressure is low
13. Repeat Nitroglycerine q. 5 minutes x 3
14. Heartburn – Mylanta, 1 ounce (30 ml) x 1 time
15. Further orders as per MD

## C. Patient teaching

1. Encourage patient to relax since chest pain is not always serious, but a nurse or doctor should check the patient over
2. For recurrent chest pain, the patient should do the following:
  - a. Sit down for a few minutes
  - b. RELAX. Getting nervous will tighten up chest muscles and make the heart beat faster.
  - c. Breathe slowly and evenly with a pause between breaths
  - d. If symptoms do not go away fairly soon, see the nurse or sign up for sick call

**V. FOLLOW-UP**

As indicated by MD

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## Chest Pain – Musculoskeletal

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Non-cardiac chest pain may be symptomatic of cardiac disease such as angina pectoris, myocardial infarction, or pericarditis; or disease of the lungs such as pneumonia, pneumothorax, pulmonary embolism, or pleurisy; or caused by muscular or joint inflammation (costochondritis); or result of aortic dissection; or manifestation of referred pain from biliary or peptic ulcer disease.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has the pain been present?
  - 2. How did it start (i.e., with activity, at rest, etc.)?
  - 3. Any past medical history or family history of heart problems?
  - 4. Describe the pain (sharp, knife-like, tightness, squeezing, dull, stabbing, etc.)
  - 5. Any recent injury or muscle strain to the chest?
  - 6. Any associated symptoms (nausea, vomiting, dyspnea, dizzy, diaphoresis)?
  - 7. Pain level (1–10): At worst? Present?
  - 8. What relieves the pain? What intensifies the pain (coughing, breathing, activity)?

### II. OBJECTIVE

- A. The nurse will examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Check the heart rhythm; note any irregularities
  - 3. Listen to lungs and note any abnormal lung sounds
  - 4. Note general appearance (diaphoretic, SOB, skin coloring, fatigued)
  - 5. Observe for the following objective conditions and document:
    - a. Chest pain usually sharp and piercing which increased by deep breathing
    - b. Vital signs within normal limits
    - c. Heart sounds are regular rate and rhythm
    - d. Lungs are clear
    - e. Skin color normal
    - f. Dyspnea
    - g. Diaphoresis
    - h. Numbness radiating to arm, neck, shoulder, and jaw
    - i. If vital signs unstable or pain is severe and MD is not immediately available, call ambulance

### III. ASSESSMENT

Alteration in comfort

#### **IV. PLAN**

A. MD/PA/NP referral by nurse if:

1. Any respiratory distress – notify MD immediately
2. Notify MD immediately if there is any indication chest pain may be cardiac in origin
3. Evaluation of chronic pain
4. Any uncertainty of diagnosis
5. Presence of fever, shortness of breath, or productive cough

B. Nursing intervention:

1. If determined by MD/PA/NP to be musculoskeletal pain:
  - a. Reassure patient
  - b. Ice to affected area t.i.d.
  - c. Warm shower
  - d. For relief of discomfort, may offer: Ibuprofen 200 mg – take 2 tablets p.o. b.i.d. x 6 days
  - e. Limit activity for 3 days

C. Patient teaching:

1. Limit strenuous activity until pain has resolved
2. Take medications as ordered
3. Return if symptoms worsen or fail to resolve after 5 days to MD sick call
4. Reassure that pain is of muscular origin and not due to cardiac disease

#### **V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Chest Pain – Pleuritic

---

Chest pain (pleuritic) may be symptomatic of cardiac disease such as angina pectoris, myocardial infarction, or pericarditis; or disease of the lungs such as pneumonia, pneumothorax, pulmonary embolism, or pleurisy; or caused by muscular or joint inflammation (costochondritis); or result of aortic dissection; or manifestation of referred pain from biliary or peptic ulcer disease.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has the pain been present?
  - 2. How did it start (i.e., with activity, at rest, etc.)?
  - 3. Any past medical history or family history of heart problems?
  - 4. Describe the pain (sharp, knife-like, tightness, squeezing, dull, stabbing, etc.)
  - 5. Any recent injury or muscle strain to the chest?
  - 6. Pain level (1–10): At worst? Present?
  - 7. What relieves the pain? What intensifies the pain (coughing, breathing, activity)?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note presence of audible wheezing
  - 3. Note any appearance of being in respiratory distress
  - 4. Measure Peak Expiratory Flow Rate (PEFR)
  - 5. Skin color (pink, mottled, cyanotic, gray, pale, flushed)
  - 6. Skin temperature (warm, hot, cool, clammy, dry)
  - 7. Observe for the following objective conditions and document:
    - a. History of recent upper respiratory infection, arthritis, cardiac problems
    - b. Presence of abnormal vital signs with elevated respirations, elevated pulse, elevated systolic blood pressure, elevated temperature
    - c. Cyanosis, wheezing
    - d. Rhonchi, rales
    - e. Short, painful non-productive cough

### III. ASSESSMENT

Alteration in health maintenance

#### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. All cases of pleuritic pain
  - 2. History of recent infection
  - 3. Abnormal vital signs or high temperature
  - 4. Wheezing
  - 5. Evaluation of underlying disease
  
- B. Nursing intervention:
  - 1. Advise to splint rib cage when coughing
  - 2. May apply heat to relieve symptoms of discomfort for next 2–3 days. Instruct to change position and to lie on affected side occasionally to splint chest wall.
  - 3. Advise to follow prescribed treatment regimen and if no improvement in 3 days, get fever or cough up mucous, or experience SOB return to sick call
  
- C. Patient teaching:
  - 1. Limit strenuous activity until pain has resolved
  - 2. Take medications as ordered
  - 3. Reassure that pain is not of cardiac origin

---

## Chicken Pox/Shingles – Mild (Herpes Zoster)

---

Chicken pox is a viral infection, self-limiting that results in mild constitutional symptoms and macropapular eruptions on body.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Duration of symptoms
  - 2. Presence of rash, fever, general malaise
  - 3. Cough, shortness of breath, runny nose, upper respiratory infection
  - 4. Any known recent exposure to chicken pox

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note appearance of rash and distribution (rash associated with chicken pox is macular-papular-pustular in variety)
  - 3. Evaluate ear canals, oral mucosa, and eyes
  - 4. Note intensity of itching

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. All cases: implement the following protocol while awaiting MD evaluation.
    - a. Isolate until no drainage noted.
    - b. Bed rest
    - c. For relief of discomfort, may offer: Acetaminophen 325 mg – take 1–2 tablets p.o. b.i.d. x 6 days p.r.n. pain
    - d. Notify the infection control nurse
    - e. Calamine lotion to lesions p.r.n. for itching, dispense 1 bottle
    - f. Diphenhydramine 25 mg p.o. b.i.d. p.r.n. x 3 days for itching (D.O.T.)
- B. Patient teaching:
  - 1. Avoid scratching
  - 2. Will remain in isolation until lesions have crusted over (approx. 10–12 days)
  - 3. If oral lesions exist, give a bland diet

---

## Cold (Rhinitis/Sinusitis)

---

A cold is a contagious viral infection of the upper respiratory tract, usually caused by a strain of rhinovirus. It is characterized by rhinitis, myalgias, low-grade fever, and malaise.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has the cold been present?
  - 2. Is there any nasal congestion, runny nose or post-nasal drip?
  - 3. Any chest congestion? A cough? Productive or non-productive? If productive, determine color and amount.
  - 4. Any pain in the throat, ears or face? Tenderness in the sinuses?
  - 5. Past history of sinusitis or allergies?
  - 6. Any headache? Fever?
  - 7. Any medical problems?
  - 8. On any medications? Any allergies?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note lung sounds and presence of any sputum
  - 3. Examine ear canal for redness or other abnormalities
  - 4. Note absence or presence of redness or drainage of eyes
  - 5. Check neck area for enlarged or tender lymph nodes
  - 6. Look into throat, note redness, inflammation, or presence of exudates

### III. ASSESSMENT

Alterations in health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Temperature is > 101°F
  - 2. Symptoms not resolved within 5 days
  - 3. Cough is severe or productive in nature
  - 4. Throat is bright red
  - 5. Increased pulse rate/shortness of breath
  - 6. Patient has chronic lung disease
  - 7. Patient is pregnant

**B. Nursing intervention:**

1. Advise patient to rest in bed and increase fluid intake
2. Instruct patient on proper hand washing technique
3. For rhinorrhea, sneezing or post-nasal drip: Give Loratadine 10 mg p.o. daily x 5 days (D.O.T.)
4. For muscle aches or low-grade fever: Give Acetaminophen 325 mg tabs 2 p.o. q. b.i.d. p.r.n. x 6 days or Ibuprofen 200 mg tabs 2 p.o. b.i.d. p.r.n. x 6 days
5. For cough: Give Guaifenesin 200 mg 2 tabs p.o. b.i.d. p.r.n. x 5 days (D.O.T.)

**C. Patient teaching:**

1. Increase fluid intake
2. Medication instruction
3. No smoking

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist for over 5 days

---

## Cold Sores/Fever Blisters/Herpes Simplex

---

Cold sores are a common, contagious viral infection caused by the herpes virus that invades the skin. Sores are most common on the lips but can be on the cornea (rarely) and the genitals.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When did the ulcer appear?
  - 2. Have you experienced these before and what treatment did you receive?
  - 3. History of sexual activity if sores are apparent on genitals.

### II. OBJECTIVE

- A. The nurse will examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Size and location of all affected areas
  - 3. Assess for any precipitating physical or emotional distress

### III. ASSESSMENT

- A. Alteration in skin integrity
- B. Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral:
  - 1. Immediate referral if eyes or genitals are involved
  - 2. Refer to mental health if extreme anxiety is present
  - 3. Pustules are severe and patient appears in serious distress
- B. Nursing intervention:
  - 1. Apply an ice cube for 1 hour during the first 24 hours after a lesion appears
  - 2. Acetaminophen 325 mg 1–2 tabs q. 4 hours p.r.n. for minor discomfort x 6 days
  - 3. Notify provider
- C. Patient teaching:
  - 1. Blisters are contagious and may be transmitted by person-to-person contact
  - 2. Good hand washing to prevent spread to other areas of the body
  - 3. Avoid excess sun exposure. To prevent flareups, use sunscreen on lips when spending time outdoors.
  - 4. Medication teaching for any antiviral medications that are ordered

**V. FOLLOW-UP**

- A. Return to clinic in 1 week if sore has not healed
- B. Return to clinic if new lesions appear or if fever becomes present

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## Conjunctivitis/ Pinkeye

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Conjunctivitis is an inflammation of the eyelid's underside and the white part of the eye. May be caused by virus, bacteria, chemical irritant, or allergies.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When did the symptoms appear?
  - 2. Is discomfort an itch, burning sensation, or both?
  - 3. Have you noticed any discharge from the eye?
  - 4. Have you experienced these before and what treatment did you receive?

### II. OBJECTIVE

- A. Examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, O<sub>2</sub> Sat, and blood pressure
  - 2. Presence of any discharge
  - 3. Presence of crust on lashes
  - 4. Presence of swelling of the eyelid
  - 5. Sensitivity to bright light

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral if:
  - 1. Redness, pain, and discharge are present
  - 2. Fever is present of 99.4°F or above
- B. Nursing intervention (verify medications and allergies prior to treatment):
  - 1. Acetaminophen 325 mg 1–2 tabs q. 4 hours p.r.n. for minor discomfort x 6 days
  - 2. Cool water rinse to eye as indicated
- C. Patient teaching:
  - 1. Avoid touching eye
  - 2. Good hand washing as this is most often spread by hand contact
  - 3. Use disposable tissues for drainage and dispose properly
  - 4. Avoid eye makeup or other potential irritants as long as any symptoms are present
  - 5. Medication teaching

**V. FOLLOW-UP**

- A. Return to clinic in 5 days
- B. Return to clinic if symptoms worsen or if fever becomes present
- C. Return to clinic immediately if vision is affected

---

## Constipation

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Constipation is defined as difficult passage of stools, manifested as either decreased stool frequency, an incomplete evacuation of stool or passage of hard stools.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. When was your last bowel movement?
2. What is the color and consistency of your stools?
3. Any pain, nausea, vomiting, and/or abdominal distention (if yes, refer to these specific protocols additionally)?
4. Current medications?
5. Any similar episodes in the past? Treatment utilized?
6. Is this a chronic, longstanding problem?
7. What is your current level of physical activity?
8. Dietary patterns?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Presence or absence of abdominal distention
3. Presence or absence of bowel sounds
4. Any apparent discomfort when standing erect
5. Presence of hemorrhoids

### III. ASSESSMENT

Alteration in elimination

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. Temperature > 101°F
2. Patient indicates constipation is alternating with diarrhea
3. Presence of pain
4. Unexplained vomiting
5. If symptoms persist after 3 days
6. Inability to stand erect
7. Diminished or absent bowel sounds
8. Blood in stool
9. Pregnancy

## B. Nursing intervention:

1. Milk of Magnesia 30 cc q.h.s. x 3 days followed by a glass of water then p.r.n. q.h.s. x 3 days (avoid MOM in patients with renal insufficiency)
2. Fiber-lax - p.o. b.i.d. x 3 days (D.O.T.)
3. Colace 200 mg p.o. b.i.d. x 3 days (D.O.T.)

## C. Patient teaching:

1. Medication instruction
2. Increase oral fluid intake
3. Increase level of physical activity if able
4. Select fruit and vegetables for diet when possible
5. Follow-up to sick call if symptoms persist after 3 days, or if they worsen in severity

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Contusions – Mild

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Contusions result from trauma to soft tissues with discoloration and bruising.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. What caused the injury (accident, work related, assault, self-inflicted)?
  2. Where did it happen and at what time?
  3. What type of object caused the injury?
  4. Any history of allergies, excessive bleeding, diabetes, asthma, or any other chronic illnesses?
  5. Last tetanus?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Note area of injury, size, presence of any bleeding, serious drainage, swelling, edema, or discoloration of skin
  3. Assess for any disfigurement or alteration of ROM
  4. If extremity involved check for palpable distal and proximal pulses
  5. For abdominal injuries, evaluate abdominal bowel sounds, organomegaly
  6. Note if patient is on Coumadin therapy

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
1. Wounds over joints
  2. Any impairment of function
  3. Poor peripheral pulses
  4. Any assault wounds to the head, face, chest, abdomen, or back
  5. Swelling/edema covering large surface
  6. Associated syncope, loss of consciousness, or other abnormal neurological status
  7. If injury is self-inflicted, refer to mental health

B. Nursing intervention:

1. Apply cold pack p.r.n.
2. Immobilization/ace wrap/splint as indicated
3. For self-inflicted injuries, refer to mental health staff
4. Acetaminophen 325 mg 2 tabs b.i.d. p.r.n. x 6 days

C. Patient teaching:

1. Keep area immobile for 24 hours
2. Return to sick call the next day, or sooner if any problems occur (i.e., impaired circulation)
3. If work-related injury, instruct in preventive measures to prevent recurrence

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Coronavirus (aka: COVID-19)

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COVID-19 is an easily transmitted coronavirus. A coronavirus is transmitted through droplets and through the air. For personal safety and to help prevent the spread of COVID-19, Personal Protective Equipment (PPE) including masks, face shields, gowns, gloves, and social distancing are recommended for a positive diagnosis of COVID-19.

For nurse sick call, PPE would include mask (N-95), face shield (if risk of droplet exposure), gloves, and gown. Thorough handwashing before and after patient contact are a must. In addition, have the patient don a surgical mask.

Although symptoms can vary, the most common symptoms of COVID-19 include fever (>100.4 F), cough, and shortness of breath.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have the symptoms been present?
  - 2. Any cough? Productive? (describe)
  - 3. Any shortness of breath?
  - 4. Any pain in the throat, ears or face? Tenderness in the sinuses?
  - 5. Past history of sinusitis or allergies?
  - 6. Any headache? Fever?
  - 7. Any nausea/vomiting?
  - 8. Any medical problems?
  - 9. On any medications? Any allergies?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O2 sat, and weight
  - 2. Note lung sounds and presence of any sputum
  - 3. Is the patient in respiratory distress?
  - 4. Note color of skin and mucous membranes

### III. ASSESSMENT

Alterations in health maintenance

#### IV. PLAN

A. MD/PA/NP referral by nurse:

1. Temperature is > 100.4°F
2. Pulse ox < 94% on room air
3. Cough is severe or productive in nature
4. Increased pulse rate/shortness of breath
5. Patient has chronic lung disease
6. Patient is pregnant

B. Nursing intervention:

1. Isolate the patient
2. Advise patient to rest in bed and increase fluid intake
3. Instruct patient on proper hand washing technique
4. Perform a rapid COVID-19 test
5. If rapid COVID-19 test is positive and the inmate-patient has already completed a course of zinc and vitamin D, notify the provider for further orders
6. For fever: Give Acetaminophen 325 mg tabs 2 p.o. q. b.i.d. p.r.n. x 6 days or Ibuprofen 200 mg tabs 2 p.o. b.i.d. p.r.n. x 6 days
7. For cough: Give Guaifenesin 200 mg 2 tabs p.o. b.i.d. p.r.n. x 5 days (D.O.T.)
8. Notify provider, nursing supervisor, site mgr., and security of suspected COVID-19 case
9. Symptomatic patients require close monitoring for respiratory distress. Notify provider for orders to admit to the medical unit

C. Patient Teaching:

1. Isolation and use of face mask
2. Hand washing guidelines
3. Increase fluid intake
4. Medication instruction
5. No smoking

#### V. FOLLOW-UP

1. The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
2. The individual's other symptoms have improved (e.g., cough, shortness of breath) **AND**
3. The individual has tested negative in at least two consecutive respiratory specimens collected at least 24 hours apart

- B. For individuals who will NOT be tested to determine if they are still contagious:
  - 1. The individual has been free from fever for at least 72 hours without the use of fever-reducing medications **AND**
  - 2. The individual’s other symptoms have improved (e.g., cough, shortness of breath) **AND**
  - 3. At least 10 days have passed since the first symptoms appeared
  
- C. For individuals who had a confirmed positive COVID-19 test but never showed symptoms:
  - 1. At least 10 days have passed since the date of the individual’s first positive COVID-19 test **AND**
  - 2. The individual has had no subsequent illness

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## Cough/Chest Congestion

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A cough is a sudden audible expulsion of air from lungs. Coughing is an essential protective response that serves to clear the lungs, bronchi, or trachea of irritants and secretions or to prevent aspiration of foreign material into the lungs. Chronic coughing may be indicative of post-nasal drip syndrome, URI, pneumonia, tuberculosis, lung cancer, bronchiectasis, bronchitis, allergies, or asthma.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. How many days have you had the cough?
2. Is the cough productive or non-productive? If productive, amount and color of sputum. Have you coughed up blood?
3. Any other associated symptoms (congested or runny nose, stiff neck, headache, fever, earache, sore throat, SOB, chills, diaphoretic, wheezing, tightness in chest, chest pain)
4. Any history of asthma, allergies, cigarette smoking, or heart problems?
5. Any medical problems? Currently taking any medications?
6. Any allergies to food, medication or environmental agents?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Listen to lung sounds
3. Examine throat, nasal passages, and ear canals
4. Presence or absence of lymph node enlargement
5. Note skin color: pink, mottled, cyanotic, gray, pale, flushed
6. Note skin temperature: Warm, hot, cool, clammy, dry

### III. ASSESSMENT

Alteration in health maintenance

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. Fever > 101°F
2. Severe headache
3. Stiff neck
4. SOB
5. Blood is coughed up
6. Cervical lymph node enlargement is noted
7. Evidence of night sweats
8. Evidence of weight loss
9. Recurring diarrhea
10. Diminished breath sounds
11. Pain with cough
12. Cough unresolved after protocol implemented x 5 days

## B. Nursing intervention:

1. For muscle aches or low-grade temp: Give Acetaminophen 325 mg 2 tabs p.o. b.i.d. p.r.n. x 6 days
2. For dry cough: Give Guaifenesin 200 mg 2 tabs p.o. b.i.d. p.r.n. x 5 days (D.O.T.)
3. For allergy symptoms: Give Loratadine 10 mg p.o. daily p.r.n. x 5 days (D.O.T.)

## C. Patient teaching:

1. Increase fluid intake
2. Proper hand washing
3. Medication instructions
4. No smoking
5. Follow-up after 5 days to sick call if symptoms have not improved, or if symptoms worsen

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist for more than 1 week

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## "Crabs" (Pediculosis): Body, Head and Pubic Lice

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“Crabs” is an infestation of a body louse with predilection for body, head, or pubic area resulting in intense itching.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Duration of symptoms?
  - 2. Any itching or crawling sensations of scalp, body, or pubic area?
  - 3. Are your close contacts (cellmate, etc.) experiencing similar symptoms?
  - 4. Any past history of pediculosis? If so, past treatment?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Utilize a hand magnifier if available and assess the scalp, body, and pubic area for crabs or live louse (separate the hairs with a wooden toothpick)
  - 3. Note areas of itching, rash, and any associated secondary infections

### III. ASSESSMENT

- A. Alteration in comfort
- B. Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. If infestation persists after 2 treatment applications and/or signs of infection
  - 2. If infestation involves eyelashes
  - 3. If patient is allergic to pyrethrin preparations
  - 4. If inmate is pregnant
- B. Nursing intervention (verify medications and allergies prior to treatment):
  - 1. Head lice
    - a. Have the patient wash their hair with regular shampoo, rinse with water, and towel dry so it remains damp but not wet
    - b. Instruct the patient to apply lice-killing shampoo or lotion to wet hair and to entire body. Leave on for 10 minutes then rinse with warm water. Do not throw away the remainder since a second treatment may be needed.
    - c. After 7 days, reevaluate. If crabs still present, apply second treatment
    - d. Notify security/housing unit so they may follow their procedures

2. Pubic lice
  - a. Apply lotion to affected area and wash off after 10 minutes. Do not throw away the tube.
  - b. Remove nits with fingernails or with fine-toothed comb and put on fresh clothing
  - c. Repeat treatment in 10 days if lice are still found using the original bottle or tube

C. Patient teaching:

1. Follow medication label instructions
2. Wear clean clothing. If item cannot be laundered, dry clean or isolate in a sealed plastic bag for 30 days.
3. Instruct the patient to wash combs or brushes with soap, and rinse in hot water for 5–10 minutes
4. Importance of follow-up in 7 days to be rechecked in sick call. Another application may be necessary if nits continue to be present.
5. Reassurance

## V. FOLLOW-UP

Return to sick call if symptoms worsen or persist for more than 1 week

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## Dandruff (Seborrhea)

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Dandruff is the normal exfoliation of the epidermis of the scalp in the form of dry, white scales.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has this problem existed?
  - 2. Is this a recurring problem? Past treatment and effect?
  - 3. Are flakes noticeable?
  - 4. Hygiene practices (i.e.; type of shampoo and how often hair is shampooed)

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Degree of flaking (extensive, mild, minimal)
  - 3. Check scalp for open sores or localized redness
  - 4. Check eyebrows and nose creases for involvement

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. If open sores, localized redness or recurring problem that does not resolve with treatment protocol after 1 month
  - 2. Secondary infection present
  - 3. Previous treatment by physician
- B. Nursing intervention:
  - 1. Dandruff shampoo from commissary, 3 times a week (x 6 packets)
- C. Patient teaching:
  - 1. Shampoo use as prescribed. Be aware that oil glands will be stimulated to produce more oil by excess scalp massage. Avoid contact with eyes. Rinse thoroughly after use to prevent hair discoloration. Protect from heat – decreases effectiveness. Discontinue use if sensitivity occurs x 4 days.

### V. FOLLOW-UP

- A. Return to sick call if symptoms worsen or fail to improve after 1 month

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## Dermatitis

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Contact dermatitis is an inflammatory condition of the skin, characterized by erythema, pruritis and/or pain.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. How long has this been bothering you?
  2. Any similar episodes in the past? If so, how was it resolved, and was it effective?
  3. Were you in contact with any known or new irritant (i.e., soap, different foods, environmental exposure, etc.)? Any history of allergies?
  4. Shortness of breath?
  5. Are you taking any medications?
  6. Are you experiencing itching?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Note location of rash or skin lesions, type of rash, and size
  3. Observe all skin eruptions carefully for signs of infection such as heat, redness, drainage, or honey-colored circular lesions, which could indicate a staph infection and requires MD referral
  4. List of medications – any new orders or antibiotics
  5. Name of recent contacts
  6. HIV status?
  7. Check for any associated secondary infections

### III. ASSESSMENT

Altered skin integrity

#### IV. PLAN

A. MD/PA/NP referral by nurse:

1. Anytime shingles is suspected
2. Abnormal vital signs
3. Numerous blisters involving large area
4. Lesions around eyes
5. Lesions with signs of infection
6. Difficulty breathing
7. Skin condition resistant to treatment protocol after 2 weeks associated with secondary infection
8. Temp > 101.4°F
9. Draining lesions
10. HIV (+)

B. Nursing intervention:

1. Cleanse skin well. Apply calamine lotion p.r.n. itching and dispense 1 tube.
2. Instruct patient to not scratch the rash and wash daily with soap and water.
3. Hydrocortisone 1.0% Cream. Apply b.i.d. Do not apply to open wounds/lesions or suspected fungal infections. Otherwise, may use as needed for 5–7 days.

C. Patient teaching:

1. Avoid substances causing the irritation
2. On proper medication use
3. Wash skin regularly with soap and water. Dry skin well. Removing oil from skin prevents spread of some rashes.
4. Avoid scratching and picking to prevent infection. Keep nails clean and short.
5. Cold showers may give temporary relief
6. Encourage exposure to air when possible
7. Keep the involved area clean and dry
8. Importance of follow-up in sick call if no improvement is seen with treatment or if symptoms worsen
9. Wash hands frequently

#### V. FOLLOW-UP

Return to sick call if symptoms worsen or persist after treatment plan is followed

---

## Diarrhea

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Diarrhea refers to the frequent passage of loose, watery stools. The stool may also contain mucous, pus, blood, or excessive amounts of fat.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. When did the diarrhea start?
2. How many stools have you had?
3. What is the color and consistency? Have you noticed any blood or mucous?
4. Is there any pain involved (if yes, refer to protocol on stomach ache)?
5. What did you eat and drink before the diarrhea began?
6. Have you had any accompanying nausea/vomiting?
7. Stressful events in your life?
8. Any associated fever, chills, night sweats, vomiting, or weight loss (if yes, screen for any high-risk behavior such as homosexuality, IVDA, blood transfused, sexual contact with an HIV positive partner)?
9. Any similar episodes in the past? If so, did you seek treatment, and was it effective?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Listen to bowel sounds in all 4 quadrants. Assess abdomen for any tenderness.
3. Abdominal distension?
4. Evaluate stool if available
5. Evaluate skin turgor for signs of dehydration

### III. ASSESSMENT

- A. Alteration in elimination
- B. Alteration in comfort

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. Fever > 101°F
2. Presence of blood or mucous in the stool
3. Presence of vomiting
4. Dehydration is suspected
5. Abdominal pain present for 24 hours if noted to be high risk for HIV or known HIV positive
6. Absent bowel sounds
7. Abdomen distended
8. Severe pain; severe bleeding
9. Pregnancy
10. Symptoms continue despite treatment protocol

## B. Nursing intervention:

1. Pepto Bismol 15 ml (1 tbsp) or 1 tab every 2 hours for diarrhea p.o. x 3 days. Instruct patient not to exceed 8 doses per day. Dispense 1 bottle or 24 tabs
2. If no relief after 3 days, dispense loperamide 4 mg (2 caps) x 1, then ask patient to return if symptoms present

## C. Patient teaching:

1. Reduce intake of solid foods. Instruction of what food to avoid/limit.
2. Increase oral fluids
3. Diet instructions for food to choose to promote good bowel habits once diarrhea has subsided
4. No dairy products for 3–6 days

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist for more than 3 days

---

## Dizziness (Vertigo)

---

Dizziness (vertigo) is a sensation of faintness or inability to maintain normal balance in a standing or seated position, sometimes associated with giddiness, mental confusion, nausea, and weakness.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have you been dizzy?
  - 2. Other symptoms (i.e., nausea, vomiting, hearing loss, noisy sounds in the ear, diplopia)?
  - 3. Have you experienced recent head injury or loss of consciousness?
  - 4. Are you experiencing problems walking?
  - 5. Is dizziness related to a change of positions?
  - 6. Any similar episodes in the past? If so, did you seek treatment, and was it effective?
  - 7. What medications are you taking (be alert to anti-hypertensives, analgesics, psychotropic, sedatives, and diabetic agents)?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, O<sub>2</sub> Sat, blood pressure lying, sitting, and standing if possible (note for a systolic drop of > 15 mm hg.), and weight
  - 2. PERRLA, check for equal hand grasps; watch for ability to walk a straight line with eyes closed
  - 3. Inspect ear canal for redness or other signs of infection
  - 4. Determine pregnancy status

### III. ASSESSMENT

- A. Alteration in comfort
- B. Alteration in health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Any recent head trauma or loss of consciousness
  - 2. Patient appears to be in acute distress
  - 3. Any difficulty walking noted
  - 4. Symptoms indicate possible ear infection
  - 5. Abnormal vital signs and/or PERRLA or hand grasps
  - 6. Reported or objective finding of lateralizing weakness or numbness in any extremity
  - 7. Symptoms that persist or worsen despite treatment protocol

B. Patient teaching:

1. Relative to the cause of dizziness (i.e., medication induced vs. inner ear infection vs. dehydration)
2. Limit activity if dizzy to prevent fall or injury
3. Relevant dietary instruction
4. Instruct to:
  - a. Avoid standing quickly from a supine position
  - b. Eat properly with adequate fluid intake
  - c. Get adequate rest

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist longer than 2 days

---

## Drug Overdose

---

A drug overdose is an excessive and potentially toxic amount of medication, given in error, or taken intentionally.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. What was taken (number, dose)
  2. Any other medication ingested such as acetaminophen or other OTC?
  3. Alcohol or other substance ingested?
  4. Time of overdose?
  5. Reason for overdose (suicide attempt or other)?
  6. Have you vomited?
  7. Current symptoms – nausea, dizziness, etc.?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following:
1. Temperature, pulse, respirations, O<sub>2</sub> Sat, and blood pressure every 10 minutes
  2. Assess orientation, behavior
  3. Check pupillary reflex
  4. Note any unusual odors
  5. Evaluate for any injuries
  6. Reconcile history with medication administration record and other sources, as available

### III. ASSESSMENT

Altered health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
1. All cases of suspected overdose
  2. If intentional and self-induced notify mental health
- B. Nursing intervention:
1. Administer 75 grams activated charcoal if gag is present; await further physician's orders (do not give if ingestion of caustic substance is known or suspected)
  2. Per MD order, start IV, normal saline at 250 cc/hour
  3. Keep under direct observation while in health care unit
  4. EKG, stat. blood work on physician's order

- C. Patient teaching
  - 1. Potential for organ damage from overdose

**V. FOLLOW-UP**

- A. Ensure future DOT (directly-observed therapy)
- B. Mental health follow-up

---

## Drug Psychosis

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An individual who has used either an illicit or prescription drug which has caused the patient to have delusions.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Have you been diagnosed or treated for mental health problems in the past?
  - 2. Are you currently on any medications? When was the last time you took this medication?
  - 3. Are you using any street drugs? What type? How much? How often?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Look for signs and symptoms described or displayed by the patient
  - 3. Schedule the inmate to be seen by the psychologist
  - 4. The psychologist, upon completion of an assessment, shall make the determination as to whether the local mental health agency should be called for a temporary detention order screening or if the individual shall be placed in infirmary/observation, to be monitored closely.
  - 5. Prior to contacting the psychologist, the individual shall be placed in infirmary/observation, to be monitored closely.

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

- A. Treatment:
  - 1. Refer to MD/psychiatrist

---

## Dry Skin

---

Dry skin is the scaling/peeling of skin resulting from excessive dryness and repeated washing in winter months.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have you had this problem?
  - 2. Any itching?
  - 3. Recent exposure to chemical or environmental agents?
  - 4. What medications are you taking?
  - 5. Daily fluid intake?
  - 6. Any past history of dry skin? Any past treatment utilized?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note skin condition: areas of dryness, flaking, open areas due to scratching and signs of secondary infection.

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Chronic problem unresponsive to treatment protocol
  - 2. Secondary infection
- B. Nursing intervention:
  - 1. Self-administered application of body lotion (buy from commissary) at least daily (twice preferred)
- C. Patient teaching:
  - 1. Topical lotion should be applied immediately after bathing (before drying) while the skin is damp. Towel dry lightly. Use caution to avoid slipping.
  - 2. Avoid the use of hot water as it has a drying effect. Tepid water is preferred. Limit use of soap.
  - 3. Increase oral fluid intake
  - 4. If no relief after 1 month, may return to sick call for follow-up

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Dysmenorrhea (Menstrual Cramps)

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Dysmenorrhea is periodic pelvic (uterine) cramps associated with first day or 2 of menses (period).

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have you had the cramps, and where are you in your menstrual cycle?
  - 2. Do you have history of cramps with your menstrual cycle?
  - 3. Onset, duration and quality of cramping/pain?
  - 4. Other related symptoms (i.e., bleeding, back pain, swelling, nausea, diarrhea, headache, etc.)?
  - 5. Are you/could you be pregnant?
  - 6. Any past treatment, relief measures tried, and effectiveness of relief measures?
  - 7. Have you had past gynecological surgeries?
  - 8. Current medications/BCP?
  - 9. Any bleeding, clotting, or foul odor noted?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Associated abdominal cramping, assess abdomen, and bowel sounds

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. If pain persists despite medication x 3 days, if accompanied with severe bleeding
  - 2. If patient is pregnant
  - 3. If abdominal exam is abnormal
  - 4. If blood pressure < 100 systolic and/or pulse > 90
- B. Nursing intervention:
  - 1. For relief of discomfort, may offer: Ibuprofen 200 mg – take 2 tablets p.o. b.i.d. x 6 days p.r.n.  
OR
  - 2. Acetaminophen 325 mg – take 2 tablets p.o. b.i.d. x 6 days p.r.n.

C. Patient teaching:

1. Medication use
2. Warm applications p.r.n. as indicated
3. If able, increase level of physical activity to decrease pain and cramping
4. Dietary instruction (decrease salt, limit caffeine)
5. Encourage maintenance of menstrual cycle calendar to monitor cycles
6. Importance of follow-up to sick call if no relief within 7 days, or if symptoms worsen

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Earache/Ear Wax Impaction

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An earache is a pain in the ear, sensed as sharp, dull, burning, intermittent, or constant. Common causes include inflammation or infection of the external canal (otitis externa or (“Swimmer’s Ear”), middle ear infections (otitis media), excessive wax build-up, foreign bodies and sinus problems. Other disorders may result in referred pain to the ear, such as disorders of the sinuses, nose, oral cavity, larynx, temporomandibular joint, and scalp.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have you had the earache, and in which ear?
  - 2. Have you recently had a cold, cough, fever, or sore throat?
  - 3. Is the pain mild or severe?
  - 4. Has there been any drainage or hearing loss?
  - 5. Have you put anything in your ear(s)?
  - 6. Have you been swimming recently?
  - 7. Any past history of earaches, ear infections, or ear surgery?
  - 8. Any recent medications added?
  - 9. Allergies to medication?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Look into the ear, nose, and throat for swelling, drainage or redness, color of tympanic membrane, any perforation
  - 3. Appearance of scalp, face, external ear, and oral cavity (note any rash, swelling, dental caries, redness or exudates in the tonsillar area, etc.)
  - 4. Check neck for node enlargement or pain
  - 5. Test hearing (grossly) by rubbing fingers together at ear or placing watch to ear

### III. ASSESSMENT

- A. Alteration in comfort
- B. Alteration in health maintenance

**IV. PLAN**

## A. MD/PA/NP referral by nurse if:

1. If redness with fever > 101°F
2. Patient appears in acute distress
3. Any abnormalities noted ear exam
4. Drainage or swelling noted from either ear
5. There is excessive ear wax build-up apparent requiring medication or manual extraction
6. Hearing loss is noted
7. Inability to visualize tympanic membranes
8. Enlargement of or tenderness of lymph nodes of neck noted
9. Symptoms that fail to respond to treatment protocol

## B. Nursing intervention:

1. Debrox per instruction  
OR
2. Irrigate ear using warm water then remove with ear syringe
3. Refer to clinic for warm water irrigation after 3 days
4. For relief of discomfort, may offer: Acetaminophen 325 mg – take 1–2 tablets p.o. b.i.d. x 3 days p.r.n.  
OR
5. Ibuprofen 200 mg – take 2 tablets p.o. b.i.d. x 3 days p.r.n.

## C. Patient teaching

1. Do not put anything in the ear
2. Importance of follow up in 3 days

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Eye Injuries

---

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. When and how did the injury happen?
  2. Are you experiencing any visual changes?
  3. Are you in pain?
  4. Last tetanus?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Describe the eye if any external injury is apparent
  3. Look for foreign body
  4. Conduct visual acuity and PERRLA, except when a chemical injury has occurred

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
1. All eye injuries will be referred to the MD as per the following:
  2. For corneal abrasions: if abrasion is deep or large, if a change in visual acuity, or any abnormal PERRLA
  3. For foreign body: if object on cornea, not freely moveable, or if unable to locate the foreign body
  4. For contusions: if bleeding into the orbit anterior chamber
  5. For penetrating injuries, flash burns, or chemical burns: always refer to MD
- B. Nursing intervention:
1. Black eye (contusion)
    - a. Apply cold pack
    - b. Refer to MD immediately if bleeding is severe, or on next visit if bleeding is minor
    - c. Ibuprofen 200 mg 1 – 2 tabs p.o. b.i.d. p.r.n. x 6 days

2. Penetrating object
    - a. Do not remove object
    - b. Bandage around the object and patch eye
    - c. See MD stat.
  3. Flash burn (welding)
    - a. Cool, moist compress to eyes
    - b. Acetaminophen 1-2 tabs b.i.d. p.r.n. x 6 days
    - c. Keep in dark room
    - d. Refer to MD
  4. Chemical
    - a. Flush eye with at least 500 cc of normal saline with IV tubing using Morgan lens (if not available, flush with water, and transport to infirmary ASAP and flush there)
    - b. Refer to MD
- C. Patient teaching:
1. Do not rub eyes
  2. Reinforce pertinent treatment plan (patch eye, dark room, etc.)
  3. If injury could have been prevented, instruct on safety measures
  4. Importance of prompt follow-up to physician as instructed, or if any problems occur (i.e., change in visual acuity, increase in pain)

## V. FOLLOW-UP

Return to sick call if symptoms worsen or persist

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## Fracture, Dislocation, Sprains

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A fracture is a break in a bone or cartilage. A dislocation is a displacement of a body part, especially the temporary displacement of a bone from its normal position. A sprain is a painful wrenching or laceration of the ligaments or joints.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. Allergies?
2. When did the injury occur?
3. How did it happen?
4. Did it swell immediately?
5. Describe the type and intensity of pain
6. Any previous injury to the same site?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Assess for deformity, alteration in ROM, swelling, discoloration, numbness, temperature
3. Note any loss of function
4. Note any loss of sensation
5. Check pertinent pulses

### III. ASSESSMENT

- A. Alteration in comfort
- B. Alteration in mobility potential

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  1. Anytime fracture or dislocation is suspected or apparent notify MD stat. and be prepared to activate EMS if indicated
  2. Any deformity apparent
  3. Severe pain or swelling noted at injury site
  4. Discoloration noted at injury site
  5. Any impairment of ROM
  6. Lack of warmth to touch
  7. Pulses diminished or absent

B. Nursing intervention:

1. Cold pack times 24 hours, then heat x 24 hours for suspected sprains
2. Acetaminophen 325 mg., 1–2 tablets, t.i.d., p.r.n. times 4 days
3. Immobilize with ace wrap/splint
4. May issue lay in x 2–3 days
5. Complete injury report

C. Patient teaching:

1. Medication use
2. Application of cold
3. No weight bearing, elevation
4. Crutch walking, if applicable
5. Safety measures
6. Importance of follow-up

---

## Headache

---

A headache (or cephalgia) is a pain in the head from any cause. Common types of headaches include migraine headaches, tension headaches, sinus headaches, and headaches from medication.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. Have you experienced any recent head trauma, seizures, migraines, allergies, hypertension, stress?
2. Can you touch your chin to the chest without opening your mouth?
3. Are you drowsy or confused? Was there an aura before the onset?
4. Where is the pain (is the pain generalized or localized around the eyes, ears, throat, etc.)?
5. Describe the pain
6. Is there nausea, vomiting, dizziness, blurred vision, diplopia or photophobia?
7. How long have you had the headache?
8. Do you have a history of similar episodes? If so, what treatment is effective?
9. Any recent ingestion of medication?
10. Allergic to medication?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Observe for substance abuse (i.e., altered level of consciousness, needle marks, slurred speech, etc.)
3. PERRLA, hand grasps
4. General appearance
5. Ability to touch chin to chest with mouth closed (test for stiff neck)
6. Visual acuity

### III. ASSESSMENT

Alteration in comfort

#### IV. PLAN

A. MD/PA/NP referral by nurse:

1. If any recent head injury reported
2. Patient complains of or Nurse notes stiffness of neck
3. Patient is confused, or vital signs abnormal
4. Pain localized at eyes, ears
5. Nausea or vomiting reported
6. Dizziness or photophobia noted
7. Diplopia noted
8. Headache continues despite treatment protocol
9. First occasion of SEVERE headache
10. Comment "Worst headache I have ever had" and patient appears in acute distress

B. Nursing intervention:

1. For relief of discomfort, may offer:
  - a. Acetaminophen 325 mg – take 1–2 tablets p.o. b.i.d. x 6 days p.r.n.  
OR
  - b. Ibuprofen 200 mg, 2 tabs p.o. b.i.d. p.r.n. (max OTC dose is 1200 mg per day) x 6 days
2. Cool compresses to head if desired

C. Patient teaching:

1. Relative to cause of headache
2. Take Rx as instructed
3. Referral to physician clinic if symptoms persist, or if they intensify (i.e., development of stiff neck, nausea, vomiting)

#### V. FOLLOW-UP

Return to sick call if no improvement in 3 days

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## Heat Exhaustion

---

Heat exhaustion is an abnormal condition characterized by fatigue, weakness, anxiety, nausea, muscle cramps, and sometimes loss of consciousness, caused by depletion of body fluid and electrolytes as a result of exposure to high ambient temperature.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When and for how long were you exposed to excessive heat?
  - 2. Other symptoms (i.e., weakness, dizziness, headache with muscle cramps, dim or blurred vision, mental confusion, muscular incoordination)
  - 3. When did symptoms start?
  - 4. Have you had any nausea and vomiting?
  - 5. Have you had any uncontrolled shaking or tremors?
  - 6. Chronic medical problems?
  - 7. Medications? Allergies?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Observe for the following objective conditions and document:
    - a. Weakness, dizziness, and headache with muscle cramps
    - b. Skin turgor, color, cool to touch, pale, moist, dry or hot
    - c. Vision dim or blurred
    - d. Presence of mental confusion and muscular incoordination

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Fever > 101°F, pulse > 120 or SBP < 90
  - 2. Patient does not rapidly respond to nursing interventions
  - 3. Abnormal mental status is apparent
  - 4. History of chronic illness on medication

**B. Nursing intervention:**

1. If patient appears in an emergent condition may start IV normal saline and obtain subsequent order. Prepare to activate EMS and begin cooling methods below:
  - a. Place patient in a cool place in reclining position and remove clothing
  - b. Aggressively cool external body with fans and cool water bath
  - c. Elevate feet
  - d. Give water if alert and able to swallow

**C. Patient teaching**

1. Drink at least 8 glasses of water a day (if not contraindicated)
2. Avoid strenuous exercise during the heat of the day
3. Occasionally shower, or sponge off with a cool damp cloth throughout the day and at night
4. Watch color of urine; if urine becomes dark yellow, drink more water
5. When outside, try to avoid the sun. If you must be in the sun, keep your head covered.
6. Report to the health care unit if you experience dizziness, weakness, swelling in your arms and legs, muscle cramps, nausea, vomiting, diarrhea, shaking, or if you stop sweating

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Head Injury

---

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long have the symptoms been present?
  - 2. Have you ever had this problem before? If yes, when? Describe.
  - 3. Abnormal behavior observed by whom?
  - 4. If signs of trauma are present, describe the injury.
  - 5. Any dizziness, blurred vision, headache, loss of consciousness?
  - 6. Any nausea/vomiting? If so, describe frequency and duration.
  - 7. Use of alcohol or drugs in the past 2 weeks? Describe.
  - 8. Any fever, chills, diaphoresis?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature
  - 2. Pulse
  - 3. Respirations
  - 4. blood pressure
  - 5. O<sub>2</sub> Sat
  - 6. Weight
  - 7. Neurological examination
    - a. Level of consciousness
    - b. Behavior
    - c. Speech pattern
    - d. Eye examination
    - e. PERLLA
    - f. Facial symmetry
    - g. Hand grips
- B. Breath sounds
- C. Skin evaluation
  - 1. Temperature
  - 2. Color
- D. Injury

E. Glasgow Coma Scale

Response	Description	Points	Score
Opens Eyes	Spontaneous	4	
	To voice	3	
	To painful stimuli	2	
	No response	1	
Verbal Response	Oriented	5	
	Confused, disoriented	4	
	Inappropriate words	3	
	Incomprehensible sounds	2	
	No response	1	
Motor Response	Obeys commands	6	
	Localizes painful stimuli	5	
	Flexion/withdrawal from painful stimuli	4	
	Abnormal flexion to painful stimuli (decorticate response)	3	
	Extension to painful stimuli (decerebrate response)	2	
	No response	1	
		SCORE	

**III. ASSESSMENT**

Alteration in mentation

**IV. PLAN**

A. Urgent MD/PA/NP referral by nurse

1. Abnormal vital signs (T > 100, P > 100, SBP < 100)

1. Loss of consciousness

2. Glasgow coma scale ≤ 13

3. Nausea/vomiting x ≥ 24 hours

4. Weak/abnormal hand grips

5. Unequal pupils

6. Facial asymmetry

7. Headache and stiff neck

A. Nursing interventions

1. Notify provider as indicated

2. Prepare to activate EMS (document arrival and transport times, and facility transferred to)

B. Patient education

1. Notify medical if symptoms persist or worsen

2. Patient verbalizes understanding

**V. FOLLOW-UP**

A. Follow up with nurse \_\_\_\_\_.

B. Follow up with practitioner

C. Other \_\_\_\_\_.

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## Heat Stroke (Hyperpyrexia)

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Heat stroke is a medical emergency that can lead to death if not treated. It represents a failure of the body's heat controlling mechanisms and is characterized by a very high core body temperature (often > 105°F), warm, flushed and dry skin, rapid bounding pulse, absence of sweating, delirium, and sometimes seizures.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When and for how long were you exposed to excessive heat?
  - 2. Other symptoms (i.e., weakness, dizziness, headache with muscle cramps, dim or blurred vision, mental confusion, muscular incoordination)
  - 3. When did symptoms start?
  - 4. Have you had any nausea and vomiting?
  - 5. Have you had any uncontrolled shaking or tremors?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, and blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Observe for the following objective conditions and document:
    - a. Skin hot to touch, dry
    - b. Strong rapid pulse, elevated temperature
    - c. Sudden loss of consciousness

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Patient experiences sudden loss of consciousness following excessive exposure to heat or sun
  - 2. All cases of suspected heat stroke
- B. Nursing intervention:
  - 1. Notify EMS if heat stroke is suspected
  - 2. Place inmate in cool, shady area, and remove all clothing
  - 3. Sponge with tepid water
  - 4. Direct fan on the patient to promote faster cooling
  - 5. Heat stroke is an emergent condition therefore begin the infusion of 0.9% normal saline solution at 120 cc/hour and obtain subsequent order

C. Patient teaching:

1. Drink at least eight glasses of water a day
2. Avoid strenuous exercise during the heat of the day
3. Occasionally shower, or sponge off with a cool damp cloth throughout the day and at night
4. Watch color of urine; if urine becomes dark yellow, drink more water
5. When outside, try to avoid the sun. If you must be in the sun, keep your head covered.
6. Report to the health care unit if you experience dizziness, weakness, swelling in your arms and legs, muscle cramps, nausea, vomiting, diarrhea, shaking, or if you stop sweating.

**V. FOLLOW-UP**

Per physician depending on severity of symptoms and response to treatment

---

## Hemorrhoids

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Hemorrhoids are varicose veins in the lower rectum or anus caused by congestion of the veins of the hemorrhoidal plexus.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Past history of hemorrhoids, constipation, rectal intercourse?
  - 2. Duration of current symptoms?
  - 3. Any bleeding, blood in stool, itching, rectal pain, protrusions from the rectum?
  - 4. Describe your bowel habits. Any recent changes?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Do visual inspection of anal area
  - 3. Any skin tags – inflamed or not
  - 4. Any evidence of torn skin around patients’ anal area
  - 5. Bleeding around anal area? How much?
  - 6. Trauma?

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Temperature > 101.5°F
  - 2. Patient appears to be experiencing severe pain
  - 3. Severe engorgement, distention and/or bleeding noted
  - 4. If unresponsive to treatment after 2 weeks
  - 5. Strangulated/prolapsed hemorrhoid is apparent or suspected
  - 6. Patient has experienced trauma to the area
  - 7. Patient is pregnant

**B. Nursing intervention:**

1. Advise the patient to:
  - a. Avoid prolonged standing and lifting
  - b. Avoid straining during bowel movement
  - c. Keep anal area clean and dry
  - d. Increase fluid and bulk in diet
2. Dibucaine 1% (Nupercainal) ointment applied t.i.d. as a local anesthetic to affected area for 1 week.
3. Cool compresses topically to the rectum q.i.d. x 3 days.
4. Hemorrhoidal ointment b.i.d x 5 days topically to affected area to reduce inflammation.
5. Docusate Sodium 100 mg p.o. b.i.d. x 3 days (D.O.T.)
6. If patient returns to sick call within a week, dispense hydrocortisone rectal cream 1% (Proctosol HC) to be applied bid x 7 days.

**C. Patient teaching:**

1. Perianal area should be cleaned with soap and water daily
2. Instruct on medication usage
3. Increase fluid and fiber in diet (vegetables, fruits, cereal)
4. After acute period, increase physical activity to prevent constipation
5. Avoid straining
6. Return to sick call if symptoms persist or worsen after 2 weeks

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist beyond 1 week

---

## Heroin/Opiate Withdrawal

---

Physical and psychological symptoms that occur after the sudden absence of heroin/opiates in those persons with a long history of use. Signs and symptoms vary with the type of drug that had been abused.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. What symptoms are you experiencing (restlessness, anxiety, diaphoresis, abdominal cramping, diarrhea?)
2. What drug/drugs have you been using?
3. Amount used?
4. How long has it been since last use of drug?
5. What is your pattern of use? How often?
6. History of withdrawal symptoms?
7. History of other medical problems?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Level of distress apparent: mild moderate severe calm cooperative
3. Diaphoresis present?
4. Tremors apparent?
5. Muscle spasms present?
6. Abdomen: soft, bowel sounds present, tender to palpation
7. Gait: normal unsteady needs assistance
8. If inmate is unmanageable in current housing location, move to Medical Housing Unit

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

A. Nursing intervention:

1. Push fluids
2. Initiate diphenhydramine 50 mg p.o. t.i.d. p.r.n. x 3 days (D.O.T.)
3. Imodium 2 caps t.i.d. p.r.n. for diarrhea x 3 days (D.O.T.)
4. Acetaminophen 325 mg p.o. t.i.d. p.r.n. discomfort x 4 days

- B. Refer to MD/ PA/ NP
  - 1. Any time drug withdrawal is suspected

---

## "Hot Flashes" Secondary to Menopause

---

"Hot Flashes" are episodic, irregular subjective manifestations of excessive heat and redness; premenopausal.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Onset and duration of symptoms?
  - 2. Last menstrual period and history of menstrual cycle (including duration of flow, amount of flow, other associated symptoms such as cramping, bloating, headaches, etc.)?
  - 3. Number of pregnancies, deliveries, miscarriages and/or abortions
  - 4. Any complaints of vaginal itching, burning, bleeding or discharge?
  - 5. Any personality or mood changes?
  - 6. Any hair/facial changes?
  - 7. Any weight gain?
  - 8. Familial history of breast or uterine cancer?
  - 9. Past gynecological surgeries or other interventions?
  - 10. Current medications? Were BCP's ever utilized?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note skin for dryness and/or diaphoresis

### III. ASSESSMENT

Altered comfort level

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Any new complaint of "hot flashes"
  - 2. Hormonal therapy
  - 3. Bleeding outside of cycle or if menopausal
  - 4. Recent weight gain
  - 5. Complaints of cramping
  - 6. Headache
  - 7. Vaginal burning, itching or discharge

B. Patient teaching:

1. Importance of body hygiene during periods of intense diaphoresis
2. Replacement of fluid loss by increasing fluid intake
3. Explain rationale of hormonal changes causing flashes
4. Importance of Physician follow-up if symptoms increase in severity and/or if abnormal bleeding develops

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist beyond 1 week

---

## Hunger Strike

---

A hunger strike occurs when an inmate or inmates refuse the vitamins, minerals, calories, and water necessary to sustain health for 6 consecutive meals for reasons other than physical illness.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record
  - 1. Allergies?
  - 2. What is the cause of the hunger strike?
  - 3. Any chronic illnesses?
  - 4. When was the last time food and water was taken?
  - 5. What medications are you taking?
  - 6. Do you plan on continuing medications?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. If specimen obtained voluntarily, conduct urinalysis
  - 3. Check for level of hydration (mouth/eye moisture, skin turgor, frequency of urination)
  - 4. Conduct mental health assessment (activity level, conversation level, alertness, appropriateness of speech)
  - 5. After 24 hours, vital signs lying, sitting and standing (note for a drop > 15 mm HG)

### III. ASSESSMENT

Potential altered nutritional status

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. All patients for physical exam
  - 2. Any inmate refusing prescribed medications due to hunger strike
  - 3. Any inmate exhibiting signs and symptoms of impaired hydration
- B. Nursing intervention:
  - 1. Refer inmate to mental health provider for evaluation
  - 2. Inform provider and facility administrator of hunger strike
  - 3. Assess daily
  - 4. Document refusals of any medications and any medical care

C. Patient teaching:

1. Inform the inmate regarding the negative effects of long-term fasting and dehydration

---

## Hyperglycemia

---

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Are you experiencing excessive thirst?
  - 2. Any urinary frequency?
  - 3. Any nausea/vomiting?
  - 4. Any abdominal pain?
  - 5. Weakness or fatigue?
  - 6. Shortness of breath?
  - 7. Any history of diabetes?
  - 8. How long have the symptoms been present?
  - 9. Describe diet (excessive sweets, junk food, etc.)

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, weight
  - 2. Fingertstick blood sugar
  - 3. Fruity odor on breath noted?
  - 4. Mental status? Alert, oriented? Disoriented? Confused?
  - 5. Lethargic? Unresponsive?
  - 6. Urine dip
  - 7. Skin temperature? Moist/dry?
  - 8. Bowel sounds present?
  - 9. Abdomen tender to palpation?
  - 10. Abdominal distention?
  - 11. Review MAR for medication compliance.
    - a. Is patient compliant with medications? If no, specify.

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

- A. Immediate MD/PA/NP referral by nurse:
  - 1. Fingertstick blood sugar > 350
  - 2. Altered mental status

- B. MD/PA/NP referral by the nurse to be seen at next provider clinic:
  - 1. Fingertstick blood sugar > 250
  - 2. Abdominal pain, distention, or decreased/absent bowel sounds
  - 3. Abnormal urine dip
  - 4. Excess thirst
  - 5. Frequent urination
  - 6. Nausea/vomiting
  - 7. Fruity odor on breath
  
- C. Patient education:
  - 1. Follow up with provider as directed
  - 2. Signs and symptoms of hyperglycemia
  - 3. Causes of hyperglycemia
  - 4. Notify medical for continued or recurrent symptoms

---

## Hypertension – Uncontrolled

---

Hypertension is defined as an abnormally high pressure, generally considered as sustained pressure equal or above 140/90 mm. Hypertension can be classified as primary, that is without obvious cause (most common) or secondary, due to renal disease, endocrine disorders, medication induced or other cause. Over 90% of hypertension is primary. Hypertension is one of the major risk factors of coronary artery and other vascular diseases and is virtually always controllable with medication and lifestyle modification. The goal in treatment of hypertension is the restoration of a normal range blood pressure without inducing hypotension that may have serious adverse consequences.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Do you have a history of hypertension?
  - 2. Have you been on blood pressure medication or should be on medication for hypertension? Any adverse effects to medication prescribed in the past?
  - 3. Family history of hypertension?
  - 4. Alcohol intake?
  - 5. Do you smoke?
  - 6. Do you have any of the following symptoms?
    - a. Dizziness
    - b. Blurred vision
    - c. Headache
    - d. Shortness of breath
    - e. Swelling of your legs

### II. OBJECTIVE

- A. The nurse should examine the patient and document in the record
  - 1. Temperature, pulse, respirations, O<sub>2</sub> Sat, blood pressure (2 blood pressure readings, 5 minutes apart), and weight
  - 2. Note if patient appears in any acute distress
  - 3. Note presence or absence of any abnormal sounds in lungs
  - 4. Note presence of any abnormal murmur or rhythm of heart
  - 5. Note any apparent edema in lower extremities

### III. ASSESSMENT

Altered health maintenance

#### IV. PLAN

A. MD/PA/NP referral by nurse if:

1. Patient experiencing chest pain, refer to provider stat.
2. Blood pressure > 200/110, or if lower and accompanied by headache, blurred vision, or dizziness – call provider stat.
3. Blood pressure > 180/90 but < 200/110: Notify provider during daylight hours (next morning if during night shift) and schedule for next provider sick call
4. Blood pressure > 120/80 but < 140/90: Educate on importance of salt restriction, weight loss, exercise, and alcohol moderation
5. If prescribed medication is soon to expire

B. Nursing intervention:

1. If patient is experiencing chest pain give ASA 325 mg p.o. stat., NTG .4 mcg stat., put on O<sub>2</sub>, obtain stat. EKG and refer to provider stat.
2. Place in infirmary or medical housing
3. Schedule for baseline hypertension clinic
4. Baseline hypertension clinic labs, EKG, etc., per protocol
5. Place on nursing blood pressure checks q. day if SBP > 160 or DBP > 100 x 5 days and then chart review (CR) by provider
6. Blood pressure checks 2x/week x 2 weeks if SBP > 140 but < 160 or DBP > 90 but < 100 and then chart review by provider

C. Patient teaching:

1. Purpose and goals of treatment
2. Potential side and untoward medication effects
3. Importance of compliance – DAILY
4. Need and importance of lifestyle modifications
5. When to notify the medical unit

#### V. FOLLOW-UP

- A. Blood pressure checks per protocol per MD order
- B. Hypertension clinic follow-up

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## Indigestion/Heartburn

---

Indigestion (or dyspepsia) is a vague feeling of epigastric discomfort, generally felt after eating. There may be an uncomfortable feeling of fullness, heartburn, bloating, and nausea. Rarely, dyspepsia may be a manifestation of coronary artery disease.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Onset, duration and location of the pain
  - 2. Describe the pain (i.e., burning, fullness, gas, discomfort in upper stomach, and/or chest, etc.)
  - 3. Is the pain related to food intake?
  - 4. Has your appetite been normal? Time of your last meal?
  - 5. What did you have to eat?
  - 6. Is this the first occurrence, or do you have a history of previous similar episodes (i.e., ulcer disease)?
  - 7. Medication? Allergies?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. General appearance: Normal, flushed, diaphoretic, pale, gray, cyanotic, jaundiced?
  - 3. Note skin: warm, hot, cool, dry, moist
  - 4. Note presence of any abdominal distention
  - 5. Note findings of abdominal palpation: soft, rigid, guarding, tenderness, rebound tenderness
  - 6. Location of point and/or rebound tenderness (quadrant)
  - 7. Listen and note bowel sounds: normal, hyperactive, hypoactive, absent

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Abnormal vital signs
  - 2. Pain that continues despite treatment protocol implementation
  - 3. Patient has history of HTN
  - 4. Patient has history of cardiovascular disease
  - 5. Pain radiates to back, chest, neck, arm, or jaw
  - 6. Pain is associated with nausea, vomiting, sweating, or shortness of breath

**B. Nursing intervention:**

1. Recheck any abnormal vital signs and report to provider if indicated
2. If none of above are present, give calcium carbonate (Tums) and instruct the patient to take up to 2 tabs after a meal p.r.n. heartburn for 16 days or give Mylanta 30 ml after meals and at bedtime for 3 days
3. If patient returns after 2 weeks with complaints of GERD, call provider for a possible H2 blocker or PPI order

**C. Patient teaching:**

1. Avoid overeating and foods that are known to cause distress (roughage, coffee, tea, carbonated drinks)
2. Remain in upright position 1–2 hours after eating
3. Avoid eating rapidly. Chew food thoroughly.
4. Avoid chewing gum and smoking which creates more air in abdomen
5. Avoid eating 3–4 hours prior to bedtime
6. Report to sick call if discomfort increases or persists

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or do not improve in 1 week

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## Influenza

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### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. How long have the symptoms been present?
  2. Any cough? Productive? (describe)
  3. Any shortness of breath?
  4. Any pain in the throat, ears or face? Tenderness in the sinuses?
  5. Past history of sinusitis or allergies?
  6. Any headache? Fever?
  7. Any nausea/vomiting?
  8. Any muscle aches? Rate on scale of 1 - 10
  9. Any medical problems?
  10. On any medications? Any allergies?
  11. Did the patient receive the flu vaccine? When?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O2 sat, and weight
  2. Note lung sounds and presence of any sputum
  3. Is the patient in respiratory distress?
  4. Note skin turgor

### III. ASSESSMENT

Alterations in health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
1. Temperature is > 101°F
  2. Pulse ox < 94% on room air
  3. Cough is severe or productive in nature
  4. Increased pulse rate/shortness of breath
  5. Patient has chronic lung disease
  6. Patient is pregnant

B. Nursing intervention:

1. Advise patient to rest in bed and increase fluid intake
2. Instruct patient on proper hand washing technique
3. For fever: Give Acetaminophen 325 mg tabs 2 p.o. q. b.i.d. p.r.n. x 5 days or Ibuprofen 200 mg tabs 2 p.o. b.i.d. p.r.n. x 6 days
4. For cough: Give Guaifenesin 200 mg 2 tabs p.o. b.i.d. p.r.n. x 5 days (D.O.T.)

C. Patient teaching:

1. Hand washing guidelines
2. Increase fluid intake
3. Medication instruction
4. No smoking

**V. FOLLOW-UP**

If symptoms persist for 7 days

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## Insulin-Induced Hypoglycemia

---

An abnormally small concentration of glucose in the circulating blood. Symptoms include weakness, shakiness, sweating, and other symptoms.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Document insulin dosage, last injection.
  - 2. Changes in food intake and exercise?
- B. If inmate is unable to answer questions, defer until assessment and treatment is given

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Presence of sweating, tremors, headache, confusion, and lack of coordination
  - 3. Perform fingerstick for blood sugar determination

### III. ASSESSMENT

Altered health maintenance

### IV. PLAN

- A. Emergency
  - 1. Lethargic, comatose or convulsive patient. Contact physician immediately and give first aid.
- B. MD/PA/NP referral by nurse if:
  - 1. Any inmate with signs of insulin-induced hypoglycemia
- C. Nursing intervention:
  - 1. Administer GlucoTabs 2 tabs p.o. OR Glucogel 1 tube sublingually if conscious
  - 2. If lethargic administer 1 tube of Glucogel sublingually
  - 3. If emergent, as evidenced by loss of consciousness, per MD order, start IV of NS and give 50 cc of 50% glucose IV
  - 4. If IV is unavailable or unable to establish in a timely manner, give Glucagon 1 mg IM
  - 5. Do not release inmate from medical until a re-check of blood sugar by fingerstick and inmate has eaten carbohydrates and protein (if patient has experienced symptoms more severe than mild which required more intervention than GlucoTabs or Glucogel physician should be notified)

**V. FOLLOW-UP**

- A. If symptoms severe, patient should be scheduled for Glucoscans t.i.d. and schedule for next provider clinic
- B. If symptoms only mild and treated successfully with GlucoTabs, schedule Glucoscans t.i.d. have chart reviewed by provider next clinic

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## Jaundice

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Jaundice is a yellowish discoloration of the whites of the eyes, skin, and mucous membranes caused by deposition of bile salts in these tissues. It occurs as a symptom of various diseases, such as hepatitis, that affect the processing of bile.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Do you have any allergies?
  - 2. When was jaundice first noticed?
  - 3. Are you experiencing any pain?
  - 4. Are you experiencing any vomiting?
  - 5. Are you experiencing any itching?
  - 6. Do you have any history of jaundice?
  - 7. Have you ever been diagnosed with liver disease?
  - 8. What medications are you taking?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note color of sclera (in daylight, if possible)
  - 3. Note ascites or increased abdominal girth
  - 4. Check MAR for current medications

### III. ASSESSMENT

Altered health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. All patients with jaundice
- B. Nursing intervention:
  - 1. Refer to provider

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## Muscle Pain/Sprain – Mild

---

A sprain is a traumatic injury resulting from a stretched or torn ligament. Ligaments connect 1 bone to another bone at a joint and help keep the bones from moving out of place. A strain is a traumatic injury resulting from a stretched or torn muscle or tendon. Tendons attach muscle to bone. Both injuries may be characterized by pain, swelling, and/or discoloration of the skin over a joint or muscle.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. What caused the pain (i.e., lifting, sports, etc.)?
  - 2. Was there any twisting or turning of the joint when injured?
  - 3. How long has the pain been present?
  - 4. Describe location, type, characteristic, and pattern of pain
  - 5. Was swelling immediate or delayed?
  - 6. Are you experiencing weakness or numbness?
  - 7. Was a “pop” heard when the body part was injured?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note appearance at rest and at movement
  - 3. Inspect the area for swelling, ecchymosis, redness, bruising, tenderness on touch, limited ROM, or difficulty bearing weight

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Any suspected fracture or dislocation
  - 2. Any difficulty walking is noted
  - 3. If numbness is noted
  - 4. Presence of severe pain or swelling is apparent
  - 5. Presence of deformity and/or fever is apparent
  - 6. Inability to bear weight or use the affected body part
- B. Nursing intervention:
  - 1. Cold compresses x 48 hours as indicated
  - 2. Elevate affected part

3. May offer one of the following:
  - a. Acetaminophen 325 mg – take 2 tablets p.o. b.i.d. x 6 days p.r.n.  
OR
  - b. Ibuprofen 200 mg, 2 tabs p.o. b.i.d. p.r.n. (max OTC dose is 1200 mg per day) x 6 days  
OR
  - c. Crutches/non-weight bearing (if indicated) for 3 days (follow policy to notify security)
  - d. Lay in (if indicated) for up to 72 hours
  - e. Immobilization of injured part with ace wrap or other splint
  - f. Schedule or refer to MD if pain is unrelieved

C. Patient teaching:

1. Medication use
2. Use of cold/hot applications
3. Avoid weight lifting, sports, or strenuous activity until area has healed and is free of pain (approximately 2 weeks)
4. As applicable, application of compression device, and how to monitor circulation (i.e., area should be warm to touch, normal color, nail beds blanch)
5. Importance of proper body mechanics to avoid injury
6. If injury could have been prevented, instruct on future safety measures (warm up before exercises, etc.)
7. Importance of follow-up to physician if symptoms fail to resolve within 5 days or if symptoms worsen (pain persists, swelling fails to subside, etc.)

## V. FOLLOW-UP

Return to sick call if symptoms worsen or persist without improvement for more than 5 days

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## Nausea and Vomiting

---

Nausea is a sensation often leading to the urge to vomit. Vomiting is the forcible voluntary or involuntary emptying of the stomach contents through the mouth.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. When did symptoms begin?
2. Is the nausea accompanied with vomiting? If vomiting, describe frequency and type of vomitus.
3. Are you experiencing other associated symptoms (i.e., weakness, vertigo, headache, fever, anorexia, abdominal pain, menstrual history, sexual contact)?
4. Are you on any medication?
5. Has there been any exposure to noxious fumes, chemicals, or recent head trauma?
6. Have you had recent emotional distress?
7. Describe your bowel habits and when was your last bowel movement?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Assess the bowel sounds and note any area of tenderness/abdominal distention
3. If complaining of emesis, observe for 30 minutes
4. If emesis present, note color and consistency, any evidence of “coffee grounds” emesis, or bright red blood

### III. ASSESSMENT

Alteration in comfort

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. Temperature > 101°F
2. Presence of abnormal vital signs, blood pressure systolic < 100 or > 160, diastolic < 60 or > 110
3. Presence of fever and abdominal pain
4. If head trauma, abdominal trauma, diabetes, chest pain is noted
5. Noted evidence of dehydration
6. Patient appears in acute or extreme pain
7. Emesis observed and contains blood
8. Symptoms persist after 24 hours despite implementing treatment protocol
9. If patient is immuno-compromised

## B. Nursing intervention:

1. Clear liquids as tolerated x 24 hours
2. Consider medical lay-in/activity restriction p.r.n.
3. Pepto-Bismol 15 ml p.o. t.i.d. x 24 hours if indicated (D.O.T.)
4. Avoid laxatives, antacids, and aspirin use
5. No kitchen duty until no vomiting for 48 hours

## C. Patient teaching:

1. Importance of fluids to prevent dehydration
2. Importance of rest to conserve energy
3. If symptoms persist after 24 hours, return to Physician sick call

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist for more than 24 hours

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## Non-Specific Discomfort

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This protocol should be used when patient presents with discomfort that is not addressed by a specific protocol.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Do you have any allergies?
  - 2. Describe location of pain/discomfort
  - 3. Describe pain (i.e.; stabbing, throbbing, constant, intermittent, etc.)
  - 4. Have you had this pain before, and how was it treated?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Document signs of obvious discomfort
  - 3. Document observations related to body part affected

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Patient presents more than twice at NSC for c/o same discomfort
  - 2. Patient presents with signs of acute, severe discomfort
- B. Nursing intervention:
  - 1. Acetaminophen, 1–2 tablets t.i.d. p.r.n. for pain x 5 days

### V. FOLLOW-UP

Return to sick call if discomfort does not improve

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## Nose Bleed (Epistaxis)

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Epistaxis is the medical term for bleeding from the nose. It typically originates from the nasal septum when the nasal mucosa overlying a dilated blood vessel is injured. Epistaxis may, however, signal an underlying condition such as a coagulation disorder, so the treating practitioner must be alert for signs of serious illness. Most nosebleeds stop spontaneously within 5 minutes with or without pressure to the forehead, nose, or upper lip.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. When did the nosebleed start?
  2. Is this a chronic problem, and if so, how often does the bleeding occur?
  3. Did you put anything in your nose, sneeze, pick or blow hard, or suffer any trauma to the nose?
  4. Do you have any allergies or chronic illnesses (i.e., HTN)?
  5. What medications are you on (ask specifically about hypertensives, anticoagulants, warfarin, Plavix, and aspirin)?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Inspect nasal passage and note presence of any lesion, polyp, foreign body
  3. If bleeding is active, note amount, and color

### III. ASSESSMENT

Alteration in health maintenance (potential)

### IV. PLAN

- A. MD/PA/NP referral by nurse:
1. Persistent bleeding despite treatment protocol
  2. Fever, tachypnea, pulse > 110 or SBP > 160 or DBP > 100
  3. Patient has bleeding or clotting disorder or is on blood thinning medication
  4. Second episode within 1 week
  5. Nasal septal perforation or nasal trauma

**B. Nursing intervention:**

1. Sit quietly with head forward, squeeze nose with thumb and index finger x 5–20 minutes
2. Apply ice/cold pack locally to bridge of nose
3. If bleeding is associated with cold symptoms, may offer of the following:
  - a. Saline nasal spray, 2 sprays in each nostril as needed for 7 days
  - b. If above fails, notify MD

**C. Patient teaching:**

1. No harsh nose blowing or picking of the area
2. If packing is placed by clinician, return in 24 hours
3. Importance of follow-up if bleeding persists

**V. FOLLOW-UP**

Return to sick call if nosebleed recurs

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## Opiate Overdose – Suspected

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Opiates include morphine, codeine, oxycodone, methadone, Vicodin, and heroin. An overdose is an excessive and potentially toxic amount of 1 or more substances, and can be intentional or accidental. Patients are generally unresponsive with a slow respiratory rate or apnea.

### I. SUBJECTIVE

- A. If possible, ask the patient and document the following in the record:
  - 1. What was taken (amount)?
  - 2. Any additional substances ingested?
  - 3. Time of ingestion/injection?
  - 4. Reason for overdose (suicide attempt or other)?
  - 5. Any vomiting?
  - 6. Current symptoms?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat with continuous monitoring for shallow respirations/apnea and bradycardia
  - 2. Orientation, behavior (unresponsive, lethargic, decreased alertness, inability to talk)
  - 3. Pupillary reflex or constriction
  - 4. Decreased muscle tone or weakness/limp body
  - 5. Slurred or unintelligible speech
  - 6. Pale, clammy skin
  - 7. Peripheral cyanosis
  - 8. Choking sounds
  - 9. Note any unusual odors or recent injection marks
  - 10. Evaluate for injuries
  - 11. Reconcile history with medication administration record and other sources as available

### III. ASSESSMENT

- A. Altered health maintenance
- B. Impaired gas exchange

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. All cases of suspected overdose
  - 2. If intentional and self-induced, notify mental health

**B. Nursing intervention:**

1. Perform basic life support as needed
2. Administer Naloxone (Narcan):
  - a. No IV access:
    - i. Administer 4 mg Naloxone intranasally.
    - ii. Repeat dose every 2 -3 minutes as needed, alternating nostrils  
OR
    - iii. Administer 2mg Naloxone IM into the anterolateral thigh
    - iv. Monitor for respirations
    - v. If no effect within 5–10 minutes, repeat the dose to a maximum of 10 mg.
  - b. IV access WITHOUT cardiac arrest:
    - i. Dilute 1 mg in 9 ml normal saline for a concentration of 0.1mg/ml (or 2 mg in 18 ml NS for a concentration of 0.1 mg/ml)
    - ii. Administer 0.4 mg (4 ml) dose IV over 30 seconds, while checking for respirations
    - iii. If no respirations within 2 minutes, repeat the dose until the maximum of 10 mg has been given, or spontaneous respirations return
  - c. IV access WITH cardiac arrest from opioid overdose:
    - i. Dilute 2 mg of Naloxone in 18 ml NS and administer over 30 seconds via IV
    - ii. Repeat dose q. 2 minutes until respirations return or maximum dose of 10 mg has been reached
  - d. Once respirations have returned:
    - i. Monitor vital signs, pupil size, and level of consciousness q. 15 minutes for a minimum of 2 hours
    - ii. Observe for signs of opiate withdrawal
  - e. If no response to Naloxone, check fingerstick blood glucose. If low, refer to the hypoglycemia nursing protocol.
  - f. Prepare for emergency transport if indicated
  - g. Notify the physician and obtain verbal order for the Naloxone

**V. PATIENT TEACHING**

Health risks associated with substance abuse

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## Poison Oak and Poison Ivy

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Dermatitis resulting from irritation or sensitization of the skin by the toxic resin of the plants. There is no absolute immunity, although susceptibility varies greatly, even in the same individual. Symptoms include itching or burning sensation soon after exposure followed by small blisters. Blisters usually rupture and are followed by oozing of serum and subsequent crusting.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has the rash been present?
  - 2. When and where did you come in contact with the environmental exposure?
  - 3. Are you experiencing itching?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note the location of rash, type, and size
  - 3. Check for any secondary infections

### III. ASSESSMENT

- A. Alteration in comfort
- B. Alteration in skin integrity

### IV. PLAN

- A. Nursing intervention:
  - 1. Cleanse the skin by dabbing so not to spread the irritated area
  - 2. Apply topical lotion of choice – Hydrocortisone 1% b.i.d. x 3 days or calamine lotion p.r.n. x 1 week.
  - 3. If the itching is intense, may administer Loratadine 10 mg p.o. daily x 3 days p.r.n. (D.O.T.)
- B. Refer to MD/PA/NP:
  - 1. If rash persists, if symptoms worsen, or there are no signs of improvement

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## Pregnancy

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A condition of the female carrying a developing embryo in the uterus. Presumptive signs are amenorrhea, nausea and vomiting, inordinate appetite, changes in breast appearance, and nipple sensitivity, changes in the cervix and uterus (softening and progressive enlargement), vaginal and cervical discoloration, and frequent urination. Positive signs are hearing the fetal heartbeat, detection of movements of the fetus and use of ultrasound to detect the fetal outline.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Last menstrual period? Was it a normal flow?
  - 2. Pregnancy test and results?
  - 3. Complications with past pregnancies?
  - 4. Previous prenatal care?
  - 5. Medical history?
  - 6. Drug, alcohol, social history? STD history?
  - 7. History of menses – regularity.

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Complete vital signs and weight
  - 2. Check for any edema, discharge
  - 3. Ask about abdominal cramping

### III. PLAN

- A. Nursing intervention:
  - 1. Complete pregnancy test if pregnancy has not been confirmed
  - 2. Prenatal vitamins (1 daily)
  - 3. Pregnancy diet – education
  - 4. Bottom bunk
  - 5. Education: alcohol/drug use, exercise restrictions
- B. MD/PA/NP referral:
  - 1. Urgent referral for any current symptoms or history of complicated past pregnancies
  - 2. All pregnant inmates
  - 3. MD will initiate referral for consulting OB/GYN physician

### IV. FOLLOW-UP

- A. Return to clinic per provider order

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## Premenstrual Syndrome (PMS)

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Premenstrual syndrome describes a constellation of symptoms, including nervous tension, irritability, weight gain, edema, headache, mastalgia, and dysphoria occurring the last few days of the menstrual cycle before the onset of menstruation.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Describe difficulties experienced with the menstrual cycle
  - 2. How long have symptoms persisted?
  - 3. When, in each menstrual cycle, do symptoms begin (may begin 10 days or more prior to menstrual flow onset)?
  - 4. When does pain diminish (usually 1 or 2 days after menstruation begins)?
  - 5. Do you experience other symptoms (i.e., edema, breast swelling, abdomen distention transitory because of increase in water content in tissue, palpitation, backache)?
  - 6. Do you experience other changes such as irritability, sleep disturbance, lethargy, depression, headache, vertigo, paresthesia of hands and feet?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. If patient reports associated abdominal cramping, assess abdomen and bowel sounds
  - 3. Note any peripheral edema
  - 4. Note any change/abnormality in mood, behavior, cognitive status

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. If no relief from analgesics and/or pain not related to menstruation cramps
  - 2. Fever or other abnormal vital sign is noted
  - 3. Any abnormality in abdominal assessment is noted

**B. Nursing intervention:**

1. Encourage patient to explore ways and means to avoid stress
2. Teach relaxation techniques
3. Restrict sodium intake and limit use of caffeine and stop tobacco
4. For relief of discomfort, may offer:
  - a. Ibuprofen 200 mg, 2 tabs p.o. b.i.d. p.r.n. (max OTC dose is 1200 mg per day) x 56days  
OR
  - b. Acetaminophen 325 mg – take 2 tablets p.o. b.i.d. x 6 days p.r.n.

**C. Patient teaching:**

1. Any indicated medication use
2. If able, increase level of physical activity to decrease pain and cramping
3. Dietary instruction (decrease salt, limit caffeine)
4. Encourage maintenance of menstrual cycle calendar to monitor cycles

**V. FOLLOW-UP**

Advise to return to sick call if no relief in 5 days or if symptoms worsen

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## Puncture Wounds

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Puncture wounds result from penetrating injury or trauma.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. What caused the injury (accident, work-related, assault, self-inflicted)?
  - 2. Where did it happen and at what time?
  - 3. What type of object caused the injury?
  - 4. Any history of excessive bleeding?
  - 5. Are you a diabetic, asthmatic, or have any other chronic illnesses?
  - 6. What medications are you taking (watch for aspirin, Coumadin, steroids)?
  - 7. Do you have any allergies?
  - 8. When was your last tetanus?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, pertinent pulses, O<sub>2</sub> Sat, and weight
  - 2. Assess location and depth of injury
  - 3. Note any contaminants, ground in debris, bleeding or other drainage, swelling
  - 4. Evaluate for any pain, loss of range of motion or disfigurement, signs of shock

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Wound that has ground in debris
  - 2. Wound is over a joint, chest, back, or abdominal site
  - 3. Uncontrolled bleeding
  - 4. Patient that is on medication that may impair healing
  - 5. Wounds that do not respond to treatment protocol
  - 6. If injury is self-inflicted, refer to mental health

**B. Nursing intervention:**

1. Apply direct pressure to wound with sterile compress if needed to control severe bleeding. For penetrating wound with foreign object, leave object in place. Never pull it out. Small items, such as splinters, may be removed with tweezers if protruding. Do not attempt to remove embedded items.
2. Paint with Betadine or similar product, then rinse with normal saline
3. Cover with dry dressing
4. If break in skin and no allergy, contact MD for tetanus toxoid if > 10 years since last.
5. For minor discomfort give
  - a. Acetaminophen 325 mg 2 tabs p.o. b.i.d. p.r.n. x 6 days  
OR
  - b. Ibuprofen 200 mg 2 tabs b.i.d. p.r.n. x 6 days
6. Minor/superficial clean wound
  - a. Clean wound with Betadine (normal saline if allergic)
  - b. Place Steri-strips to bring edges together
  - c. Apply triple antibiotic ointment, Band-Aid or gauze dressing as indicated x 5 days
  - d. Schedule dressing changes if needed
7. Acute contusion
  - a. Apply cold/ice pack as indicated

**C. Patient teaching:**

1. Signs and symptoms of infections (i.e., swelling, pus formation, redness, local heat, streaking, etc.)
2. Signs and symptoms of impaired circulation (i.e., blanching nails, cold extremities, etc.)
3. If injury could have been prevented, instruct on safety measures

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Seizures

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A seizure is a sudden, involuntary change in behavior, muscle control, consciousness, and/or sensation. A seizure is often accompanied by an abnormal electrical discharge in the brain. Symptoms of a seizure can range from sudden, violent shaking and total loss of consciousness to muscle twitching or slight shaking of a limb. Staring into space, altered vision, and difficult speech are some of the other behaviors that a person may exhibit while having a seizure. Approximately 10% of the U.S. population will experience at least 1 seizure in their lifetime.

### I. SUBJECTIVE

- A. Ask the observer/witness and document the following in the record:
  - 1. Inquire as to where patient was and his/her activity when seizure noticed
  - 2. Did patient lose consciousness?
  - 3. How long did seizure last?
  - 4. Was patient injured during seizure?
  - 5. Describe what they saw
  - 6. When patient is able to respond determine if the patient had an aura before the seizure (i.e., bright light, strange feeling, unusual sound)?
  
- B. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Determine if patient is oriented to time, place, and person (if conscious)
  - 3. Not if the patient has a history of seizures
  - 4. What type of activity was the patient involved in prior to the seizure?
  - 5. History of alcohol or other substance abuse? If so, date of last drink/drug administration
  - 6. Is patient currently on any medications, and if so, is patient compliant?

### II. OBJECTIVE

- A. If seizure in progress, examine the patient and document the following in the record:
  - 1. Airway patency
  - 2. Level of consciousness
  - 3. Vital signs (if attainable)
  - 4. Duration (as specific as possible; do not estimate)
  - 5. Muscular contractions, body parts involved
  - 6. Tongue biting
  - 7. Urinary or fecal incontinence
  - 8. Eye movement
  - 9. Sudden onset, brief duration

B. Post-seizure assessment:

1. Airway patency
2. Level of consciousness; vital signs
3. Evidence of head or other bodily trauma
4. Lung sounds
5. Gross neurological examination for facial symmetry, grip strength, leg movement
6. Tongue laceration present
7. Urinary or fecal incontinence
8. Document presence of post-ictal state (deep sleep, headache, confusion, and muscle soreness) and the duration of the state

### III. ASSESSMENT

Altered health status

### IV. PLAN

A. MD/PA/NP referral by nurse:

1. All seizure activity
2. Repetitive seizures, loss of consciousness, and severe respiratory distress necessitate emergency care
3. Call 911 for emergency transport to ER if:
  - a. Airway compromise
  - b. Repetitive seizures
  - c. Persistent altered level of consciousness after seizure not consistent with post-ictal state

B. Nursing intervention:

1. Maintain clear airway, turn to 1 side to provide drainage of secretions, do not attempt to place objects in mouth
2. Do not restrain patient during the seizure activity. It is not possible to stop the seizure and restraining the patient may increase the possibility of injury.
3. After the seizure, the patient will likely awaken confused and disoriented
  - a. Place the patient in recovery position on the left side
  - b. Maintain airway
4. Monitor vital signs
5. Check blood glucose level stat.
6. If glucose is < 80 mg/dl, administer oral glucose solution (if the patient is awake and airway is not compromised) or half ampule of 50% dextrose intravenously
7. Keep patient in a dark and quiet room
8. Observe and be able to describe seizure
9. Notify physician that patient has had seizure

C. Patient teaching:

1. Advise patient to notify medical personnel of any seizure activity or impending feelings of seizure activity
2. Always take medication as prescribed by physician
3. Importance of lab draws as ordered by physician

**V. FOLLOW-UP**

As per practitioner order

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## Sexual Assault

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A sexual assault results from any unwanted sexual contact.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. Type of alleged assault:
    - a. Contact between the penis and the vulva or the penis and the anus, including penetration, however slight
    - b. Contact between the mouth and the penis, vulva, or anus
    - c. Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument
    - d. Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person, excluding contact incidental to a physical altercation
  2. Date and time of alleged assault
  3. Description of the incident
  4. Is the perpetrator known?
  5. Was custody notified by the alleged victim?
  6. If so, who was notified and when?
  7. Are you currently having any pain? If yes, rate on a scale of 1–10.
  8. Are there any open areas? If yes, where?
  9. Is there any drainage present? Describe.
  10. Have you changed your clothes since the incident?
  11. Have you bathed/showered since the incident?
  12. Have you douched since the incident?
  13. Have you urinated since the incident?
  14. Have you defecated since the incident?
  15. Have you eaten any food or drank any liquids since the incident?
  16. Have you combed your hair since the incident?
  17. Have you brushed your teeth since the incident?
  18. What medications are you currently taking?
  19. Do you have a history of HIV, Hepatitis B, Hepatitis C, Psychiatric illness, Pregnancy? If yes, explain.

## II. OBJECTIVE

- A. DO NOT TREAT ANY INJURIES THAT ARE NOT LIFE-THREATENING. THEY MAY BE USED FOR FORENSIC EVIDENCE COLLECTION OR PHOTOS.
  - 1. Is a chaperone present during the exam?
  - 2. If yes, what is the name of the chaperone?
  - 3. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, weight
  - 4. Does the patient appear to be in acute distress?
  - 5. Level of consciousness and orientation
  - 6. Signs of physical assault:
    - a. Body site involved:
      - i. Oral cavity. Describe.
      - ii. Anal. Describe
      - iii. Genital. Describe.
      - iv. Other. Describe.

## III. ASSESSMENT

- A. Potential for alteration in comfort
- B. Risk for infection

## IV. PLAN

- A. Notify practitioner for all reported PREA incidents:
  - 1. Name of practitioner notified
  - 2. Time
  - 3. Review with provider MAR, medical record
  - 4. Document any orders received and that the order was read back and verified
- B. Mental health referral

## V. EMERGENT INTERVENTION

- A. Place bloody hands in a paper bag to protect evidence (not plastic bag or latex gloves as this can cause sweating)
- B. EMS process activated. Time.
- C. EMS arrival. Time.
- D. EMS transport. Time.
- E. Facility transported to

**VI. NURSING INTERVENTIONS**

- A. Notify custody
- B. O<sub>2</sub> at 2L via nasal cannula

**VII. PATIENT EDUCATION**

- A. Notify medical if symptoms develop or worsen. Written or verbal instructions.
- B. Patient demonstrates an understanding of self-care, symptoms to report and follow-up care

**VIII. FOLLOW-UP**

Follow up as needed for new or worsening symptoms

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## Sexually Transmitted Infection - Suspected

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### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. Are you experiencing any burning sensation during urination?
  2. Are you experiencing any urinary frequency?
  3. What is the color of the urine?
  4. Has there been any unusual odor to the urine?
  5. Any vaginal or penile discharge? Describe.
  6. Number of current (within the past 3 months) sexual partners?
  7. Male or female?
  8. Type of sexual contact? Oral? Vaginal? Anal?
  9. Do they have any known sexually transmitted disease? If yes, what type?
  10. Is any form of protection used during sex? If yes, describe.
  11. Date of LMP.
  12. Are you diabetic or immunocompromised?
  13. Current medications?
  14. Allergies?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, weight
  2. Describe vaginal or penile discharge
  3. If oral sex, observe and describe mouth/throat
  4. Pain scale 1–10

### III. ASSESSMENT

Alteration in health maintenance

### IV. PLAN

- A. MD/PA/NP referral by nurse
1. Abnormal vital signs (T > 100, P > 100, SBP < 100)
  2. Abnormal urine dip
  3. Presence of discharge
  4. Signs of mouth/throat infection

B. Patient education

1. Follow up with provider as directed
2. Take medication as prescribed
3. Notify medical if symptoms persist or worsen
4. Patient verbalizes understanding

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## Shave Rash

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### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Do you experience irritation of skin in beard area
  - 2. Inquire as to what, where, and when
  - 3. Inquire as to shaving technique
  - 4. Have you experienced this rash before, and what treatment did you receive? Was the treatment effective?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Vital signs (temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight)
  - 2. Document size, appearance, and location of rash (i.e. papules, pustules, blackheads, ingrown hairs)
  - 3. Document presences or absence of signs/symptoms of infection (i.e. drainage, increased redness, malodorous discharge, streaking, increased warmth)

### III. ASSESSMENT

Alteration in skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Signs of infection present
  - 2. Condition not responding to protocol (i.e., improvement after 2–3 months of aggressive self-care.)
- B. Nursing intervention:
  - 1. Instruct inmate per inmate education
  - 2. May give shave pass if:
    - a. Numerous pustules present after 2–3 weeks of aggressive self-care
    - b. True Pseudofolliculitis Barbae is present
- C. OTC medication available per protocol:
  - 1. Hydrocortisone Cream 1% bid to area x 7 days. Dispense 14 packets KOP.
  - 2. Benzoyl Peroxide 10% every other day initially (to avoid irritation)

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## Sore Throat

---

A sore throat may result from infectious, allergic, nutritional, and mechanical causes. As a result, the evaluation of a sore throat is not always straightforward.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. How long has the sore throat been present?
  - 2. Have you had any recent history of cold, cough, fever, earache, headache, swollen glands, nausea, vomiting, abdominal pain?
  - 3. Are you experiencing pain on swallowing?
  - 4. Are you experiencing post-nasal drip?
  - 5. Do you have history of recurrent sore throats?
  - 6. What are your smoking habits?
  - 7. Have you had a tonsillectomy?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Assess the throat and document presence of redness, exudate, any lesions, enlarged tonsils
  - 3. Assess ear canals and tympanic membrane and note any redness
  - 4. Palpate neck and note enlarged and/or tender lymph nodes
  - 5. Note presence of any rash

### III. ASSESSMENT

- A. Alteration in health maintenance
- B. Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse if:
  - 1. Temperature 101°F or above
  - 2. Condition present for 3 days, despite implementing treatment protocol
  - 3. Any rash is present
  - 4. Patient has swollen glands and/or if exudate present
  - 5. Patient is experiencing difficulty swallowing

**B. Nursing intervention:**

1. If patient has sore throat and none of the above is present, offer one of the following (if no contraindication):
  - a. Acetaminophen 325 mg – 2 tablets p.o. b.i.d. x 3 days p.r.n. (D.O.T.)  
OR
  - b. Ibuprofen 200 mg – take 2 tablets p.o. b.i.d. x 3 days p.r.n. (D.O.T.)
  - c. Warm salt water gargle p.r.n.
2. Dispense 18 throat lozenges or other cough drops with instructions to use a lozenge every 2 hours p.r.n. for symptoms

**C. Patient teaching:**

1. Gargle and medication instruction
2. Increase fluids

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or persist

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## Stomach Ache (Abdominal Pain)

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Abdominal pain is acute or chronic localized or diffuse pain in the abdomen.

Common conditions causing abdominal pain that may require surgery include appendicitis, acute or severe and chronic diverticulitis, acute and chronic cholecystitis, cholelithiasis, acute pancreatitis, perforation of a peptic ulcer, various intestinal obstructions, abdominal aortic aneurysms, and trauma affecting any of the abdominal organs.

Gynecologic causes of acute abdominal pain that may require surgery include acute pelvic inflammatory disease, ruptured ovarian cyst and ectopic pregnancy. Abdominal pain associated with pregnancy may be caused by the weight of the enlarged uterus, rotation, stretching or compression of the round ligament, or squeezing or displacement of the bowel. Uterine contractions associated with labor may produce abdominal pain.

Non-abdominal causes of abdominal pain include myocardial ischemia, pneumonia, nephrolithiasis, diabetic ketoacidosis, various toxic exposures/ingestions, and electrolyte abnormalities.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. Onset, duration and location of the pain?
2. Describe the pain (i.e., burning, aching, knife-like, cramping, etc.). Rate on a scale of 1–10.
3. When was last BM? Any blood or black, tarry stool noted?
4. Is pain accompanied by any nausea, vomiting, diarrhea, or constipation? If yes, refer to these protocols as well.
5. Is pain accompanied by any urinary discomfort, frequency, or hesitancy? Any penile or vaginal discharge?
6. Are you experiencing any chest pain, SOB, back pain, weakness?
7. Is the pain related to food intake?
8. Is this the first occurrence, or do you have a history of previous similar episodes (i.e., ulcer disease)?
9. What medications do you take?
10. Do you have any allergies to medication?

## II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Observe appearance for and note any paleness, diaphoresis, and expressions of pain
  3. Note level of consciousness and orientation
  4. Note appearance of abdomen (obese, distended, rigid, bruised, or otherwise discolored)
  5. Note presence or absence of bowel sounds
  6. Note if patient appears in severe pain (cannot stand erect, drawn knees to abdomen when lying down)
  7. Is pain produced or elicited or exaggerated by very gentle abdominal palpation
  8. Presence of vaginal discharge or bleeding
  9. Check abdomen and note distention, rigidity, organomegaly, guarding

## III. ASSESSMENT

Alteration in comfort

## IV. PLAN

- A. MD/PA/NP referral by nurse:
1. Temperature > 101°F, pulse < 60 or > 100, blood pressure < 100/60 or > 160/100, respirations < 10 or > 24
  2. Pale, discolored or clammy skin
  3. Severe, localized or generalized pain
  4. Genitourinary symptoms, chest pain, SOB, back pain
  5. Diagnosis of renal, liver, or heart disease, diabetes, or HIV
  6. Abnormal vital signs
  7. Bloody or black stool
  8. Vomiting
  9. Abdominal firmness, rigidity, discoloration, or distention
  10. Absent bowel sounds
  11. Pain present x 24 hours
  12. RLQ pain or pain that continues despite treatment protocol implementation

**B. Nursing intervention:**

1. If vital signs are WNL, pain is minimal and there is no nausea or vomiting:
  - a. For upset stomach: Give Maalox/Mylanta 30 cc p.o. q.i.d 1 hour pc and hs x 3 days p.r.n.
  - b. For diarrhea: Pepto-Bismol 15 ml (1 tsp) every hour p.r.n. diarrhea; up to 8 doses in 24 hours.
  - c. For constipation: Milk of Magnesia 30 cc in a glass of water; may repeat x 1 in 12 hours p.r.n.
  - d. For fever > 101°F, Acetaminophen 325 mg, 2 tabs, t.i.d. x 2 days (D.O.T.)

**V. FOLLOW-UP**

Return to sick call if symptoms persist or worsen

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## Testicular Pain/Swelling

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Testicular pain/swelling may be caused by an infectious process (orchitis, epididymitis abscess), fluid collection (hydrocele, hematoma), or torsion resulting in strangulation and ischemia. Torsion is an emergency and if not promptly recognized may result in orchiectomy.

### I. SUBJECTIVE

- A. Ask the patient and document the following the record:
  - 1. How long has it been swollen?
  - 2. Has this pain or swelling occurred before?
  - 3. Have you experienced any recent trauma?
  - 4. Have you experience any dysuria?
  - 5. Are you having any pain? If so, did the pain begin gradually or abruptly?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Any gross swelling/enlargement
  - 3. Warmth/erythema of scrotum sac
  - 4. Signs of acute distress
  - 5. Presence of testicular pain or tenderness

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

- A. MD/PA/NP referral by nurse:
  - 1. Immediately if acute onset of pain
  - 2. Urgent MD sick call if insidious onset of pain
  - 3. Routine referral for all others

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## Toothache/Dental Complaints

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A toothache refers to pain in the tooth, usually caused by caries that have extended into the dentin or pulp, or by trauma, causing dislodgement or fracture.

### I. SUBJECTIVE

A. Ask the patient and document the following in the record:

1. Describe onset, duration and location of pain.
2. Describe the pain.
3. Are you experiencing sensitivity to heat, cold or air?
4. When was your last dental exam or treatment?
5. Any restriction in jaw movement?
6. Any recent trauma in the area?

### II. OBJECTIVE

A. The nurse should examine the patient and document the following in the record:

1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
2. Note any swelling, bleeding, discharge, foul smell

### III. ASSESSMENT

Alteration in comfort

### IV. PLAN

A. MD/PA/NP and/or dental referral by nurse:

1. Facial swelling is moderate to severe and/or temperature is > 101°F
2. Any severe, continuous, uncontrolled bleeding
3. A tooth is avulsed – out of mouth < 2 hours
4. A tooth is displaced – out of place, still in socket
5. Discharge
6. Foul smell
7. Restricted jaw movement or s/p trauma
8. Be prepared to activate EMS if facial swelling is extreme, swelling under tongue or throat is present and/or airway is compromised or threatened

## B. Nursing intervention:

1. Topical cold compresses
2. Salt H<sub>2</sub>O rinse p.r.n.
3. For relief of discomfort, may offer:
  - a. Acetaminophen 325 mg – take 2 tablets p.o. b.i.d. p.r.n. x 6 days  
OR
  - b. Ibuprofen 200 mg – take 2 tablets p.o. b.i.d. p.r.n. x 6 days
4. INSTRUCT PATIENT TO SWALLOW ORAL MEDICATION AND NOT TO PLACE MEDICATIONS DIRECTLY ON THE TOOTH OR GUMS
5. REFER TO SPECIFIC COMPLAINT FOR TREATMENT PROTOCOL:
  - a. ORAL BLEEDING
    - i. Have patient bite on 2x2 gauze pad for 20-minute intervals until bleeding stops
    - ii. Keep patient's head elevated
    - iii. May apply ice pack to site
    - iv. Instruct patient against:
      - Spitting (patient may allow any blood in mouth to passively drip into cup)
      - Sucking through straws
      - Drinking carbonated drinks
      - Rinsing out mouth
      - Chewing on gauze pads
      - Excessive talking
      - Strenuous exercise
    - v. If bleeding continues, return to clinic or notify nurse

## b. TRAUMA

## i. Fractured tooth

- Refer to dentist on next dental clinic day
- Advise patient to avoid area when chewing or drinking hot/cold liquids

## ii. Displaced tooth (still in socket, but out of place)

- Instruct patient to reposition tooth to correct position if not already done
- Instruct patient to hold tooth in place
- Refer to physician for tetanus evaluation within 48 hours

## iii. Avulsed tooth (out of mouth/socket &lt; 1 hour)

- Instruct patient to replant tooth at site of injury by gently easing tooth into socket
- Instruct patient to hold tooth in place
- Refer to physician for tetanus evaluation within 48 hours
- Dental referral next clinic

## iv. Avulsed tooth (out of mouth/socket MORE than 1 hour)

- DO NOT replant tooth
- If still bleeding, have patient hold 2x2 gauze in place for 2-minute intervals until bleeding stops
- Schedule dental evaluation on next dental clinic date

## c. INFECTION OR TOOTHACHE

If pain is constant, throbbing, swelling is present next to tooth only or mild facial swelling, and no fever is present, refer to MD/DDS for evaluation within 24 hours

## d. BLEEDING GUMS

For non-emergent condition, refer chart to dental department the next day for evaluation

## C. Patient teaching:

1. Avoid extreme hot or cold substances
2. Use of medication
3. Need for follow-up by dentist in 3 days if no relief of symptoms

**V. FOLLOW-UP**

Need for follow-up by dentist in 3 days if no relief

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## Urinary Tract Infection (Bladder Pain – Blood in Urine)

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Cystitis is the most common urinary tract infection and is characterized by urinary urgency, frequency, hesitancy, dysuria, and/or hematuria. It occurs in the lower urinary tract (the bladder and urethra) and nearly always in women. In most cases the infection is brief and acute and only the surface of the bladder is infected. In some cases, the infection may progress to involve the upper urinary tract.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Are you experiencing any burning sensation during urination or low back pain?
  - 2. Are you experiencing frequency in urination?
  - 3. What color is the urine?
  - 4. Has there been an unusual odor to your urine?
  - 5. Have you experienced any chills or fever?
  - 6. Do you have any difficulty in voiding?
  - 7. Do you have bank/flank pain?
  - 8. Are you experiencing any discharge from vagina/penis?
  - 9. Date of LMP?
  - 10. Have you had any past urological procedure?
  - 11. Known congenital urological anomalies (horseshoe kidney, polycystic kidney disease, etc.)?
  - 12. Are you diabetic or immunocompromised?
  - 13. Current medications?
  - 14. Do you have any known allergies?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Examine abdomen and note distention, back tenderness
  - 3. Note skin appearance: normal, flushed, cyanotic, gray, jaundiced, pale, bruises, petechiae, hematoma
  - 4. Note skin turgor: normal, tenting
  - 5. Obtain a urine specimen and perform a dip-stick examination
  - 6. Urine pregnancy test for females unsure of LMP and/or possibly pregnant
  - 7. Obtain UA (urinalysis)

### III. ASSESSMENT

- A. Alteration in health status
- B. Alteration in comfort

**IV. PLAN**

## A. MD/PA/NP referral by nurse:

1. If patient has temperature > 101°F
2. The patient is > 40 years old
3. Distended abdomen apparent
4. Patient is experiencing difficulty in voiding
5. Hematuria is present
6. Significant vaginal or penile discharge is present
7. Patient is experiencing back pain or other acute discomfort
8. Symptoms have been present more than 36 hours
9. Urine is dark, contains blood, or has a foul odor, contact Physician for same-day treatment or Physician orders
10. If gonorrhea, chlamydia, or syphilis is suspected

## B. Nursing intervention:

1. Advise to drink at least 8 glasses of water daily
2. Advise to void q. 2–3 hours during the day
3. Instruct in personal hygiene to prevent bacterial infection
4. Give Acetaminophen 325 mg 2 tabs p.o. b.i.d. p.r.n. x 6 days  
OR
5. Ibuprofen 200 mg 2–tabs p.o. b.i.d. p.r.n. x 6 days

## C. Patient teaching:

1. In addition to nursing intervention instructions, advise inmate to submit a medical request form if discomfort or symptoms persist after treatment regimen initiated.

**V. FOLLOW-UP**

Return to sick call if symptoms worsen or fail to improve after treatment regimen completed

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## Vaginal Yeast Infection “Candidiasis”

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An infection of the skin or mucous membrane with any species of candida but chiefly candida albicans. Usually localized in skin, nails, mouth, vagina, vulva, bronchi, or lungs but may invade the bloodstream. Chief complaint of the patient normally involves a white or yellow vaginal discharge with pruritis.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. When did symptoms begin?
  - 2. Describe vaginal discharge, itching, burning, foul, or fishy smell?
  - 3. Is there any possibility that you may be pregnant?
  - 4. Recent medical history – have you been on antibiotic therapy?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Note discharge if present: odor, consistency, and color

### III. ASSESSMENT

Alteration in comfort level

### IV. PLAN

- A. Nursing intervention:
  - 1. Miconazole nitrate vaginal cream 1 applicator full q.h.s. x 7 days
  - 2. If signs and symptoms persist after 7 days, refer to MD
- B. MD/PA/NP referral by nurse:
  - 1. If signs and symptoms persist after completion of the above treatment
- C. Patient teaching:
  - 1. Medication use
  - 2. Good perineal hygiene
  - 3. Importance of follow-up in sick call if symptoms persist

### V. FOLLOW-UP

Return to sick call if symptoms persist following protocol

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## Varicose Ulcers/Venous Insufficiency

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Decreased blood flow through the periphery causing a breakdown of the skin and/or ulcer formation due to lack of oxygen.

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
  - 1. Are you experiencing pain at the ulcer site?
  - 2. Do you have a history of varicose veins, thrombophlebitis, and IV drug use?
  - 3. Do you have a history of congestive heart failure?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record
  - 1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  - 2. Check for swelling, redness, heat, and drainage
  - 3. Check Homan's sign

### III. ASSESSMENT

Altered health maintenance

### IV. PLAN

- A. Treatment:
  - 1. Refer to MD

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## Warts

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Warts are a skin manifestation of a viral infection, usually of the extremities (i.e., fingers, hands, etc.)

### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. How long have you had the wart?
  2. Describe locations of all current warts (if genital warts, inquire as to sexual history)
  3. Have you ever been evaluated/treated for this before? If so, what treatment did you receive, and was it effective?
  4. Do you have history of diabetes?
  5. Have you noticed any change in the wart (size, color)?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respirations, blood pressure, O<sub>2</sub> Sat, and weight
  2. Note location and size of wart

### III. ASSESSMENT

Altered skin integrity

### IV. PLAN

- A. MD/PA/NP referral by nurse:
1. All genital warts
  2. Warts that change in size and/or color or are present on multiple sites
  3. Patient is diabetic with a significant wart
- B. Patient teaching:
1. Procedure for application of medication, if applicable
  2. Follow-up by physician if no improvement after 14 days

### V. FOLLOW-UP

Return to sick call if symptoms worsen or persist.

## Wound Care

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### I. SUBJECTIVE

- A. Ask the patient and document the following in the record:
1. Do you have known allergies?
  2. Have you ever been diagnosed with diabetes?
  3. When did you first notice wound?
  4. How long have you had it?
  5. Was it caused by an injury?
  6. How have you been treating it?
  7. Is it painful?
  8. Have you ever been diagnosed with MRSA?
  9. Was this caused by a bite?

### II. OBJECTIVE

- A. The nurse should examine the patient and document the following in the record:
1. Temperature, pulse, respiration, blood pressure, O<sub>2</sub> Sat, and weight
  2. Location of wound
  3. Edges of wound approximating well?
  4. And drainage present and description of drainage; amount, color, consistency, odor
  5. If wound is located on an extremity check pulses.

### III. ASSESSMENT

Altered skin integrity

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**IV. PLAN**

## A. MD/PA/NP referral if:

1. Notify provider immediately for any cut or laceration > 1/2-inch long in which you can see fat or deeper tissues (muscle or bone)
2. Notify provider immediately if bleeding is brisk or blood spurts with heartbeat or does not stop after 10 minutes
3. Notify provider for wounds accompanied by temp, foul smelling drainage, or other indication of infection
4. Notify physician during daylight hours if there is still dirt and debris in an abrasion after your best attempt at cleaning the area
5. Notify provider during daylight hours if any redness extending from the wound after 2 days or yellow drainage from the area
6. Refer patient to next provider clinic if wound has been apparent for 1 week without signs of healing
7. Chart review by provider for all diabetic foot wounds

## B. Nursing intervention:

1. Cleanse wound by flushing with saline. Cover with sterile Telfa dressing treated with antibiotic ointment.
2. Ibuprofen 200 mg 2 tabs b.i.d. p.r.n. for pain x 5 days.

**V. FOLLOW-UP**

Return to sick call if discomfort, redness or drainage increases or as ordered by provider.